Nursing as 'Decent Work': Questions of 'Rights' and 'Equity' in Care Profession

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Table of Contents

Abstract of the Study

This study has evolved within a background which is very much typically to Kerala. Kerala has an enviable position when it comes to the number of nurse professionals hailing from this land. There are regions in Kerala, where there is at least one nurse in every household, and most of whom are working abroad, either in the gulf region or in Europe. These households are visibly depended on these nurse members for the income they used to contribute since many decades. Most households even managed to build beautiful houses and started showing signs of financial lavishness over the years, with the money that these nurses managed to accumulate with their services abroad.

In the initial stages of immigration, which happened around the 1980s, everything was indeed looking pretty with most of them managing to go either to America or to the gulf regions. In the next phase, which happened between the 1990s and 2010, the predominant direction of immigration was to the European countries, like Austria, Switzerland, U.K, Ireland, and Australia. Some opted to be in Asian region itself, like Singapore. Afterwards, the scenario suddenly started to change. Although, the nurses' number continued to increase following the relaxation of norms in the context of admissions for nursing education, and also with the mushrooming of nursing schools and colleges all over, the number who manages to immigrate came down significantly. The reasons were numerous. It includes the outburst of religious fundamentalist conflicts in regions like Middle East, and the changes in immigration laws and policies in the European countries and so on. The most serious consequence was that, within the country itself, the attraction of nursing profession started to come down. Even those who got appointed started feeling the pulse of a declining prospects and many started to remain even jobless at home as the salary structure was not at all attractive. This was indeed quite an eye opener for many, and some resorted to unionise and stage protest movements.

The events attracted the attention of scholars and planners from different backgrounds. The government also took some interest and constituted committees to look into the disturbing events in this sector. The study reports were submitted. Nothing much has happened afterwards. The nurses continue to face a lot of agony and pain. Large majority of them are very much underpaid and subjected to exploitative working conditions.

This research was formulated with the objective of documenting this situation. The study was framed under the logic of an evaluative objective of assessing the working contexts of the nurse professionals in Trivandrum region based on the theme of Decent Work Agenda,

proposed by International Labour Organisation (ILO). This theme was evolved by ILO as a tool of self assessment and monitoring to ensure certain standardization of the status of labour, especially in the informal sector. The theme was evolved around ten basic parameters.

The present research, adopted these parameters as the variables for assessment of the labour status of nurse professionals in the private and public sectors within a comparative framework. The results of the study show that, the parameters are largely missing from both the private and public sectors, although, the situation in the public sector is a little better with regard to some parameters. The study also points to the problem of increasing informalisation of nursing labour and argues that, the most fundamental consequence of all these is an ever decreasing 'quality of care', in Kerala's health sector.

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List of Tables

List of Figures

List of Abbreviations

MMR	**Maternal Mortality Rate**
CMR	**Child Mortality Rate**
DHS	**Directorate of Health Services**
DWA	**Decent Work Agenda**
WHO	**World Health Organisation**
ILO	**International Labour Organisation**
UNICEF	**United Nations Children's Fund**
KNMC	**Kerala Nurses and Midwife's Council**
INC	**Indian Nursing Council**
GNM	**General Nursing and Midwifery**
INPA	**Indian Nurses Parent's Association**

CHAPTER 1

INTRODUCTION

Introduction

The health care system in Kerala has always been a widely appreciated model since many decades. This was indeed a reflection of the priorities that Kerala had always placed on the health status of its population. As Oommen states, 'ever since the Thiruvitamkore- Kochi and Malabar regions of the British Madras Presidency came together to form Kerala as a state, based on the policy of linguistic reunification of states in 1956, various governments have focused on social sector developments, including that of health (1999) This model status was also instrumental in attracting the academic and political discussions on Kerala about its achievements in health care system.

The initial discussions of this happened around the theme of 'Kerala Model of Development.' Within that framework, it always appeared along the positive graph and Kerala was praised for its achievements in the health indices like family welfare, low maternal mortality rate (MMR), low child mortality rate (CMR), high rate of expectancy of life, near total immunization and the like. The scenario was that Kerala was ranked among the most developed regions of the world, for instance, the Scandinavian countries.

The statistics still support these claims. The region of Kerala remains in stark contradiction with the national averages in almost all health indices even today. The CMR in Kerala is just two per thousand in contrast to the national average of fifteen per thousand and neo natal mortality rate of Kerala is a meager seven when compared to the national average of thirty five. The mortality rate of children under five years of age of Kerala is numbering just fourteen, while the country as a whole is still above

seventy. Maternal mortality rate vary as 66.00:178.00 while the perinatal mortality rate variation is 13:35 between Kerala and India. (DHS report, 2013). A quick look at the table below would give us more clarity on these remarkable achievements. The table contains only the statistics on selected variables and it is compiled from the DHS Report 2013.

Table 1.1: Comparison of Vital Health Indicators of Kerala and India

Sl No	Indicator	Location	Kerala	India
1	Birth Rate	Rural	15.10	23.10
		Urban	14.20	17.40
		Total	**14.90**	**21.60**
2	Death Rate	Rural	7.00	7.60
		Urban	6.50	5.60
		Total	**6.90**	**7**
3	Infant Mortality Rate	Rural	13.00	46.00
		Urban	9.00	28.00
		Total	**12.00**	**42.00**
4	Child Mortality Rate	Rural	2.00	17.00
		Urban	2.00	9.00
		Total	2.00	15.00
5	Under Five Mortality Rate	Rural	14.00	76.00
		Urban	12.00	43.00
		Total	14.00	69.00

Source (Compiled from the Directorate of Health Services Report, 2013, pp;40-41)

The table amply manifests the extraordinary position of Kerala in its health sector achievements. This is not to say that, Kerala's health sector has no problems to worry about at the moment. Notwithstanding these achievements, the discussions on the health care system of Kerala cannot simply overlook some of the deep rooted problems that still remain and also some of the emerging problems, which are posing serious threats to the age old status mentioned above. Because, this sector is indeed having multiple dynamics, all of which cannot be reduced down to a couple of statistical details alone. There are a variety of emerging concerns which include, issues of frequency of spreading epidemics like fevers of several variety, decreasing levels of nutrition status, particularly among the marginalized sections like the tribals, growing incidence of life threatening diseases like cancer, diabetics and many other lifestyle related risks and even of possible epidemic threats resulting from the near total absence of waste management programmes etc,. The irony is that all these are happening at a time when the health care systems are going through an unprecedented scale of expansion especially in the private sector in Kerala. This raises a number of very pertinent questions like the sustainability of our health indices as well as that of enabling the machinery to cater to the emerging challenges of commercialization of this sector, which has already started the process of converting the service of health care as an industry. How it has transformed the quality of our health care system has already evolved as a dominant concern for everyone in Kerala and especially for the policy makers.

At the same time, the impact of these changes on the health professionals as such is hardly a point of enquiry to many in this sector. Obviously, this also requires a deeper examination as they form the backbone of this sector and unless their wellbeing is ensured, there can never be any prospect of a healthy, health care sector. The present research is conceived against this backdrop, and it is focused on one of the primary stakeholders, the nurse professionals, who are being adversely affected by the above mentioned changes. Nurses are the prominent constituents among the health professionals and no one can even imagine this sector without looking at the professional roles fulfilled by them.

Nurses of Kerala are a widely known professional group, all over the world. They comprise one of the largest segments of women migrant labourers, to the Middle East, and Europe as well as to the other regions in India, especially to the metros, Mumbai and New Delhi. In spite of this size, their presence in those regions was, however, not so much noticed until the last five or six years. In fact, they became visible only with the outbreak of a series of protests, staged against the inhuman policies of some of the private hospital managements in and around Delhi. Suddenly they attracted the attention of national media and the general public in an unprecedented manner. That made the movement quite effective and as Sreelekha (2016) argues, 'contributed a lot to the improvement of their visibility.' Although, a large majority of those who participated in these movements were nurses from Kerala, however, the situation within Kerala still remained the same, uninterrupted by the dynamics elsewhere in the country. The most apparent anomaly here is that, Kerala has always been known for the militancy of its labour force and the labour movements have always had a decisive role in transforming the work culture of Kerala. Still, the nurses of Kerala almost as a whole remained insulated from all those events in the surroundings. The question is why? This is despite the enormity of a variety of ill-treatment from many corners. Why the nurses of Kerala still remain an unorganized segment till date? Why they are denied of even the bare minimum rights entitled to them, although, they are themselves working hard to protect and ensure the wellbeing of all of us who are in need of their service?

Obviously, there is a need to address these questions without any further delay as the things are indeed taking a very problematic direction. There is hardly any ray of hope as the growing process of privatization of health care, along with that of the evolving global scenario of informalisation of labour are resulting in a near total elimination of their bargaining capacity in the job market. The large population of Nurses in Kerala has been affected by this transition in a very big way and, very slowly, although, they too are making efforts to come out in the open. In other words, there are signs of protests taking shape from all corners in Kerala.

Very recently they managed to join together in the state capital demonstrating their protest on the 25th of February, 2016. Still the question is do they need to keep knocking at our doors to secure their basic rights as a labour segment? How far can the system be blindfolded at a time when there are widespread imageries of their vulnerabilities everywhere? Is it in anyway going to promote our prospect of a quality health care, at a time when the sector as such is being transformed in to the logic of commercial considerations?

As everyone knows, Nurses of Kerala are not simply one labour segment in Kerala. It is their remittance money send by those nurses working abroad, in Middle East or European countries, which forms the backbone of the economy of Kerala. More significantly, from a social point of view, they form the backbone of the care sector, which has lot more importance in the emerging contexts of declining health status. In other words, we need them for our own survival. Hence, there is a need to safeguard their interests too. Although, of late there is a lot of hue and cry bringing to light the manifold issues that this sector is living with, very often, such discussions are focused more on the issues of nurses working abroad, and more specifically during times when the nurses working abroad are forced to return to Kerala due to the insecurities of war or similar other conflicts. The issues of nurses who came back from Yemen, Iraq, Libya, Saudi Arabia, and of late even from United Kingdom, as a result of the changes in their residency rights and work permit are all coming under this category.

There is no denial of the fact that all these are problems to be addressed. Still, are they the only problems as far as this employment sector is concerned? This question indeed demands a detailed investigation as the nurses of Kerala are apparently coming out in the open demanding better treatment. Within the last five years period, there were several movements of protests, organized by this otherwise unorganized category of workers. This is perhaps an indicator of the standards of their work, although, there are hardly any studies carried out to prove these claims.

Statement of the Problem

The present research was framed against this background. The study intended to look at the level to which the standards of their employment meet with international labour status. As is widely known, while the profession of nursing has substantial standardization across most part of the globe, there is hardly any such effort taking place here. The fact is that the increasing privatization is only resulting in a process of informalisation of their labour and in the process being denied of any decent conditions of work. The study also probes into the factors that are generally considered to be determining the conditions of women's work, including the issues of gender, human rights and so on. The fact that, it is women who are largely the members of this workforce, genuinely demands an investigation along these dimensions, as otherwise, there is no common sense explanations available to establish the reasons why such a large scale workforce still remain largely unorganized and unprotected. This becomes very much an anomalous situation considering the widely portrayed radical nature and character of the general workforce in Kerala. Hence the study aim to explore the general working conditions of the nurses in various sectors as a whole and especially in an increasingly privatized health sector in Kerala, using the International Labour Organization's parameters of 'Decent Work Agenda'(DWA).

The concept of 'Decent Work' is conceived as a monitoring framework to deal with the problems of precarious work situations emerging in the global context of informalisation of work. It is constituted around the four basic pillars of rights of the workers, productive employment status, social protection and dialogue. They are visibly important to this segment of labour force, as the nursing profession has

significant contexts of vulnerabilities with regard to all these parameters. Also it is important to recollect here the fact that, Indian state had made several attempts to improve the medical system in general, by setting up various committees, exploring the possibilities of implementing the guidelines and resolutions provided by international agencies like the World Health Organisation (WHO), International Labour Organisation (ILO), and UNICEF. The Government of India appointed several committees to facilitate this process. The recommendations made by such committees, as early as 1943, however, remain unimplemented even today. The 'decent work agenda'(DWA) assumes its significance against this situation.

There are also several other studies carried out pointing to the needs of such policy reorientations. The studies like that of the, women migrant labourers engaged in the domestic work conducted by, V V Giri National Labour Institute, Delhi, (2012) has highlighted this problem in a big way. As they argue, there is a fundamental requirement of framing new programmes and policies to cater to the needs of such increasingly feminized segments of labour as, they are otherwise, kept in silence, using the weapons of stigma and stereotyping. As is widely known, this segment is largely occupied by women workforce and the fact that they are largely coming from a particular socio-economic background, demands that it is monitored and assessed using international labour standards. This is the only possible way in which, the issues of precariousness of labour, which is normally attached to such sectors could be tackled.

Significance of the study

The private health sector in Kerala has grown very significantly, when the successive governments withdrew their investment due to fiscal strain. Currently the private sector accounts for more than 70% of all medical facilities and 60 % of all hospital beds in Kerala. The types of ownership range from corporate to single proprietor. They vary in sophistication from single doctor hospital to multi-specialty hospitals and have become the preferred providers for the affluent and the middle class. Eyeing at the large scale profit, possibly of hospital industry, huge investments has began to flow into Kerala. Both emigrant business groups from Kerala, as well as investors from outside began to concentrate on this industry of Kerala. As argued by Biju

(2013) ‘Less state regulations, non-unionization and vast consumer market, made it a favourable condition for the private entrepreneurs to invest in the private health care system of Kerala.’ These investments, however, was done with the sole objective making profit and therefore, did not have any sort of service orientations. The labour force, constituting this sector was left at the mercy of those who made the cash investments and as a result was outside the purview of any protective laws. It is this situation that made them more and more vulnerable to inhuman working conditions and that demands the immediate intervention of the authorities to ensure a decent work status to everyone under this system. Present study may bring to light once again the dynamics that still persist here, so that some reorientation of policies could be facilitated.

Profession of Nursing in Kerala: Statistics in Brief

Majority of nurses in India as a whole are from Kerala. In Kerala, may be as elsewhere, nursing is a profession socially accepted and categorized as a female profession. According to the 2014-15 annual report of Indian nursing council, there are 2,53,925 registered nurses and auxiliary nurses in Kerala, which forms a major share of the total registered nurses in India. To meet the growing demand for nursing education, Kerala has 219 institutes that offer a diploma in general nursing and another 126 that offer a bachelor's degree in nursing, with the bulk of the 13,705 seats falling in the private sector, according to Indian Nursing Council figures. Apart from these, a huge number of nursing aspirants are studying and working outside Kerala.

More than their existence across India, Kerala nurses have a prominent place in the global context too. According to some estimates, the number of Indian nurses in the Gulf is between 40,000 and 50,000 and 90 percent of them come from Kerala. (Sreelekha, Percot and Rajan) Despite this, nurses are largely outside vicinity. Women teachers and doctors are highly visible, and nurses, who are seen as personification of women professionals, are almost completely absent. In this context, the present study analyses the condition of nurses who are working in a formal government sector with possibly all the social protection schemes in combination with that of nurses in private hospitals who are devoid of any such social security in a comparative framework.

Thus the study gives an opportunity to analyse the contradiction existing between the formal and informal sectors.

Chapter 2: Review of Literature

Nursing: the Unseen Profession

Nursing: the Unseen Profession

The topic of this research is not so much a widely studied area in any discipline. As Sreelekha (2012) writes in the introductory section of her book on migrant Malayali nurses in Delhi, … in spite of their widespread presence, … nurses seldom appear in academic debates …. The 'phenomenon of the nursing boom in Kerala' has been explained away without any serious attempt to document their lives…'(p-1) Only limited number of studies has been carried out on this profession. There are, however, very relevant documents evolved through governmental committees like the Balaraman Committee report, Veerakumar committee report and so on. All these reports have been found very helpful to the present research in a very significant manner. They provided the initial insights needed for the study. The Balaraman committee report for instance had identified several areas of concern after the inspections and interactions that they have carried out in hospitals and with the professionals from among the hospitals, all across Kerala. They made fifty major recommendations to the government, based on a very systematic evaluation of the ground realities from all over Kerala in 2012. They provide a very fundamental view of the nature and character of this sector and the researcher has utilized the recommendations in a big way to identify the questions of the present research. Incidentally, they were mostly in line with the criteria of decent work identified by ILO, thereby; substantiate the relevance of the present study in a significant manner. They include the following.

Recommendations of the Balaraman Committee Report

> "Based on the observations and examination of complaints/representations received, the committee places the following recommendations for the consideration and implementation by the Government" (pp 23-31).

1. The committee recommends that the Government may give strict directions to the hospitals to appoint candidates having prescribed qualification (General Nursing and Midwifery/B.Sc Nursing) and registration with Kerala Nurses and Midwives Council (KNMC) as nurses. Stringent action may be taken against hospital authorities violating these norms.

2. It is desirable to conduct a pre-registration examination by the KNMC for those who have completed their nursing program outside Kerala. The nursing council may be entrusted with this responsibility.
3. The Kerala Nurses and Midwives Council shall issue Identity Card for nurses with RN RM numbers
4. All private hospitals should ensure an organized nursing service department with a qualified and experienced Nursing Superintendent, an administrative office, ministerial staff, equipment, machinery, supplies, communication and documentation system
5. Those nurses having basic qualification may be appointed through a formal written examination, skill test and interview by an expert committee in nursing. The government may adopt steps to make policies of recruitment, selection and placement process of nurses in private sector through an authorized body under the Dept. of Health and Family welfare.
6. The hospital authorities may be directed to issue appointment order specifying the terms and conditions of service
7. Appointment of various nursing personnel such as Nursing officer, Nursing Superintendent , Nursing Supervisor, and Head Nurse may be strictly based on INC norms
8. Appointment of nursing personnel in higher cadre may be based on their qualification, years of experience and performance appraisal.
9. As per INC norms nurses with additional qualification in nursing, may be given weightage in terms of increment. For those with post basic diploma in specialty nursing of one year duration one additional increment, with basic/post basic B.Sc degree in nursing, two additional increments and with post graduate degree in nursing, three additional increments may be given.
10. Considering the existing reservation for admission to GNM programme by INC, twenty percent of the vacancies in a hospital may be filled with male nurses.
11. Availability of senior nursing personnel in each ward may be ensured for guidance and supervision of staff for safe practice and quality assurance.
12. Specific uniform code shall be maintained for all the nurses working in different private hospitals in Kerala. All other category of hospital staff shall be prohibited from using similar uniform.

13. Urgent steps may be taken by the Government to review the existing job description of various categories of nursing personnel and made available for ready reference of the staff.
14. The eligibility of the nursing staff for the post of Head Nurse shall be minimum 8 years of clinical experience as staff nurse for Diploma nurses (GNM) and minimum 5 years of clinical experience as staff nurse for Graduate nurses.
15. State service rules may be followed for the nurses working in the private hospitals also with regard to regularization of service, declaration of probation, promotion, other service benefits and disciplinary procedures.
16. All institutions shall keep various records of all nursing staff which include personal, professional, health and service records in the Nursing Service Department.
17. The administration shall ensure a harmonious and conducive working environment in the hospital.
18. The nurse- patient ratio shall be maintained as per the INC norms
19. Three shift systems with maximum 8 hours duty may be introduced immediately and implemented in a full fledged manner within a period of 3 months.
20. Weekly working hours of staff shall be limited to 48 hours and extra working hours may be documented and compensated either by leave or by extra emoluments.
21. The night duty shall be scheduled in such a way that each nurse is assigned not more than 6 days night shift per month with an eligible night off and weekly off.
22. Leave benefits shall be ensured: Casual leave -12, Annual leave-12, Sick leave-12 and Public holidays-13 may be sanctioned for all category of nursing staff. Compensatory off shall be given whenever they are engaged on holiday duty.
23. Well equipped nurse's station with adequate supplies, equipment and personal protective equipment shall be made available in the wards for safe practice.
24. Adequate basic facilities such as safe changing room with dining and toilet facilities for male and female staff, sick room, transportation at odd hours of duty shifts, quarters and subsidized canteen facility shall be ensured for nursing staff.

25. All qualified and registered nursing personnel working in the private hospitals may be provided with a basic salary as proposed.
    - HRA and CCA: As per the location of the hospital and rate fixed by the government.
    - Uniform allowances: Rs.1000/- per annum
    - Bonus: one month salary for the nursing staff drawing basic salary up to Rs.15000/-
    - Festival allowance: Rs.1000/- annum for the nurse employee drawing basic salary above Rs.15000/- per month
    - Special/risk allowance-Rs.500/- per month.
    - Night shift allowance: Rs.50/- per night
    - Overtime allowance - Rs.150/- per hour.
26. Monthly salary shall be disbursed through banks before the 5th of every month.
27. If nurses are eligible for ESI and EPF benefits they shall be enrolled on time and communicated to the concerned.
28. Medical benefits - initial and annual medical checkup, investigations and treatment, protective vaccinations and maternity benefits may be extended to eligible candidates from the same institution free of cost.
29. Incentives and rewards may be given for special achievements and outstanding performances
30. Employee may be allowed to resign and relieve from the institution with one month prior notice.
31. The hospitals shall appoint sufficient number of supporting staff such as nursing assistants, attendants, housekeeping staff and other class IV employees and the nurses shall be completely relieved from non- nursing activities to maintain smooth and efficient patient care services
32. There shall be specific uniform with colour code prescribed for the supporting staff and they shall wear identity card while on duty.
33. The supporting staff shall be brought strictly under the purview of the Minimum Wages Act.

34. The different categories of supporting staff also require serious consideration with regard to job description, working conditions, medical benefits and remuneration.
35. Orientation/ induction program for 4-6 weeks shall be conducted for newly appointed staff nurses.
36. In-service education program shall be conducted on regular basis by the hospital for the nursing personnel for updating their knowledge and skills to ensure safe delivery of nursing care.
37. Opportunities may be given to attend 30 hours of in-service education per year which is mandatory for the renewal of registration every five years as prescribed by INC.
38. Regular performance appraisal shall be done for all the nursing personnel and supportive interventions and training arranged as required.
39. Bond and posting of nurses as trainee/observer without adequate remuneration is illegal and against INC norms. Such practices existing in some of the hospitals shall be stopped forth with.
40. Government may establish a system for ensuring the compliance to the above recommendations by the hospital authorities.
41. Registration of all health care institutions in the state may be made mandatory. The health care institutions which are under the Kerala Shops and Commercial Establishment Act 1960 and rules 1961 at present have to be brought under the purview of Clinical Establishment Bill which is under consideration of the Government.
42. Classify and Grade the private health care institutions, according to the facilities and services offered to the public.
43. Urgent steps may be initiated to amend Kerala Nurses and Midwives Council Act 1953, the draft of which is under review by the Government.
44. Legislation may be made at State and National level stipulating salary and service conditions of different category of nurses.
45. State and District level Grievance cell may be formed consisting of local members of the public, nurses' association representatives, senior nursing officials, government nominees, and nursing council representatives.

46. Action may be taken to cancel registration/affiliation against those hospitals who appoint staff nurses withholding original certificates, demanding deposits/bond and withholding experience certificate which is against Hon. Supreme Court Verdict and Nursing Council/ Government directions.
47. Urgent steps may be taken to wipe out unrecognized institutions conducting training and issuing fake certificates in nursing.
48. The Government may take necessary steps to establish a Nursing Directorate under the Department of Health and Family Welfare, as directed by the Govt. of India to streamline the administrative and academic control, service conditions, remuneration, and career prospects, moral and ethical behavior and practice standards of nurses.
49. The government may take an interim measure for declaring moratorium for the repayment of educational loan at least for one year or till a stable source of income is ensured, to the deserving candidates. The government may also consider waiving off such educational loans or reducing the EMI or make the loan interest free.
50. The committee strongly recommends that the income and expenditure in hospitals shall be properly accounted and audited.

Each of the recommendations was based on their assessment of the conditions that prevail here and was therefore fundamentally related to the topic of this research too. The terms of reference of this committee was focused on the seven most important aspects of the nursing sector and they include the nature of job specification, job description, working environment, remuneration and other benefits, support staff availability, bond/contract conditions, and prevalence of in-service training. All these aspects were looked at in great detail and the report, therefore, deserved a thorough evaluation from the point of view of this present research too. It is already four years since the commission had submitted its recommendations. Hence, it is still very important to have a re-examination of their terms of reference yet again to see if at all there are any changes happening to the context of work of nurse professionals.

Veerakumar Committee report

Equally important, although, a bit limited in coverage, was another report prepared under the Labour department initiative to study the working hours of nurses, (Veerakumar committee, 2013) This study was more focused on the working contexts of nurses in the private sector. However, the committee had sought the opinions of all categories, including the management and has also attempted to make a viable set of proposals catering to the concerns of both the nurse professionals as well as that of the management. This include recommendations like, giving directions to the management to abide by the instructions of the government, calling for a comprehensive law covering the service conditions of the nurses, maintaining a prescribed a staff strength, especially sufficient number of qualified nurses as identified by the Indian Nursing Council, ensuring the payment for overtime duty, and a proposal for fixing the working hours as 6-6-12 hours within the following pattern of

Morning Shift- 7.30 A.M to 1.30 P.M

Evening Shift- 1.30 P.M to 7.30 P.M

Night shift - 7.30 P.M to 7.30 A.M

They also made a very significant observation that, while fixing this pattern, the night shift employees should be given 4 hours of rest, although their services could be utilized when the situation so warrants. Here again, the recommendations are all apparently based on an understanding that, there are very serious discrepancies that are widely prevalent across the state in terms of all these issues. The committee has made several critical observations against the claims raised by the managements too.

Although, it was mentioned above that the nurse's issues are not widely discussed in any discipline, still it is not something totally alien to academic analysis either. Several scholars from very different backgrounds have made certain significant efforts to capture their problems since some time. This includes the studies made by scholars from various disciplinary backgrounds like, Economics, Women studies, Sociology, Demography and so on. Reference can be made to the works of Oommen (1978), Roberts & Rajan (2007), Kodoth &Varghese (2012), Biju (2013) Sreelekha (2012) Sreelekha & Percot (2015) et al. Some of them have also studied the latest protest movements among the nurses community in various parts of India (Sreelekha

(2016), Biju(2013) et al.). Most of these studies were pointing to the miseries of this community of work force. What was more striking here is the fact that, the governmental authorities themselves have made several attempts in the form of committees constituted under the leadership of prominent personalities starting from 1943-1946, Sir Joseph Bhore, known as Bhore Committee to look into these issues and have made several recommendations, many of which are, as Sreelekha claims, still unimplemented. The following table would give us a historical view of the other different attempts made in this manner

Table 2. 1 List of important health related committees constituted in India

Name	Year	Recommendations	Implications on Nursing
Bhore Committee	1946	Establishment of degree courses for nurses, fixing of doctor: nurse ratio	Became the major basis for nursing reforms, still many suggestions left unimplemented
Viswanathan	1953	Measures dealing with shortage of nurses	Measures taken, but inadequate
Shetty Committee	1954	Standardization of Nursing across India, Public Health Nursing made part of nursing curriculum	Appointed to look exclusively at nursing
Mudaliar Committee	1961	Grading and specialization of nursing	Implications on hierarchy within nursing
Chadha Committee	1963	Integration of different nursing services	Led to the development of basic health services
Kartar Sing Committee	1973	Advocated the integration of nursing services	--
Shrivastava Committee	1975	Training of voluntary, part time community based workers	Community Health Workers scheme
Bajaj Committee	1986	Increase the number of trained paramedical personnel and health-related vocational courses	A few Health Universities were established

Source: Sreelekha Nair; op cit., p-36

‘These committees, were appointed by the government of India at different times to improve the health sector, Sreelekha opines, and yet the implementation of various measures suggested by the committees and the progress in the sector in general, and the nursing profession in particular, are still incomplete.’ (p-37)This would easily reflect how the different governments have largely stayed away from resolving the problems affecting the nurse professionals, in spite of the fact that, they were all well informed about the seriousness of the problem. Balaraman Committee, as late as 2012, still had the same or similar set of terms of reference as it was the case of committees constituted as early as 1943 or the Shetty Committee of 1954 or the High power committee of 1989. All the committees have pointed to the unscientific nurse patient ratio, inadequate remuneration system and so on. The recommendations were also very much similar. Balaraman Committee, for instance had made a very fundamental proposal for the salary revision of the nurses in various categories as follows

Table 2.2 : Pay and other allowances proposed for different category of Nurses

SL NO.	CATEGORY	BASIC PAY Rs.	INCREMENT Rs.
	Staff nurse	12900/-	250/-
	Senior staff nurse (3year experience)	13650/-	300/-
	Head Nurse	15180/-	350/-
	DeputyNursingSuperintendent	17740/-	400/-
	Nursing Superintendent	19740/-	450/-
	Nursing Officer	21360/-	500/-

The specific recommendation on the basic pay was that it should be made available for all the category of nursing staff in all hospitals irrespective of the location/bed

strength/classification of the hospital etc. Unfortunately, this is not yet found to be followed even in the public sector as even the present study has clearly revealed the fact that, even if we set apart the proposal of dearness allowance based on consumer price index there are clear violations happening even today. The researcher had come across entry grade staff nurses who are literally ill-informed about their salary status, even in the public sector hospital. Maybe it is like, what Sreelekha(2012) poses 'When nurses are "angels," we need not worry about whether they suffer or need the basic things that other human workers do'. The most striking element here is that many of them were even unaware of their terms and conditions of work even after being taken in as a trainee nurses in the public sector. This only substantiate their invisibilities as Sreelekha and Madelaine (2010) has argued in their paper, titled 'A Profession on the Margins: Status Issues in Indian Nursing'. In their words, Indian society tended to view nursing as not only menial and morally dubious, but also as polluting work typical of lower castes… Gender, class, ideology and the practical notions of hierarchy entrenched in Indian society have contributed towards the present status of nursing profession here (p-2).

As Sreelekha further argues (2012), they are denied of their rights to equality and citizenship and she shows how the identities of gender, ethnicity and class, become the sites upon which they get marginalized. Also as it is evident in her study, the nursing profession does not in any way carry an element of social honour and is still quite looked at as a 'dirty profession.' Drawing from Max Weber's theory of status, she shows '… social honour is social in nature and does not mechanically result from a market or property relationship … Thus, even the near universal employability of nurses, which is a positive market situation, does not give them the social honour that they desire.' (p-6) The list of participants in her study is given in the Appendix table and it shows that most of them are quite young and are under the age of 30, belonging mainly to the private sector, and are predominantly having the educational qualification of General Nursing and Midwifery diploma. Indeed, they deserve better professional beginning, because, for them, according to her, 'their profession of 'nursing is more of a life strategy rather than merely a source of livelihood' (p-7) The fact that her study is restricted to the female participants alone, could perhaps be a reflection of the reality that, even in the national capital, the number of male nurses may not quite match up to the female nurses at all.

Biju (2013) gives a slightly different interpretation of the nurses' question, than that of Sreelekha, who was more specifically following a feminist epistemological approach, by linking it with the class dimensions of their problems. The title of the article "Angels Turning Red", itself bears evidence to this shift. According to him, the nurse's strikes indicate the outburst of a politically ignored labour's unrest in the hospital industry. It is the beginning of a different form of class struggle, a demand for a more adaptive and communicative strategy from the established trade unions and the political left (p-25).

Kodoth and Varghese (2012) provide another account of the Kerala Nurses, focusing on their status as members of migrant women groups. This is a comparative analysis, including the migrant nurses, domestic workers and out-migrant fish-processing workers and draws our attention to the critical failure of the social science scholarship to address the question of poor women migrants. It also provides an overview of state policy on migration and underlines its complicity in generating regulatory gaps. Clearly, this argument is quite applicable to the status of such labour segments within the boundaries of our country also as there are no mechanisms regulating over the unorganized labour segments within our state too. As Sreelekha (2016) has vehemently demonstrated, the expediting of the regulatory policies on the private hospital sector is the need of the hour. Quoting from the works of Percot (2006) and George (2000), Kodoth and Varghese, notes that a majority of emigrant nurses from India are Kerala Christians, mostly belonging to the affluent sections of the socially privileged Syrian Christian Community. …nurses experience greater economic mobility than the other segments of women workers. Hence, their experience could provide crucial insights into the nature of agency that emigrant women exercise. Since 1950s, as the numbers of women entering into nursing education grew steadily, it was recognized that they would contribute economically to their families. However, even in the 1990s and 2000, nurses legitimize their mobility in terms of dominant social norms, i.e., "higher" social aspirations embodied in earning for their families. (p-62)

In a similar treatment, Walton and Rajan (2013) examine this process at the structural level and shows how the health professional migration is a significant economic input for Kerala (as well as other Indian states), and that nurses are becoming more and more important as a value added 'commodity' in terms of remittances and the

associated services associated with this migration process. However, … migration begets more migration as debt needs to be fed through subsequent stints overseas, especially if few income generation options exist at home (p-1). The present research has also made a similar attempt to see how the income status of the family could have a bearing on the working condition or the bargaining ability of the nurses working within Kerala. The data clearly shows that, most of them are forced to work with low wages as their salary has a lot of livelihood value for their families too. Walton and Rajan's assessment is based on a re-survey of return nurse migrants and families of emigrant nurses still overseas.

There is no question of the fact that, India's health care system is at a crucial turning point. Obviously, there is no further turn of events that anyone can anticipate as the economic logic is against such a turn. It is already one of the most privatized in the world and our governments are only exploring all possibilities to escape from any further commitments. The increasing role of the private sector and the relative lack of health insurance schemes for the poor is a major concern when it comes to indebtedness, especially those associated with catastrophic medical costs. Against this backdrop, the training and overseas migration of nurses represents a systemic stress factor that may play an indirect role in undermining the ability of the Indian health care system to meet the needs of the most vulnerable sectors of the population. The end result is, the large segment of our health professionals too are left in the dark, and has no clue about the direction they are heading.

The health care sector is increasingly important to the economy of Kerala, but its development is firmly within a market context that is increasingly seen as diverging from the needs of the population, and rather than increasing choice and control in health care, is removing it (Jeffery and Jeffery 2008). The 'marketisation' of health is also evident in the health education system, which has seen a substantial growth in private colleges over the last few years. As a senior faculty member from the directorate of medical nursing education has pointed out in an interview as part of this study, 'it is undermining the very logic of 'quality health care', which was always the motto of our health sector'. Nursing education reflects a similar direction, if not rate, of growth since the criteria for establishing private colleges was relaxed in 2009.

As Biju (2013) says it is true that, in Kerala, in the beginning also, government institutions were few in number and majority of hospitals and clinics were run by the Christian missionaries and the doctor-turned entrepreneurs. It is only from the Third Five-Year Plan (1960s) onwards, the scope of public health system expanded greatly to realize universal healthcare in the state. Nevertheless, since the mid-1980s the profit driven private sector again surpassed the government. Fiscal crisis of the state government and changing health policy of the central government constrained the scope of state intervention in the health sector.

As Srelekha (2010) has argued in yet another paper, *although,* … since independence, many policy measures have been taken to improve the status of nursing ... *still it* has received only a step-motherly treatment within these policies, ... The fact that these initiatives have focused on patient care shifted the spotlight away from the need to improve working conditions of the nursing and other staff (p-24). The situation continues well beyond half a century and even in 2010 or beyond the questions remains the same. To borrow a usage from Oommen (1964) the 'pain of pain removers' are very much there even now.

The problems that exist are quite multidimensional ones. There are questions of class, gender, human rights, decent work, social status, stigma, casteist and rural urban dynamics, all involved. The present study primarily focuses on the 'decent work agenda as well as the 'questions of rights' issues in this context. While, this being the perceptions preexisting, the intriguing question was whether the nurses are still being given the benefits of the protective directions prescribed even by the international bodies ? Obviously, the answer that emerges out of this study is also quite negative. The fact is that, it is reflecting the economic logic of our times much more than it used to in the past. More and more members of the labour force are kept outside of the protective legislative measures, although, the international bodies are asking for the opposite. In fact, the situation in the nursing sector is just that it has further moved from bad to worse and the recent instances of strikes and protest movements among the nurses clearly point to the violation of their rights or more seriously the denial of their basic rights for a 'decent work' situation much more significantly than ever before. They are indeed forced into a precarious work situation, with large scale violation of rights of a worker, be it the issues of working hours, the job prescriptions,

infrastructural provisions, last but most importantly not even a means of subsistence. There are concerns emerging from different corners showing apathy to their causes and agitations. Even the latest agitation staged by the United Nurses Association on February 25th, 2016 was interestingly supported by an association called INPA (Indian Nurses Parent's Association). The demands raised by this association were brought out in the form of a pamphlet, and it reads as follows.

ന്യായമായ ശമ്പളത്തിനുവേണ്ടി സമരം ചെയ്യുന്ന നഴ്സുമാർക്ക്
ഇൻഡ്യൻ നഴ്സസ് പേരന്റ്സ് അസോസിയേഷൻ (INPA)
സംസ്ഥാനക്കമ്മിറ്റി ഐക്യദാർഢ്യം പ്രഖ്യാപിക്കുന്നു

- ഡോ.ബലരാമൻ കമ്മിറ്റി റിപ്പോർട്ട് നടപ്പിലാക്കുക
- നഴ്സുമാരുടെ വിദ്യാഭ്യാസ വായ്പ സമ്പൂർണ്ണമായും സർക്കാർ ഏറ്റെടുക്കുക
- നഴ്സുമാർക്ക് തൊഴിൽ സുരക്ഷിതത്വവും സാമൂഹ്യസുരക്ഷിതത്വവും ഉറപ്പാക്കുക

INPA

കേരളത്തിലെ സ്വകാര്യ ആശുപത്രികളിൽ ജോലി ചെയ്യുന്ന നഴ്സുമാർ അവരുടെ സേവനവേതന വ്യവസ്ഥകൾ പരിഷ്ക്കരിക്കണമെന്നും കൊടിയ ചൂഷണങ്ങൾക്കും പീഡനങ്ങൾക്കും പരിഹാരമുണ്ടാക്കണമെന്നും ആവശ്യപ്പെട്ടുകൊണ്ട് നടത്തുന്ന സമരത്തെ ഇന്ഡ്യൻ നഴ്സസ് പേരന്റ്സ് അസോസിയേഷൻ സർവ്വാത്മനാ പിന്തുണയ്ക്കുന്നു. പോരാട്ട രംഗത്ത് അണിനിരക്കുന്ന ഏവരേയും അഭിവാദ്യം ചെയ്യുന്നു.

സ്വകാര്യ ആശുപത്രിയിൽ ജോലിചെയ്യുന്ന നഴ്സുമാരുടെ പ്രശ്നങ്ങൾക്ക് പരിഹാരം ആവശ്യപ്പെട്ടുകൊണ്ടാണ് 2009-ൽ ഡൽഹിയിലും തുടർന്ന് നാലുവർഷം മുൻപ് കേരളത്തെയും പിടിച്ചുകുലുക്കുന്ന രീതിയിൽ അതിശക്തമായ പ്രക്ഷോഭം വളർന്നുവന്നത്. എവിടെയൊക്കെ നഴ്സുമാർ സമരരംഗത്തുവന്നോ അവിടെയെല്ലാം ഉറച്ചപിന്തുണയുമായി സമരത്തെ വിജയിപ്പിക്കാൻ രക്ഷിതാക്കളും പൊതുസമൂഹവും അണിനിരന്നു. ആശുപത്രി മാനേജ്മെന്റ് ഗുണ്ടകളെ ഇറക്കി സമരത്തെ പൊളിക്കാനും സമരക്കാരെ ആക്രമിക്കാനും തയ്യാറായെങ്കിലും പൊതുസമൂഹം നഴ്സുമാരുടെയൊപ്പം ആണെന്ന് ബോധ്യപ്പെട്ടപ്പോൾ സർക്കാരിന് ചില നടപടികൾ സ്വീകരിക്കേണ്ടി വന്നു. അങ്ങനെയാണ് നഴ്സുമാരുടെ പ്രശ്നങ്ങൾ പഠിക്കാനും പരിഹാരം നിർദ്ദേശിക്കാനും വേണ്ടി ഡോ.എസ്.ബലരാമൻ കമ്മിറ്റിയെ സർക്കാർ നിയോഗിച്ചത്. കേരളത്തിലെ ഒട്ടുമിക്ക ആശുപത്രികൾ സന്ദർശിച്ചും നഴ്സുമാരെ നേരിൽകണ്ടും ഡോ.എസ്.ബലരാമൻ കമ്മീഷൻ പ്രശ്നങ്ങളുടെ രൂക്ഷത മനസ്സിലാക്കി.

തൊഴിൽ സമയം 8 മണിക്കൂറിന് പകരം 12 മുതൽ-20 മണിക്കൂർ വരെയാണെന്ന യാഥാർത്ഥ്യവും കമ്മീഷൻ മനസ്സിലാക്കി. മാത്രമല്ല, 1500 രൂപ മാസശമ്പളത്തിന് പണിയെടുക്കേണ്ടിവരുന്ന നഴ്സുമാരും സ്വകാര്യ ആശുപത്രികളിലുണ്ടെന്നും വ്യക്തമായി. ഭക്ഷണത്തിനോ പ്രാഥമിക കൃത്യങ്ങൾക്കുപോലുമോ സമയം ആശുപത്രി മാനേജ്മെന്റ് അനുവദിക്കുന്നില്ല എന്ന യാഥാർത്ഥ്യം കമ്മീഷന് ബോധ്യപ്പെട്ടു. ജോലിയെടുത്ത് രോഗം പിടിപെട്ടാൽ പോലും അതേ ആശുപത്രിയിൽ നിന്ന് ചികിൽസ ലഭിക്കാത്ത ഗതികേടിലാണ് നഴ്സിംഗ് സമൂഹം വന്ന് പതിച്ചിരിക്കുന്നതെന്നും കേരളത്തിലും ഇൻഡ്യയിലെ മറ്റ് സംസ്ഥാനങ്ങളിലേതുപോലെ തന്നെ നഴ്സുമാർ വിവിധ തരത്തിലുള്ള പീഡനങ്ങൾക്ക് വിധേയമാകുന്നതുൾപ്പെടെയുള്ള ഞെട്ടിപ്പിക്കുന്ന യാഥാർത്ഥ്യങ്ങൾ കമ്മീഷൻ പുറത്തു കൊണ്ടുവന്നു.

ബലരാമൻ കമ്മിറ്റി റിപ്പോർട്ട് സർക്കാർ നടപ്പിലാക്കുന്നതുവഴി നഴ്സുമാർ ഇന്ന് അനുഭവിച്ചുകൊണ്ടിരിക്കുന്ന ഭൂരിപക്ഷം പ്രശ്നങ്ങൾക്കും ശാശ്വതമായ പരിഹാരം കാണാൻ കഴിയുമായിരുന്നു. എന്നാൽ സർക്കാർ തികച്ചും നിരുത്തരവാദപരമായിട്ടാണ് പെരുമാറിയത്. സർക്കാർ നിയോഗിച്ച ഒരുകമ്മീഷന്റെ റിപ്പോർട്ട് നടപ്പിലാക്കുവാൻ സർക്കാർ തന്നെ തയ്യാറായില്ല. സ്വകാര്യ ആശുപത്രി മാനേജ്മെന്റുകളെ പ്രീണിപ്പിക്കുവാൻ വേണ്ടി മാത്രമായിരുന്നു സർക്കാർ ഇത്തരത്തിൽ ഒരു നടപടി കൈക്കൊണ്ടത്.

ഇതു മനസ്സിലാക്കികൊണ്ടാണ് ബലരാമൻ കമ്മിറ്റി റിപ്പോർട്ട് ഉടൻ നടപ്പിലാക്കണമെന്നാവശ്യപ്പെട്ടു കൊണ്ട് കേരളത്തിലുടനീളം അതിശക്തമായ സമരങ്ങൾ പടുത്തുയർത്താൻ ഐ.എൻ.പി.എ പരിശ്രമിച്ചത്. ഡോ.ബലരാമൻ ഉൾപ്പെടെയുള്ള മനുഷ്യസ്നേഹികൾ ഐ.എൻ പി.എ യോടൊപ്പം അണിനിരന്നുകൊണ്ട് സമരത്തെ കൂടുതൽ ശക്തിപ്പെടുത്താൻ മുന്നോട്ടുവന്നു. എന്നാൽ ഖേദകരമെന്നു പറയട്ടെ, കേരളത്തിലെ നഴ്സുമാരെ പ്രതിനിധീകരിക്കുന്ന സംഘടനകളുടെ ഭാഗത്തുനിന്നും സമയബന്ധിതമായ ഒരു ഇടപെടൽ ഉണ്ടായില്ല. യഥാർത്ഥ ഡിമാന്റുകൾ ഉന്നയിച്ചുകൊണ്ട് ശക്തമായ ഒരു സമരം രൂപപ്പെടുത്തുവാനോ, ഐ.എൻ.പി.എ പടിപടിയായി വളർത്തികൊണ്ടുവന്ന സമരത്തെ ആത്മാർത്ഥമായി പിന്തുണയ്ക്കുവാനോ ഈ സംഘടനകൾക്ക് പലകാരണങ്ങളാൽ കഴിഞ്ഞതുമില്ല.

നഴ്സുമാരുടെ അവകാശസമരത്തിന് പൊതുജന പിന്തുണ വർദ്ധിച്ചിട്ടും വിജയത്തിനോടടുത്ത നാളുകളിൽ എത്തിയിട്ടും പ്രധാന ഡിമാന്റുകൾ നേടിയെടുക്കുവാൻ കഴിയാതെ പോയതിന്റെ യഥാർത്ഥ കാരണമെന്തെന്ന് നമ്മൾ ചർച്ചചെയ്യുകയും ആത്മപരിശോധനക്ക് വിധേയമാക്കുകയും ചെയ്യേണ്ടതാണ്. നാളിതുവരെ നമ്മൾ നടത്തിയ സമരങ്ങൾ, അതിന്റെ നേട്ടങ്ങൾ, കോട്ടങ്ങൾ, നേതൃത്വത്തിന്റെ ശക്തി, കരുത്ത് നമുക്ക് സംഭവിച്ചുപോയ പാകപ്പിഴകൾ എല്ലാം ശരിയായി കൂട്ടമായി പഠനവിധേയമാക്കുവാൻ നമുക്ക് സാധിക്കണം.

നഴ്സിംഗ് മേഖല നേരിടുന്ന മറ്റൊരു ഗുരുതരമായ പ്രശ്നമാണ് വിദ്യാഭ്യാസ വായ്പാ വിഷയം. ബഹുഭൂരിപക്ഷം നഴ്സുമാരും വായ്പയെടുത്താണ് വിദ്യാഭ്യാസം പൂർത്തിയാക്കിയത്. എന്നാൽ ജോലി ചെയ്ത് കിട്ടുന്ന തുച്ഛമായ ശമ്പളം നിത്യചെലവിന് പോലും തികയാത്ത സാഹചര്യത്തിൽ വായ്പയുടെ തിരിച്ചടവ് നടത്താൻ നഴ്സുമാർക്കാകുന്നില്ല. നാദാപുരം സ്വദേശി 82 വയസ്സുള്ള ജോസഫ് ജയിലിലടയ്ക്കപ്പെട്ടത് മകളെ പഠിപ്പിച്ച് നഴ്സാക്കിയതിന്റെ ബാധ്യതയുടെ പേരിലാണ്. മക്കൾക്ക് വിദ്യാഭ്യാസം നൽകുന്നത് ജയിലിലടയ്ക്കപ്പെടാനും ആത്മഹത്യചെയ്യാനുമുള്ള കാരണങ്ങളായി നമ്മുടെ നാട്ടിൽ മാറുന്നത് വേദനാകരമാണ്. ഈ സാഹചര്യത്തിലാണ് വിദ്യാഭ്യാസ വായ്പ സർക്കാർ ഏറ്റെടുക്കണമെന്ന ഡിമാന്റ് ഐ.എൻ.പി.എ ഉയർത്തിയിട്ടുള്ളത്.

കടമെടുത്ത് ലക്ഷങ്ങൾ മുടക്കി വിദേശത്തേക്ക് തൊഴിൽതേടി പോകുന്ന നഴ്സുമാർ ഏജന്റുമാരുടെയും വിദേശ കമ്പനികളുടെയും തട്ടിപ്പിൽ കുടുങ്ങി എല്ലാം നഷ്ടപ്പെട്ട് തിരികെ വന്നുകൊണ്ടിരിക്കുന്നതും ഈ മേഖല നേരിടുന്ന ഗുരുതരങ്ങളായ പ്രശ്നങ്ങളാണ്. ഇത്തരം ചതിക്കുഴികളിൽ പെടാതെ അവരെ സംരക്ഷിക്കുവാനോ നിയമനിർമ്മാണങ്ങൾ നടത്താനോ സർക്കാറുകൾ തയ്യാറാകുന്നില്ല. സ്വകാര്യ റിക്രൂട്ടുമെന്റിലൂടെ വിദേശത്തേക്ക് കയറ്റി അയയ്ക്കപ്പെടുന്ന നഴ്സുമാർ അടിമപ്പണി ചെയ്യേണ്ടിവരുന്നതും ലൈംഗിക വ്യാപാര കേന്ദ്രത്തിൽ വരെ എത്തിപ്പെടുന്നു എന്നുമുള്ള ഞെട്ടിപ്പിക്കുന്ന വസ്തുതയും പ്രശ്നത്തിന്റെ ആഴം വിളിച്ചോതുന്നു.

ആയതിനാൽ നഴ്സിംഗ് സമൂഹം നേരിടുന്ന യഥാർത്ഥ പ്രശ്നങ്ങൾ, അതുപരിഹരിക്കാനുള്ള ശാസ്ത്രീയമായ പരിഹാരമാർഗങ്ങൾ വീണ്ടും പൊതുസമൂഹത്തിൽ ചർച്ച ചെയ്തുകൊണ്ട് മുഴുവൻ ജനങ്ങളുടേയും പിന്തുണ ഇനിയും നേടിയെടുക്കേണ്ടതുണ്ട്. ഡിമാന്റുകൾ നേടിയെടുത്ത് സംരക്ഷിച്ച് നിലനിർത്തുമെന്നുള്ള ഉറച്ച തീരുമാനത്തിന്റെ അടിസ്ഥാനത്തിലുള്ള ശക്തമായ പോരാട്ടമാണ് ഇന്നത്തെ ആവശ്യകത. ഇത്തരത്തിലൊരു പോരാട്ടത്തിലാണ് നഴ്സിംഗ് സമൂഹം എന്ന് ഞങ്ങൾ ആത്മാർത്ഥമായി വിശ്വസിക്കുന്നു. നഴ്സുമാരുടെ സാമൂഹ്യ സുരക്ഷിതത്വം ഉറപ്പാക്കുക എന്ന പ്രഖ്യാപിത ലക്ഷ്യത്തിൽ പ്രവർത്തിക്കുന്ന ഇൻഡ്യൻ നഴ്സസ് പേരന്റ്സ് അസോസിയേഷന്റെ മുഴുവൻ സംരക്ഷണവും ഉണ്ടാകുമെന്ന് സംസ്ഥാന കമ്മിറ്റിയുടെ പേരിൽ ഞങ്ങൾ ഉറപ്പ് നൽകുന്നു. പോരാട്ടരംഗത്ത് അണിനിരക്കുന്ന നഴ്സുമാരെ ഒരിക്കൽകൂടി അഭിവാദ്യം ചെയ്യുന്നു.

ഇൻഡ്യൻ നഴ്സസ് പേരന്റ്സ് അസോസിയേഷൻ
സംസ്ഥാനക്കമ്മിറ്റിക്കുവേണ്ടി

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The demands raised in the pamphlet are closely linked with the proposals of ILO in connection with the DWA. They are all demands raised since many decades. It is looming large even now. We need more focused attempts to address them, as the nature of transformations happening in labour market is not in line with our expectations. They are in need of regulative laws and continuous monitoring. Just as the parameters identified by ILO, the demands are all very fundamental to their survival as a labour segment.

Decent Work Agenda (DWA): The ILO Initiatives and its Indian Context

Although, over the last couple of decades, India has accelerated its rate of growth as an economy, at the same time, it still continue to face a number of challenges in several sectors of our employment and labour market. The most notable in this regard is the growing number of workers in the informal sector, who are practically without any kind of socio-economic security coverage. Sampath (2016) captures this scenario quite visibly in his article entitled 'Labour in the twenty-first century' when he says that, "according to the ILO, labour market flexibility is as high as 93 percent in India. This means that, 93 percent of India's workforce anyway does not enjoy the protection of India's 144 labour laws. But the industry's solution to the labour problem is a dilution of these laws so that the mass of informal workers can be employed formally, but without legal protections." (The Hindu, February 20, P-13) The share of workers in the unorganized sector fell only marginally from 86.3 per cent in 2004-5 to 84.3 per cent in 2009-10 (and to 82.2 per cent in 2011-12). If workers without employment benefits and social security in the organized sector are included, 91.2 per cent of workers in India are informally employed. Moreover, over the period 1999-2000 to 2009-10, there has been a decline in the share of formal workers in the organized sector from 58 per cent to 49 per cent. This suggests that a process of informalisation of the organized sector has been taking place (Decent Work Country Programme: 2013-2017; p-6).

The informalisation of labour, along with the parallel processes of growing inflation and declining opportunities of work, resulting from global economic crises are all making things more and more challenging to any democratically oriented economies. It is against this backdrop that the 'Decent Work Agenda' was initiated in India in

2013 and the agenda was primarily aimed at the reduction of poverty and provision of governmental and legal protection for the otherwise unprotected workforce in the informal sector.

The researcher made use of the idea of 'Decent Work' in this study to facilitate an effective understanding of the phenomenon here. The logic of selection of this concept is that it provides a set of fundamental conditions or variables which are considered to be very relevant to any segment of labour force, especially of the informal sector. As stated above, the DWA of International Labour Organization (ILO) was evolved as a sustainable means to reduce poverty to achieve equitable, inclusive and sustainable development. In its 18th International Conference of Labour Statisticians in December 2008 ILO had presented the framework and the indicators to evaluate decent work. In the ILO manual for Decent Work Indicators (2012) it is explained that the framework covers ten substantive elements corresponding to the four strategic pillars of the DWA. The framework is based on the pillars of, full and productive employment, rights at work, social protection and the promotion of social dialogue. These four pillars are reflected in the following ten substantive elements,

i) Employment opportunities

ii) Adequate earnings and productive work

iii) Decent working time

iv) Combining work, family and personal life

v) Work that should be abolished

vi) Stability and security of work

vii) Equal opportunity and treatment in employment

viii) Safe work environment

ix) Social security

x) Social dialogue, employers' and workers' representation

These elements were used as the parameters to evolve a state of the art depiction of the working status of the nursing labour segment. The purpose was to examine the contexts of marginalization, if any, and estimation on the alleged issues of violation of

the rights of nurses as workers, who are otherwise rendering services which are quite invaluable. The parameters mentioned above are surprisingly found very close to the dynamics of this profession. The large majority of this workforce is in the informal sector, and is without any legal status as workers. As Sreelekha et al , observe in a recent article, 'All health professionals, except doctors, working in the sector have grievances about their pay scales, terms of work and jurisdiction, definition of tasks, etc., and nurses are no exception.' (2016, p- 9) Interestingly enough, it visibly brings out the violation of four basic parameters advanced by the 'Decent Work Agenda' and also concerning a fifth parameter of 'equal opportunity' status too. The fact that, these problems are not, however, applicable to the doctors, only points to the gender disparities in this sector. As everyone would know, the profession of doctors' is not as much a female dominated one as it is the case in nursing, and that could just be the reason why they are able to remain insulated against these anomalies here. Hence, the decent work parameters are indeed very relevant to any evaluation of their professional status, more specifically, when it comes to the question of the private sector.

The chapters below, especially on data analysis and interpretation may provide the required view of the field as such in a big way. The next chapter, however, deals with the methodological procedure used in this study. This would help in establishing the logical and technical criteria of this study.

Chapter 3

Methodology of the Study

Methodology

Title of the study

Nursing as 'Decent Work': Question of 'Rights' in Care Profession.

General Objective

The general objective of this study is to explore the contexts of work and the consequent character of the status of nursing professionals in different sectors of health care in Kerala

Specific Objectives

1. To document the extent to which the idea of 'decent work' is reflected in the nursing profession
2. To find out the variations prevalent between the working conditions of the nurses in public and private sectors.
3. To examine why the nurses in general are unable to mobilize into an organized labour status

Variables of the study

The study being an examination of the working condition of the Nursing professionals based on the 'Decent Work Agenda'(DWA), the criteria prescribed by ILO was adopted as the variables and the areas of productive employment, rights at work, gender equity, social protection and the promotion of social dialogue etc, were taken up as the important questions of focus. Each of these dimensions was found to be significantly relevant to the context of this research and they were further narrowed down to the data collection questions, strictly, remaining within the orbit of these parameters. In fact, this argument about the relevance of 'decent work agenda' for the nursing profession will easily come out in the open, if we make a comparison of these parameters with the recommendations made by the Balaraman committee in 2012. Many of the recommendations are apparently reflecting on the level of precariousness that is characteristic of this profession now. The parameters laid down by the DWA require everyone to maintain certain fundamental policies and values to safeguard the livelihood rights of all types of labour groups. The bare fact that, the Balaraman committee still has to propose the same parameters to be implemented in the context

of nursing labour reveals the anomalies of the practices and policies that prevails here. The report is still not accepted by the government as a policy. This is despite the fundamentally primordial nature of those recommendations. None of the parameters of the 'Decent Work Agenda' could be overlooked by any rationally oriented policy groups. They are all indeed so fundamental to the survival of any segment of labour force. They cannot be, ignored at any cause. No economic logic would withstand the denial of such provisions which are essential to the survival of its manpower. This is the context, from where all the below given parameters are adopted to be the variables of this research too.

1. Employment opportunities: This parameter explores into the nature and character of the employment opportunities that exist. As everyone would approve, nursing is a vastly prevalent sector of employment. Still, there are issues of employability, improprieties in the procedure of selection, nonstandard terms of employment, denial of appointment order and the like reported from different corners. How far it reflects in the standardization of this career is, therefore, a relevant research concern

2. Adequate earnings and productive work: Like any other sector of informal labour, the nursing sector is also turning out to be highly underpaid and undervalued. How far, these aspects are leading to a decrease in its productivity, and in the context of health care, how far it results in undermining the quality of health care is indeed a question to probe into in the interest of any socio political context.

3. Decent working time: Nursing as a sector of employment is particularly impacted by the problems of duty time and break time. Unlike most professions, nursing care is a 24 hour responsibility. Obviously, this becomes a significant context of vulnerability for those working in this sector. Several committees have also looked into this problem and have given their suggestions to standardize the time utilization. Still, they need to be probed again and again as the nurses' agitations are raising their objections even now on the improprieties of time management and near total lack of break time.

4. Combining work, family and personal life: Yet another context for assessment is the combination and complementariness existing between the work life and

the personal lives of the nurse professionals. This becomes important as the care profession is a 24 hour responsibility on the one hand and also it is women who constitute a large majority of this labour segment. As many have pointed out the question of 'second shift' is a widespread reality and that is likely to undermine the much needed value of complementariness between the work life and personal life of these professionals.

5. Work that should be abolished: Providing health care is indeed a risky responsibility, characterized by the risks of contracting diseases of several natures. Many labour segments of the informal sector are subjected to several violations of terms of employment and imposition of works which are beyond the purview of their skill levels. Nursing sector is clearly a victim of this non standardization as the nurses are very often asked to perform non nursing tasks which they are not supposed to, without any protective equipments, that they are entitled to. Also it involves instances that play a vital role in the continuation of various types of stigmas like nursing as a 'dirty profession', attached to this sector.

6. Stability and security of work: The nursing sector used to be traditionally well known for its job prospects, stability and security of employment. Is it the case still persisting is a question worth looking into? Large scale increase of migration of nurses to risky regions of the world in itself point to the growing insecurities of this sector. In the recent past, when there were reports about the attacks on hospitals and nurses in countries like, Iraq, Iran, Libya, and Yemen, the governments of India and Kerala had to issue orders repeatedly to the nurses working there to return to India. Still, many opted to continue there as they have no fall back employment opportunities over here. There were also reports that many who returned from these troubled regions still opted to go back in spite of the uncertainties that continue there. Obviously, the situation is more unstable for them back here, may be neither security nor stability!

7. Equal opportunity and treatment in employment: Nursing is conventionally considered as a female profession, although, of late men are also joining this profession. Only naturally, that raises questions of equality of opportunity as well as treatment. This is where; a lot of anomalies are being reported. An

interesting development here is that, many reported nurses' strikes in the recent past were initiated under the leadership of male nurses and as a result the private managements are discouraging the recruitment of male nurses. How will it contribute to an egalitarian division of labour? How far the entry of male nurses is contributory to the efforts in organizing the nurses? Each of these questions merits further probing.

8. Safe work environment: the nursing sector is indeed affected by a number of occupational hazards and contexts of harassment from several corners. How do they overcome such difficulties is not so much known to anyone. Yet again, there is thus the need to bring it to the limelight, so that, they are given the assurance of possible legal protection.
9. Social security: The health sector in India as a whole and Kerala in particular has been increasingly being privatized. As everyone knows, the private sector does not provide any sort of social security like pension. This is, therefore, yet another context of the violation of a decent work norm and the present research consider it as a significant variable to be looked at in more detail
10. Social dialogue, employers' and workers' representation: The tenth parameter suggested by ILO is the scope of social dialogue and the role of employers and employees in it. The concern is primarily about the scope of organizational movements provided in the sector concerned and to facilitate it, so as to promote a healthy dialogue among the various stakeholders. The nursing sector, especially the private medical sector is largely kept outside this context and how it is being integrated in it is something important to look at. The ongoing agitations organized by the nurse's organizations make it yet another defining element of their decent work status and is, therefore, adopted as a variable for the present study also.

Design of Study

The study followed a comparative design. This design is selected taking into consideration the variations which are apparently persisting between the public and private sectors of nursing profession. The researcher also used a mixed methods

approach mainly to generate an understanding from both the quantitative and qualitative dimensions. As the study had to address different categories of respondents along with those of the nurses as such, this method was found to be more effective. While the data from the nurses were collected primarily using the questionnaire, interview method was used to collect the data from the representatives of management and other authorities from this sector.

Unit, Area, and Sampling Procedure

Finding the nurse respondents and making themselves available for a study of this nature and extend was indeed the biggest hassle faced in this research. The researcher had to spend a lot of effort for this. The nurses working in the government and private sector, who were the primary units of this study, could be made available only during their duty time. The duty times are, however, generally very hectic for them too. As a result, on most occasions it became more like non/participant observation as the researcher as well as the research assistants had to accompany them in their duty stations to get the questionnaire filled up. Although, it turned out to be quite a difficult task, it still has contributed to the quality of the responses as we could elaborate on the issues related to the questions.

As there was no available means to use a probability sampling logic, the researcher identified the respondents using a network approach. This approach was quite effective especially for the private sector, as otherwise no management was open to the idea of a research like this. Even in the public sector, the permission was given by the authorities on the condition that the study would not affect their routine works. Even the sample size was not decided in advance, as there was no means to assure their availability. Finally, the researcher opted to limit it to 125 each from the public and private sectors as there was no means to identify any more from the private sector. However, efforts were taken to include a significant number of male nurses, although only from the private sector, and also to include representatives from among the different categories of nurse professionals like from the medical college, general hospital and also from the CHCs.

The area selected for this study is Trivandrum. Selection of Trivandrum district, although, based on the logic of convenience, was also based on the assumption that the population of nurses in Trivandrum will reflect a cross section of the nursing professionals in Kerala as a whole. Final selection of the sample units were done after seeking the permission of authorities and as per their direction, the names of the hospitals are not disclosed here to maintain anonymity, and ethical neutrality.

Tools of data collection

The study was carried out using a questionnaire as the primary tool of data collection from among the nurses. It comprised questions covering all criteria listed under the 'Decent Work Agenda'. The data from the managerial category was collected using unstructured/semi structured interviews. These interviews were tape recorded as much as permitted and the content was transcribed later.

Secondary data was also made use of in this study. Primary Statistics about the health sector was available at the directorate health services and they have been accessed. The first step of the study was to collect a list of Hospitals, for which the researcher approached the Directorate of Health Services in Trivandrum. The office provided with detailed statistics covering the entire state of Kerala, containing a category wise classification of Hospitals (2014-2015). According to this list there are a total of 123 government medical establishments in Trivandrum District, while the corresponding number in the state as a whole is 1299. This is inclusive of PHCs and CHCs. (Health Information Cell, Directorate of Health Services. The manual entitled 'Health at a Glance' (2014) also provides yet another relevant statistic that the total number of Nurse Professionals working in the categories of, Staff Nurses, Head Nurses, PHN Supervisors, Public Health Nurses (PHN), and Junior Public Health Nurses (JPHN) is 15602.

A similar attempt to collect a list of Private Hospitals was made with the Health Ministry too. It was, however, not successful. Nevertheless, the secondary data available, for instance the Labour Department Report of 2013, contained relevant statistics in this regard. According to this report there are a total of 705 private hospitals in Kerala (as of 2013), with an approximate strength of 50000 nurses. Out

of this 60 (sixty) hospitals are in the Trivandrum District, comprising a total employees number of nearly 15 thousand, including those whose names are not found in the register(p-17).

Pilot Study & Tool Refinement

A pre-test of the questionnaire was done before the actual study and it was modified to make it as relevant as possible. It revealed some additional areas to be covered in the study such as educational loans, duty shift pattern and so on. Also certain technical terminologies were replaced by common usages as they seemed to communicate better to the respondents.

Consultation of Experts in the Field

The study on the Nursing profession was initiated with a number of apprehensions, as the chances of identifying the respondents were quite limited. However, once it is started it has really managed to make certain significant steps ahead with the support of several persons connected to this profession. Several visits were undertaken to such Government Offices as Directorate of Health, Directorate of Medical Education, State Nursing Council. All that really helped the researcher to establish the required contacts with several nurse professionals especially some of the prominent professionals who are working towards the wellbeing of this labour force.

Limitations of the study

The study has a couple of limitations. The foremost among this is the limited scope of generalization as it is done using a non probability sampling logic. Nevertheless, it is important here to note that as far as possible all categories are included in the study and thereby this limitation is addressed to a large extent.

The second constrain that came up in the study is the issue of time factor for the respondents. The nurse professionals are generally having a heavy workload and to find enough time to even fill up a questionnaire is a major limiting factor. The

researcher addressed this limitation by personally accompanying them, which was, therefore, a very time consuming exercise.

The chapter below presents the data collected from the field. As it was pointed out in the problem statement, the data is processed here mostly in line with the specific questions or objectives of the study. It is divided in to two sections, the first looking at the quantitative details collected from the nurse professionals and the second dealing with the qualitative inputs gathered from the management and the other different professionals in the field, including a case study on a male nurse.

This chapter is divided into two sections. The first section deals with the tabulation and interpretation of the quantitative data. This is done here in line with the specific objectives of this research which was evolved from the ten different parameters, described in the chapter above, based on the decent work agenda. They include finding out the extent to which the idea of 'decent work' is reflected in the nursing profession, find out the variations prevalent between the working conditions of the nurses in public and private sectors, the level to which the 'rights' of this labour segment is protected in nursing profession, and finally to examine why the nurses in general are unable to mobilize into an organized labour status. The second section of this chapter deals with the qualitative data collected and it includes the interviews done with the representatives of the management, the academic professionals in this field and the nurses themselves.

As far as the 'decent work' indicators are concerned, it was addressed at many levels revolving around the ten substantive themes identified under this agenda by the ILO. They are broadly identified by ILO as follows. Employment opportunities, adequate earnings and productive work, decent working time, combining work, family and personal life, work that should be abolished, stability and security of work, equal opportunity and treatment in employment, safe work environment, social security, social dialogue, employers' and workers' representation. The present research, sought to measure these factors using a questionnaire containing nearly 90 major questions and several sub questions under them. As it was argued above, all these parameters were found quite strongly relevant to the analysis of the work situation of nurses the following interpretation of data would substantiate it further

Chapter 4

Data Analysis and Interpretation

Section 1

Section I

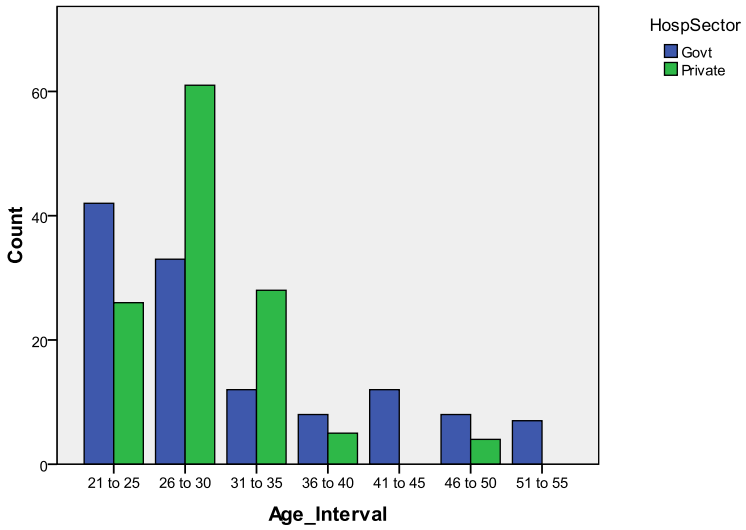
This section begins with the general profile of the respondents, including their family profile

General Profile of the Respondents

Table 4.1: Age interval

Age_Interval	Hospital Sector		Total
	Govt	Private	
21 to 25	44	27	71
26 to 30	34	61	95
31 to 35	12	28	40
36 to 40	8	5	13
41 to 45	12	0	12
46 to 50	8	4	12
51 to 55	7	0	7
Total	125	125	250

Figure 4.1: Graph showing the Age Interval



The majority of the respondents (66 %) are below the age of 30. While the govt. sector is having all categories from 21 to 55 years, private sector clearly lacks the presence of 41 and above age group categories implying that, this sector gives no consideration to the experience or skill, as it might otherwise result in more expenditure under the salary head.

Table 4.2: The age structure of respondents from Different Private sectors

Age Interval	Private1	Private2	Private3	Private4	Total
21 to 25	16	9	2		27
26 to 30	20	18	14	9	61
31 to 35	9	7	4	8	28
36 to 40	1	1	1	2	5
41 to 45					0
46 to 50			4		4
51 to 55					0
	46	35	25	19	125

This preference was well acknowledged by the management representative of the private sector in the interview conducted as part of this research too. The reasons provided are indeed so problematic having serious gender implications. She relates it with the capability of pretty young girls in pleasing the patients. The full text of the interview is provided as case two in the second section of this chapter.

Table 4.3: Gender wise classification of the respondents

Gender	Frequency	Percent
Male	35	14.0
Female	215	86.0
Total	**250**	**100.0**

Not deviating from the history profession of Nursing, a higher percent of 86 are female nurses. Although, the present research had the objective of selecting as far as possible an equal number of male and female nurses, it was later realized that, the number of male nurses in both the sectors are very limited and hence, it need not even be a logical necessity to choose an equal number. Otherwise, it will lead to a disproportionate size of representation and in the process may lead to skewing the

results in the wrong direction. Yet another relevant inference from the data above is that a large number of the young nurses in both the public and private sectors are student graduates from their respective hospitals and they remain there, mostly for the purpose of earning an experience certificate. The problem here is, it clearly shows the absence of a norm of having a specified ratio of trainees to that of the experienced staff nurses or its violation. The Balaraman committee had also pointed to this as one of the instances of exploitation by the management, as it gives them the option of hiring the service of nurses at a very cheaply. (p-14)

Table 4.4 : The religion of Respondents

Religion	Frequency	Percent
Hindu	152	60.8
Christian	86	34.4
Muslim	12	4.8
Total	**250**	**100.0**

A major portion of the respondent belongs to Hindu community and the representation of Muslim community is less than *five* percent only. This data is not a general reflection of the religious composition of nurse professionals in Kerala, as it is argued by many writers earlier. The widely identified statistics on nursing profession in Kerala reveals that it is the Christian community which outnumber others in this sector (Kodoth &Varghese, Nair &Percot, Biju et al.)

Table 4. 5: Caste of the respondents

Caste	Frequency	Percent
SC/ST	22	16
OBC	132	52.8
General	70	28
No response	26	10.4
Total	**250**	**100**

OBC dominates more in the representing population (52.8%). Only less than 30 percent are from the general community, while 10.4 percent didn't want to respond to this question.

Employment Opportunity Rate and Nursing Profession

Nursing is traditionally known for its high employment rate. Till about 2000, nursing was widely thought about as an easy channel of employment, both in India and abroad. The number of Malayalee migrant nurses in the metropolitan regions of India, as well as in the gulf regions was a clear evidence of this situation. The studies carried out by many scholars also support this claim. As Kodoth and Varghese, puts it …since 1950s, the number of women entering into nursing education grew steadily, and … even in the 1990s and 2000s, nurses legitimise their mobility in terms of dominant social norms, i.e. "higher" social aspirations embodied in earning for their families. (op. cit., p-62) Equally, important is another observation made by Roberts and Rajan (op.cit.) Kerala's position as the leading Indian state for the training and 'export' of nurses for the international market is well known.

Numerous other studies have also linked the growing interest, young women and men have in this profession to the opportunities it provides for overseas employment (Walton-Roberts 2010, Thomas 2008, Sreelekha 2012). While this is indeed a positive social condition, we have deviated from this norm in a big way in the recent times. The international conditions, like the national conflicts and terrorist attacks on hospitals in the Middle East regions along with that of the large scale supply of nurse graduates as a consequence to the unprecedented expansion of nursing colleges have contributed to this scenario. The condition of nurse's employment is not so much prospective any more. Also within the country, their bargaining capacity has gone down significantly and very often they are forced to work under inhuman conditions of low wage rate, low job securities, and literally under very exploitative terms and conditions of work. A substantial number of them are now working under the contract category, enrolling either for an experience certificate or for their internship. Once they complete, the only favourable option in front of them is to immigrate. The following table deals with a related data.

Table 4.6: Year of qualifying Nursing Degree

Year of Passing	Hosp-Sector		Total
	Govt.	Private	
Before 2000	29	4	33
2006-2010	30	61	91
After 2011	66	60	126
Total	**125**	**125**	**250**

The majority of the respondents in both sectors have passed their nursing degree after 2001. Of which the largest number is from after the 2011, implying that, majority of them are in their early stage of career or they are quite young. However, it is also important to observe here that, once again there is a clear absence of the experienced in the private sector as about 96% has only less than 10 years of service, where as the distribution is more balanced in the govt. sector.

Table 4.7: Time gap between qualifying degree and acquiring a job

Waiting period for job	Hospital Sector		Total
	Govt.	Private	
Less than 1 year	98	109	207
2 - 3 years	18	15	33
4-5 years	2	1	3
Above 6 years	7	0	7
Total	**125**	**125**	**250**

The table above clearly reflects the high rate of employment rate that exists in this sector. The fact that most of them got into a placement soon after their graduation indeed points to the prevalence of high demand for the nursing job. Still it is not working in their favour as far as the salary or their working conditions are concerned.

This means that the basic economic principles are not acting to their advantage at all. The decent work agenda clearly advances the position that, every sector of work force should benefit from the programmes of employment, irrespective of the shifting nature of economic priorities. The economy of the world has indeed gone through, fundamental transformations, under which, the priorities are shifted away from the manufacturing to the service sector in regions like India in a big way (Sampath, op.cit). The nature of this expanding sector is, however, that, they are largely being informalised. Hence, the only way in which, the community of labour force coming under this segment could be ensured with any productive means of livelihood is by ensuring opportunities of employment with sufficient protective laws. The decent work agenda is a proposal for self assessment and self monitoring, to move towards the decent work status. In the context of the present research, this conception is particularly relevant considering the informal nature of this sector of employment, together with that of the increased supply of nurse professionals in the recent past. Hence it is very important to monitor the opportunities available, so that, it does not lead to any serious issues of unemployment or under employment. The data given above, however, is highly discouraging. Apparently, the tables below also does not seem to reflect this logic as there are respondents from the private sector, falling under the contractual category, without any security of work. Also the people, who are having different educational standing, occupy the same professional position without much of differentiation. This is further aggravated by a sector wise variation too, as the GNM category clearly over represent the private sector

Table 4.8: Nature of Employment

Nature of Employment	**Hospital Sector**		**Total**
	Govt.	**Private**	
Permanent	74	56	**130**
Contract	10	46	**56**
Internship	32	20	**52**
Others **(Projects etc.)**	9	3	**12**
Total	**125**	**125**	**250**

Although, there is a higher number from the private hospital who claims to be having a permanent appointment, a closer look would give us more clarity, as 69 out of 125 nurses are actually working either contractually or as interns. Whereas 74out of 125 government nurses are having job security in real terms as they are working on permanent basis already. A large portion of the remaining people in the government sector is however, in their internship period and is not either falling under the contractual or permanent categories. Most of the tables given below would also help in understanding the precariousness with which the nurse professionals are coping with.

Table 4.9: Selection Criteria

Selection Criteria	**Hospital Sector**		**Total**
	Govt.	**Private**	
Interview	105	115	220
Group Discussion	0	0	0
Written Test	55	36	91
Others	0	6	6
Total	160	157	317

*Since there are multiple responses, the total outnumber the number of respondents

Interview and written tests are the dominant selection criteria for both sectors. Group discussion was not practiced for both sectors. The end result is that, the data point to the absence of any established procedure in appointment system. They even report that they do not receive an order of appointment.

Table 4.10: Number who received Appointment order

Appointment order Provided	**Hospital Sector**		**Total**
	Govt.	**Private**	
Yes	88	49	137
No	37	76	113
Total	125	125	250

When two-third of the government staff is getting appointment order only less than forty percent in the private sector are receiving the same. This actually is the breach of employee-employer agreement and a violation of one of the most important elements of the decent work agenda, further reaffirming the problem of insecurity of job in the private sector. At the same time, the fact that there are cases of non-provision of a proper appointment order reported from the government sector is an issue that cannot be ignored, even though; they are in their internship period. In fact, it is the same category who reported that they do not have any salary either.

The issue is indeed a result of the neglection of their rights as a worker, be it in the formal or informal sector. As a result, they do not have a proper idea about any of the terms and conditions attached to their work, as they have no documentary references available with them. Obviously, this should also be treated as an eye opener, for anyone, concerned about the decent work agenda, as these are the few dimensions which could help in securing a better treatment for them, especially in ensuring a decent wage structure, decent working time, and above all a fixed definition of their terms of employment.

Table 4.11: Crosstab - Appointment order v/s Present Designation (Govt. Sector)

Hospital Sector			Frequency		Total
			Yes	No	
Govt.	Present Designation	Head Nurse	17	2	19
		Others	16	28	44
		Staff Nurse	55	7	62
		Total	88	37	125

Table 4.12: Crosstab - Appointment order v/s Present Designation (Private sector)

Hospital Sector		Frequency			Total
			Yes	No	
Private	Present Designation	Head Nurse	3	2	5
		Others	10	10	20
		Staff Nurse	36	57	93
		Ward in charge	0	7	7
		Total	49	76	125

To affirm the above interpreted views this cross table gives more clarity, while the categories like Head nurse, Staff Nurse are getting appointment order in government, more than half of all categories are not getting the order in private. The category who reported the answer 'No' in the govt. sector is the trainee nurses who are doing their internship.

Table 4.13: Qualification of the respondents

Qualification	Hospital Sector		Total
	Govt.	Private	
M.Sc Nursing	5	2	7
B.Sc Nursing	63	41	104
GNM	55	80	135
Others	2	2	4
Total	**125**	**125**	**250**

While the BSc Nurses outnumber in Government sector, General Nursing diploma holders constitute the two-thirds in Private sector. This is also indicative of the preferences for people with low salary requirements when compared to the B. Sc Nursing graduates. The table below on qualification and salary structure in the private sector will elaborate on this.

Table 4.14: Current Salary * Qualification * Private – Cross tabulation

Classification of Salary		Qualification				
		M.Sc. Nursing	B.Sc. Nursing	GNM	Others	Total
Private1	upto 5000		0	11		11
	5001 to 10000		3	16		19
	10001 to 15000		5	11		16
	Private1 - Total	**0**	**8**	**38**	**0**	**46**
Private2	5001 to 10000		4	5	1	10
	10001 to 15000		9	16	0	25
	15001 to 20000		1		0	1
	Private2 - Total	**0**	**14**	**21**	**1**	**36**
Private3	5001 to 10000		1	5	0	6
	10001 to 15000		5	4	1	10
	15001 to 20000		2	5	0	7
	20001 to 25000		0	0	0	0
	25001 to 30000		1	0	0	1
	Private3 - Total	**0**	**9**	**14**	**1**	**24**
Private4	10001 to 15000	0	7	1		8
	15001 to 20000	1	2	6		9
	20001 to 25000	1	1	0		2
	Private4 - Total	**2**	**10**	**7**	**0**	**19**

The data is also an indicator of the nature of commercialization of the health sector of Kerala, as more than the quality; concern is always about making profit. While the world over, the health sector is getting more and more advanced and specialized, in India it is not being reflected in the nursing context at least. As Sreelekha's Appendix table also shows, only one respondent out of her 150 from among the Malayalee nurses working in Delhi, is B Sc Nursing graduate and the rest are GNM/ANM diploma holders (op cit).

Table 4.15: Type of Institute where candidate studied

	Hospital Sector		Total
Type of Institute	**Govt.**	**Private**	
Government Nursing College	57	4	61
Private Nursing College/Schools	55	120	175
Co-operative Nursing College	8	0	8
Others	5	1	6
Total	**125**	**125**	**250**

In government owned or run hospitals the nurses are equally represented from the govt. and private nursing colleges. While a majority of 96 percent nurses in the private sector are from Private Nursing colleges. This is also a clear indication of the orientation that the management hospitals have as far as quality of manpower as well as the quality of care services that they aim at. A good number of government college pass outs are seen placed in government sector. This is also a reflection of the quality of instruction that helps them get through the public service exams.

Table 4.16: Location of the institute respondent studied

Location of Institute	**Hosp. Sector**		**Total**
	Govt.	**Private**	
Within Kerala	109	78	187
Outside Kerala	16	47	63
Total	**125**	**125**	**250**

Majority of the government employed nurses studied in Kerala itself, but it is only a two-third for the private hospitals. In private sector, the waiting period also was comparatively low, as private nursing colleges with hospitals attached to it are turning to be ‘degree factories’ and source of cheap labour supply, in the sense of trainee

system. This can also be seen connected to the Table 4, on the Age distribution of the respondents, where it was evident that the young girls dominate this profession are just the most recent pass outs. When we again link it to the level of relaxation of norms by the Indian Nursing Council, it will only reaffirm the direction in which our health sector is heading to.

Adequate Earnings and Productive Work: Status of Nurses

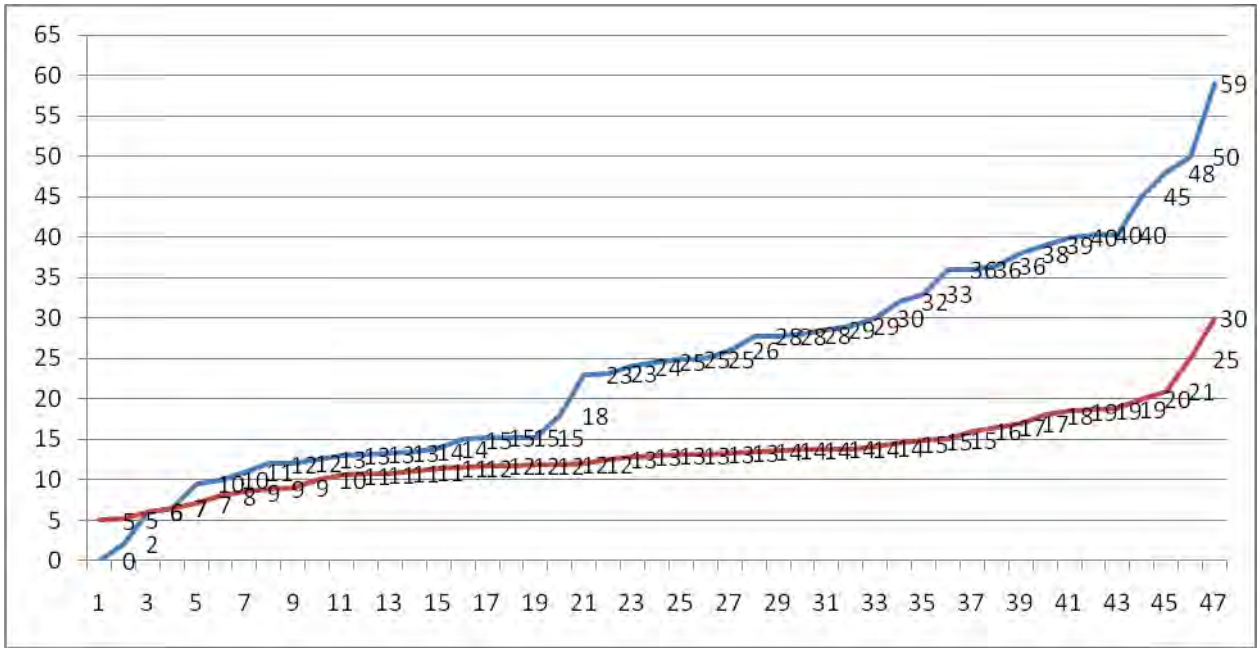
Next major pillar of Decent Work Agenda is adequate earnings and productive work status. Although most of the tables above substantially represent a variety of issues relevant to this parameter too, what is undoubtedly more relevant here are the questions whether the nurses are adequately remunerated for their services, and are they decently paid or not? The table below clearly reflects a concentration of responses in the lower ranges, irrespective of the sector. Still, the variations are also coming out in the open as there is not even a single representation from the private sector, when it comes to the upper range. This is indeed an indication of the exploitative nature of this employment sector, although, neither their age structure, nor their experience has a variation of this kind.

Table 4.17: Current Salary

Current Salary/Stipend	Govt.	Private	Total
No salary	12	Nil	12
Up to 5000	1	11	12
5001 to 10000	4	35	39
10001 to 15000	52	59	111
15001 to 20000	8	17	25
20001 to 25000	12	2	14
25001 to 30000	18	1	19
30001 above	18	Nil	18
Total	**125**	**125**	**250**

The table shows, there are remarkable difference between government and private hospitals, as we can see the highest salary range in government is 50001 & more while in private it is only up to 30000. The largest segment (84%) here is coming under the range of 15000. A consideration of the comparative average salary in the table below also reveals this non-standard character, which the Decent Work Agenda classifies as one of the characteristic features of 'precarious employment'.

Figure 4.2: Comparison of salary



Blue line= Government , Red line =Private

The graph above depicts this situation quite clearly, as in the government sector (the blue line) takes an upward route, while the private (the red line) is comparatively much flatter

Table 4.18: Average Salary

	Sector	
	Govt.	Private
Average salary	9933.00	5418.42

The average salary table also confirms the down turn in private, while the govt. sector is also indeed not so rosy looking for the nurses especially in the entry cadre, majority of them are holders of B Sc degree in nursing. Between the public and the private sectors, there is almost a 100% difference in spite of the fact that the comparison of their entry into the employment only minimally vary. In other words, although, most of them have got into the service almost around the same time, their present job status, especially their salary structure has an unjustifiable discrepancy, meaning that the Decent Work Agenda is significantly reversed against the interest of this workforce.

Table -4.19 : Comparison of salary across the Private Sector

	Private1	Private2	Private3	Private4	Total
Up to 5000	11				11
5001 to 10000	19	10	6		35
10001 to 15000	16	25	10	8	59
15001 to 20000		1	7	9	17
20001 to 25000			0	2	2
25001 to 30000			1		1
Total Number	**46**	**36**	**24**	**19**	**125**

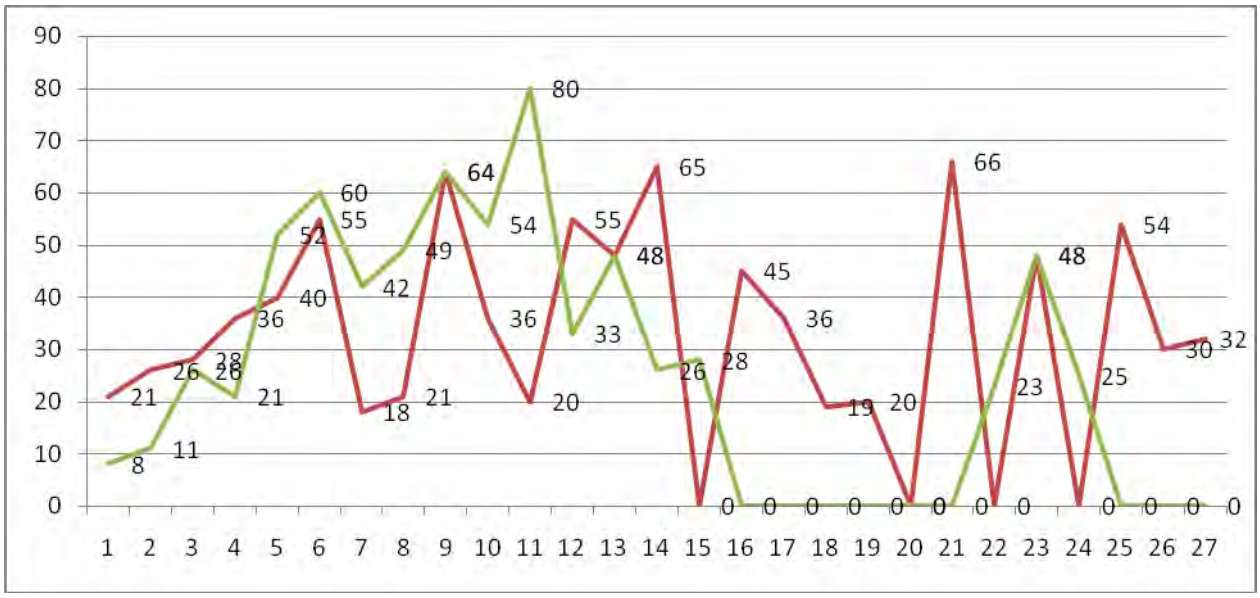
A comparison of the salary system across the different private hospitals also carry a lot of relevance as that would help in understanding the disparities that characterize this sector. Indeed the dominant majority falls below the range of 5000- 15000 rupees per month. Still, the first hospital in the private category is even below the 10000 level. In fact, it is this hospital which is the most represented section in the sample here, points to the fact that, the situation is really quite undesirable over there.

Table 4.20: Designation and Salary in Private Sector

		Present Designation				
		Staff Nurse		Others	Ward-in-charge	Total
Private 1	upto 5000	2		9		11
	5001 to 10000	16		3		19
	10001 to 15000	5		11		16
	Private1 - Total	**23**		**23**		**46**
Private2	5001 to 10000	7		3		10
	10001 to 15000	20		5		25
	15001 to 20000			1		1
	Private2 - Total	**27**		**9**		**36**
Private 3	5001 to 10000	6				6
	10001 to 15000	10				10
	15001 to 20000	7				7
	20001 to 25000					0
	25001 to 30000	1				1
	Private3 - Total	**24**				**24**
Private 4	10001 to 15000	7		1		8
	15001 to 20000	5		4		9
	20001 to 25000	1		1		2
	Private4 - Total	**13**		**6**		**19**

The reality is that, when in government sector, an entry grade nurse gets around 30,000/- rupees, whereas this is the pay for a nurse who completes 20 years or so in private sector and that too in the designation as Nursing superintendent. Unlike in many other sectors, the neither the experience, nor even the skill level entitle them to any additional monetary advantage. The tables that follow would elaborate it more The 'others' category in the above table is a vague one as it includes head nurses, Wards in charge, as well as the nursing assistants. This is the reason why there is a wide disparity in their salary terms.

Figure 4.3: Work Experience graph



Red line: Govt., Green line: Private

The graph shows the steady zigzag movement of the experience line of government hospital nurses while the green line, showing the private hospital nurses at times rest on the x axis. This is more specifically a situation at the peak stages, where there is no further increase of salary and it has a lot of implications for the nurses who are a bit aged and again possibly having a lot of life course challenges to cope with at that stage. First of all, they do not stand to get a new employment at that age, as it was already revealed above that this profession has tendency favouring the young girls, who are fresh graduates. Therefore, the only option for them would be to continue in the same hospital, where they have at least the benefits of seniority at least, although, it does not get reflected in salary or any other material contexts.

Table 4.21: Crosstab – Entry grade v/s Present Designation

			Present Designation					Total
			Head Nurse	Not responded	Others	Staff Nurse	Ward in charge	
Govt	Entry Grade		1	3	1	3	NA	8
		Head Nurse	1					1
		Nursing Trainee			13			13
		Others	1		3	7		38
		Staff Nurse	13			**52**		65
	Total		**16**	**3**	**44**	**62**		**125**
Private	Entry Grade			3	3	9		15
		Nursing Trainee	1		7	8		16
		Others		1	6	4	1	12
		Staff Nurse			4	**72**	6	82
	Total		**1**	**4**	**20**	**93**	**7**	**125**

The above table clearly states that the career prospects in the profession of nursing are very minimal or feeble. 52 among the 125 of the government nurses and 72 among the private hospital nurses have not changed the designation from Staff Nurse. A very small number of 13 got promoted to the cadre of Head Nurse. Ward-in-charge is a designation unique to Private hospitals, where during the years six got promoted from the position of Staff Nurse.

Table 4.22: Promotion Prospects

Ample scope for Promotion?	Hospital Sector		Total
	Govt.	Private	
Yes	33	23	56
No	72	92	164
No response	20	10	30
Total	**125**	**125**	**250**

Regarding the issue of promotion, the majority (72) of them from govt. and 92 of them from private, say that there is no promotion, which reaffirms the oft repeated statements earlier about the limitations of nursing career.

Table 4.23: Criteria for Promotion

Criteria for Promotion	Hospital Sector		Total
	Govt.	Private	
Educational Qualification	1	0	1
Experience	43	27	70
Others	0	5	5
Don't know	81	93	174
Total	**125**	**125**	**76**

This table is unique in itself where majority of the respondents are literally unaware of their criteria of promotion. This is quite a serious anomaly, although, it is mainly because they have no much scope of promotion on the one hand and also because, many of them have not received any clear instructions on the different terms of their appointment and evn the prospects about their profession itself.

Table 4.24: Availability of Increment

Increment	Hospital Sector		Total
	Govt.	Private	
Yes	50	66	116
No	47	51	98
NA	28	8	36
Total	**125**	**125**	**250**

One hundred and sixteen out of 250 agrees that there is increment in hospitals, but an equally relevant number says no. Amount of increment is also quite insignificant and it is just about a couple of hundreds very often. Same is the case with most other benefits attached to the services.

Decent Working Time: A concept Unknown for Nurses!

ILO had laid down very clear instructions on the issue of working time, shift system, break time, leisure time provision and so on, under the decent work agenda. Many studies across the world have brought out the gravity of this problem in the informal sector, and hence, the objective is specifically to evolve a mechanism to counter it. Accordingly, DWA laid down several protective regulations, requiring the employers to abide by in their policy contexts. Redefinition of the Eight hours duty time, provision of break time in between the duty time, provision for paid annual leave, maternity leave, all were evolved as part of this policy orientation. How far it is integrated in to the nursing profession is, however, quite an intriguing question and the data below will explain it further

Table 4.25: Day Shift Timing across the private hospitals

Day shift time	Private1	Private2	Private3	Private4	Total
7 am to 1 pm		36			**36**
7 am to 2 pm			24	19	**43**
8 am to 2 pm	46				**46**
Total	46	36	24	19	**125**

Table 4.26:Evening Shift Timing across the private hospitals

Eve shift time	Private1	Private2	Private3	Private4	**Total**
1 pm to7 pm	46	36	24		**106**
2 pm to 7 pm				19	**19**
Total	46	36	24	19	**125**

Table 4.27: Night Shift Timing across the private hospitals

Night shift time	Private1	Private2	Private3	Private4	**Total**
7 pm to 7 am		36	24	19	**79**
7 pm to 8 am	46				**46**
Total	46	36	24	19	**125**

Table 4.28: Number of Night Shift across the private hospitals

	Private Hospitals V/s No. of night shifts				Total
No. of Night shifts	Private1	Private2	Private3	Private4	
1	6	5	2	6	19
2	**40**	**31**	**22**	**13**	**106**
	46	36	24	19	125

The pattern that widely prevails in the nursing context is that, they have to work a minimum of six days in a week and the seventh day would be a holiday. However, although, the govt. sector is having a fixed timing pattern for duty, the duty timing is not so much well defined in the private sector and it varies widely among the different hospitals. This means that, there is no standardization of the norm of duty timing. The Veerakumar committee, referred earlier in the second chapter had specifically looked at this context and had made certain very pertinent suggestions in this regard. How far it is reflected in the above tables is still very much disappointing.

The data collected was further tabulated to find out how many hours the nurses are presently asked to work in a week and the data is indeed more discouraging.

Table 4.29: Hours of work per week * Private – Cross tabulation

Hours per week	**Private1**	**Private2**	**Private3**	**Private4**	**Total**
36		5			**5**
48				15	**15**
50	27	21	22	4	**74**
51			2		**2**
60	19	10			**29**
Total	**46**	**36**	**24**	**19**	**125**

Table 4.30: Hours of Work per week * Govt – Cross tabulation

Hours per week	Govt1	Govt2	Total
36	18	3	**21**
48	62	13	**75**
60	22	7	**29**
Total	**102**	**23**	**125**

The tables above apparently point to the large scale violation of the agenda of decent work time in both the sectors. ILO proposal is for 48 hours of work per week, meaning eight hours of daily work multiplied by six days and one day holiday in a week. The actual situation, however, is quite unexplainable, especially in the private sector, although, the govt. sector is not so much different. In the government sector, it is mainly due to the pressure of enormous number of patients, under their care. The nurse patient ratio in the government sector is also highly unfavourable to the nurses, and in the interviews it was even reported as 1:60 and sometimes even more.

In the private sector, however, this is clearly due to the practice of having two night shifts in a week, which is twelve to thirteen hours per duty, This in itself adds up to either 24 hours or 26 hours and the remaining four days of duty is another 24 to 32 hours minimum. Very often, these duties are never finished on time and it is extended by 30 minutes to one hour per duty. As many nurses had revealed during the interactions, 'the management is strictly following the entry time only and they never permit to be late at the time of beginning of the duty, whereas, they never even ask about the time we finish our duty as they themselves know that our duty is never finished within the allocated duty time'. The table below clearly reflects it once again, irrespective of the sector

Table 4.31: Prevalence of Overtime Work

Required to do overtime?	Hospital Sector		Total
	Govt.	Private	
Yes	102	103	205
No	17	20	37
No response	6	2	8
Total	125	125	250

Table 4.32: Provision of Overtime Allowance

Over Time Allowance	Hospital Sector		Total
	Govt.	Private	
Yes	0	25	25
No	114	84	198
No response	11	16	27
Total	**125**	**125**	**250**

There is, however, no overtime allowance in the govt. system while in private hospitals a small percent of 25 out of 125 receives an allowance. Here again the category who says that they get an overtime allowance are the nurses who work in the operation theater as otherwise, the management cannot manage to pay the overtime allowance for the doctors alone. The issue of break time was also looked into and the data is again quite discouraging. Only about 40% of them even responded and the duration of the break they get is even more insignificant. It is just about 30 minutes that they get.

Table 4.33:Availability of break time

Breaktime (in minutes)	Private1	Private2	Private3	Private4	Total
10	1	1	0	0	**2**
15	2	3	0	3	**8**
20	1	0	1	1	**3**
30	11	6	6	4	**27**
45	0	9	0	0	**9**
60	0	0	1	0	**1**
Total	**15**	**19**	**8**	**8**	**50**

However, their answer to another question on the way they spent their break time is more revealing. The time they designate as break time is actually the time they use for having their food, meaning that they are not provided with any specific time to have their food either.

Table 4.34: Mode of spending break time

Spending break time	Hospital Sector		Total
	Govt.	Private	
Having Food	51	33	84
Have No Break Time	41	24	65
Take Rest	4	4	8
Others	0	2	2
No response	29	62	91
Total	**125**	**125**	**250**

The above table shows the responses about their break time and it is interesting to note that 29 and 62 from government and private sectors respectively have no response and 41 and 24 respectively explicitly tell they don't have break time. The nurses don't really feel the 'break' as rest time as only four each from both categories have responded so.

Table 4.35: **Asked to work during Leisure time**

Leisure time working	Private1	Private2	Private3	Private4	Total
Yes	32	19	18	10	79
No	14	17	6	9	46
Total	**46**	**36**	**24**	**19**	**125**

Almost two third of the nurses feel that their leisure time is availed for work and there is no leisure as such while on duty. The fact is that many of those who have answered in the negative here have confided that, they actually do not have a leisure time. Otherwise there is no designated rest time at all for them, except for those who work in some special wards where there are no activities during the lunch break

Table 4.36: Number of Night shifts per week

No. of Night shifts	Hospital Sector		Total
	Govt.	Private	
0	1	0	1
1	80	11	91
2	34	77	121
3	4	4	8
4	1	4	5
No response	5	29	34
Total	**125**	**125**	**250**

Although, the number of night shifts during a week is two for a dominant majority, the largest number in the government sector has only one night shift per week , whereas among the private the largest number is having two night shifts per week. This is, as it was argued earlier also, the chief cause, by which the private sector nurses are made to work much above their designated duration. While we compare this with their salary pattern, it becomes easily evident that they are not only doing a 'dirty work', as claims by Sreelekha (op cit.) it is also indeed so heavy for them.

Combining Work, Family and Personal life

The general profile of the respondents, provided at the beginning of this chapter has already shown that, they are predominantly coming from a socially backward context. The table on the caste profile reveals that more than 62% belong to the OBC and SC/ST categories. The gender composition is as follows

Table 4.37: Gender of the respondents

Gender	Frequency	Percent
Male	35	14.0
Female	215	86.0
Total	**250**	**100.0**

It can be seen from the table above that more than more than 86 percent of the respondents are women and only the remaining belong to the male population. Obviously, these statistics are very much in line with the general character of population of nurses in India as provided by most studies on the nursing profession. The table on their marital status also is important to look at

Table 4.38: Marital status of the respondents

Marital status	Frequency	Percent
Single	90	36.0
Married	158	63.2
Widowed	1	.4
Seperated	1	.4
Total	**250**	**100.0**

Nearly 63% of them are married and the remaining 36 are single young women and men. It is this particular social and family status that makes this parameter of the DWA very significant to this research context. Also it is important to observe that, they predominantly come from families having low financial status too. The table below would give us more clarity in this regard.

Table 4.39: Family income of the Respondents (on monthly basis)

Monthly Family income	Hosp Sector		Total
	Govt.	Private	
upto 10000	51	59	110
10001 to 20000	40	37	77
20001 to 30000	15	17	32
30001 to 40000	10	5	15
40001 to 50000	3	5	8
above 50000	6	2	8
	125	**125**	250

Forty four percent of the respondents are falling below the category of monthly income below Rs. 10000. Another just above thirty percent falls in between 10000 and 20000.We can assume that they are one of the major bread earners of the family. Although, this is a dominant trend, despite the sector in which the work, it doesn't so much a reflection of ground reality in the government sector.

Comparatively, in the government sector the situation is much better in terms of the salary. In the present study, however, the data is a bit skewed in one direction as the respondents from this sector had sizeable number from the entry grade having very less service only. The following cross table elaborates this situation quite well.

Table 4.40: Comparison of Family Income and Salary in the Private Sector

	Private1		Private2		Private3		Private4		Total	
	FINC	**SAL**	**FINC**	**SAL**	**FINC**	**SAL**	**FINC**	**SAL**	**FINC**	**SAL**
upto 5000	8	11	1		2		1		**12**	**11**
5001 to 10000	13	19	14	10	6	6	4		**37**	**35**
10001 to 15000	6	16	5	25	9	10	4	8	**24**	**59**
15001 to 20000	4		2	1	2	7	1	9	**9**	**17**
20001 to 25000	4		2		1	1	3	1	**10**	**2**
25001 to 30000	2		1					1	**3**	**1**
30001 to 35000			2		2				**4**	
35001 to 40000			1						**1**	
40001 to 45000										
45001 to 50000	4		1						**5**	
50000 & above	5		7		2		6		**20**	**7**
Total	**46**	**46**	**36**	**36**	**24**	**24**	**19**	**19**	**125**	**125**

FINC – Monthly Family Income SAL – Current Salary

Table 4.41: Comparison of Family Income and Salary in the Govt. Sector

Govt. Sector	Total	
	Family Income	SALARY
upto 5000	13	2
5001 to 10000	32	4
10001 to 15000	23	63
15001 to 20000	14	8
20001 to 25000	8	11
25001 to 30000	6	15
30001 to 35000	3	2
35001 to 40000	7	9
40001 to 45000	2	2
45001 to 50000	1	2
50000 & above	6	1
Not responded	10	6
Total	125	125

The data provided in both the tables above is quite self explanatory. Still, it is important that the details are looked at closely as they are indeed so decisive in defining the DWA agenda Combining Work, Family and Personal life. Once again, as the data apparently shows, the nurse population is indeed in the margins as far as this parameter is also concerned, irrespective of the sector in which they are enrolled. The only difference is that, compared to the private sector, the public sector has a likely advantage over the private sector nurse professionals because of their salary factor. It is already shown above that they have a fairly better salary scale, because of which, they may enjoy a better chance of combining the work life with family life. They are also benefited further in terms of their advantageous positions with regard to better stability and security of employment, more rate of participation in social dialogue and the like.

However, the nurses in the private sector, is at a loss here. The facts that, they have very low salary, and also they are having more hours of work, especially night duty, significantly restrict their family life also. Although, this can vary from person to person and family to family the end picture cannot simply be positive at all as they have more constraints than freedom for a stable work life and family life.

Daily commutation from their home to the workplace itself is another serious obstacle acting against this balancing process. As the table below shows, majority of them stay at home.

Table 4.42: Place of Accommodation

Stay	Hospital Sector		Total
	Govt.	Private	
At home	98	110	208
Hostel	20	10	30
Paying Guest	7	5	12
Total	**125**	**125**	**250**

Table 4.43: Number affected by Commuting time

Commuting time affecting Personal/Work life	Hospital Sector		Total
	Govt.	Private	
Yes	58	66	124
No	55	56	111
No response	12	3	15
Total	**125**	**125**	**250**

The table reflects that fifty percent are affected by the commuting time since they are losing quality time to reach hospitals which they could have spent with family.

Table 4.44: Having Household Chores			
Who does the household chores?	**Hospital Sector**		**Total**
	Govt.	**Private**	
Spouse	29	34	63
Parents	65	60	125
In laws	6	6	12
Servants	2	0	2
Children	4	1	5
All of them	2	5	7
Self	18	19	37
Total	**126**	**125**	**251**
*due to multiple responses the total is greater than the no. of respondents			

Parents are a source of relief for nurses when it comes to the household chores. The second in line are their spouses. 18 and 19 respectively from govt. and private are having this responsibility for themselves. This is a number, that is not so negligible as these respondents reach home after a heavy schedule of work, which are often labeled as ‘back breaking’ and ‘dirty’. Hence, how do we assume any chances of a balancing between the work/personal lives?

Table 4.45: Presence of Family members requiring primary care

	Hospital Sector		Total
	Govt.	**Private**	
Yes	55	63	118
No	70	62	132
Total	**125**	**125**	**250**

Nearly 50 percent of them have got family members requiring primary care at home. They include infants or old age or specially challenged persons. This is another factor, which has a strong bearing on their work- life balance

Table 4.46: Time with family

Time with family	**Hospital Sector**		**Total**
	Govt.	**Private**	
Yes	67	66	133
No	58	59	117
Total	**125**	**125**	**250**

The table above shows almost fifty-fifty trend on the time they get to spend with family. Considering the data together with all the other tables provided above, it becomes apparent that the work-life is indeed so poor for this segment of labour force and it it is constrained by a variety of factors, although, there is a slight variation between the public and the private sectors.

Work that should be Abolished: the Hazardous labour in Nursing

The DWA is equally emphasizing on the need to protect the labour force of any segment from the works that should be abolished. It has identified various types of labour as coming under this category and predominantly includes child labour of all types, works that are not coming under their skill levels, hazardous employments,

insecure employments etc. The nursing job is traditionally attached with a lot of stigma and it is even considered as unclean and impure job. Many authors have even referred to it as an immoral job, mainly because it involves physical care giving for the members of opposite sex, predominantly to men by the female nurses. In the present study also, the respondents have been asked about their opinions on the risks and hazards that are attached to the profession of nursing, to integrate this parameter of the DWA and the answers point to several problematic aspects still persisting.

Table 4.47: Occupational hazards

Occupational hazards -YES	Hosp Sector		Total
	Govt.	Private	
Risky work situation	77	45	122
Lack of Personal Protective equipment.	69	84	153
Lack of Precaution towards communicable diseases	86	98	184
Lack of periodic Immunization	68	81	149

Table gives the number of respondents who answered affirmatively to the prevalence of the hazardous aspects like, prevalence of risky nature in job, absence of personal protective equipments, lack of precautions against communicable diseases, absence of periodic immunization etc. In the case of all the four factors the responses were very high and the respondents, irrespective of the sector, complain about the insecurities attached with the nursing profession.

The govt. nurses feel that they have risky work situation because of the type of patients they handle in the govt. hospitals, especially when the nurses come in close contact with the patients who come to these hospitals, who may not clearly disclose the nature and character of their illness always. Because of the nature of the job they do nurses should have been definitely be immunized towards such diseases which are easily communicable. And the data collected generally point to the absence of it.

Table 4.48: Non-nursing work

Non nursing work	Hospital Sector		Total
	Govt.	Private	
Yes	54	72	126
No	61	51	112
Total	**115**	**123**	**238**

Apart from the designated work of providing nursing care they are forced to do non-nursing works like the works of attendants, janitors or clerical jobs. Being a professional group they are not supposed to do these jobs, although. Still, it has almost become like their job, since in most hospitals, there are no persons available to perform such tasks.

Table 4.49: Serious accidents on duty

Serious accidents on duty	Hospital Sector		Total
	Govt.	Private	
Yes	24	8	32
No	94	113	207
No Answer	7	4	11
Total	**125**	**125**	**250**

In line with the earlier table on occupational hazards nurses experience, there are a few of them who met with serious accidents while on duty. Among them only a marginal number have got any compensation from their employer, and that adds to the hazards they face.

Stability and security of work

The informal sector of employment the world over is known for its insecurities and precarious nature. There is no stability factor attached with it and that is considered to be one of the most powerful reasons why, this sector is notoriously labour exploitative. Most labourers are insecure about their tenure of job and many live under the fear of losing their job at any time. The nursing sector, especially the private sector is indeed quite reflective of these dynamics and some of the interviews that were conducted as part of this study reconfirmed these concerns to a great extent.

The most significant basis of this situation is the fact that the private sector nursing is operating along very flexible regulative mechanisms and many a times there is no monitoring of their activities. Along with this, the private sector has gone through substantial levels of expansion and that has also undermined the efforts of standardization, especially since this expansion was instigated by the commercial or industrial considerations. The increased supply of nurse graduates, especially since 2009, following a serious relaxation of the norms for the establishment of nursing schools/colleges, has also contributed to the decrease of an already weakened capacity of the nurse professionals to bargain for any better terms of employment.

The interviews conducted; clearly reveals that, most of them are not even enrolled for the provisions like ESI benefits, and many female nurses even observed that they are denied of maternity benefits also. Incidentally, one observation made by a respondent was that, ‘although, the hospital management gives the promise of maternity leave, what is actually done is that, the woman who avail the maternity leave is not normally taken back after the leave, as the spot would have been already filled by another young nurse’. More seriously, the respondent further states that ‘the nurse who go on maternity leave is never provided with any salary for the period, and only if she is registered under the ESI scheme, she would get her salary, that too only 70% of it, if she comes back.’

The DWA parameter is therefore, significantly relevant to the nursing sector, although, these issues are quite taken care of in the public sector. The following tables would substantiate the situation further.

Table 4.50: Tenure of Employment

Nature of Employment	Hospital Sector		Total
	Govt.	Private	
Permanent	74	56	**130**
Contract	10	46	**56**
Internship	32	20	**52**
Others	9	3	**12**
Total	**125**	**125**	**250**

Although, there is a higher number from the private hospital who claims to be having a permanent appointment, the actual data shows an anomaly there, as 69 out of 125 nurses are actually working either contractually or as interns. Whereas 74out of 125 government nurses are having job security in real terms as they are working on permanent basis already. Most of the tables given below would also help in understanding the precariousness with which the nurse professionals are coping with. Most of the data point to the absence of any established procedure either in appointment, or in providing them with any specific job prescriptions, or in having a systematic scheme for promotions and finally in terms of provision of relevant in service trainings.

Table 4.51: Selection Criteria

Selection Criteria	Hospital Sector		Total
	Govt.	Private	
Interview	68	112	180
GroupDiscussion	0	9	9
Written Test	55	27	82
Others	30	6	36
No response	7	3	10
Total	160	157	317

*Since there are multiple responses, so the total outnumber the number of respondents

Interview and written tests are the prominent selection criteria for both sectors. Group discussion was practiced for a few in Private hospitals. The category 'others' include the 'compulsory service trainee nurses' in the government sector, who join this training on their request for the purpose of an experience certificate, rather than based on any formal channel of appointment. There is in fact, a higher demand for this as they get an assured salary of about 13000/- rupees and more importantly a widely recognized experience certificate which would be advantageous for their later career. Otherwise, they stand no chance of finding a place, which would ensure any meaningful training experience, or any prospective working conditions either. The private sector in some cases do not even provide any salary at all, even though, they would be asked to perform the all the tasks done by any other staff nurse.

Table 4.52: Provision of receiving Appointment order on joining service

Appointment order Provided	**Hospital Sector**		**Total**
	Govt.	**Private**	
Yes	88	49	137
No	37	76	113
Total	125	125	250

When two-third of the government staff is getting appointment order less than forty percent only are receiving the same in the private sector. This is actually the breach of employee-employer agreement and a violation of one of the most important element of the DWA, further reaffirming the insecurity of job in the private sector.

Table 4.53: Promotion Prospects

Ample scope for Promotion?	Hospital Sector		Total
	Govt.	Private	
Yes	33	23	56
No	72	92	164
No response	20	10	30
Total	**125**	**125**	**250**

The nurses, irrespective the sector of their work, are denied of a proper system of promotion. A large majority, 58% from government sector and 74% from private sector are saying that there is no ample promotion system for them, which affirms the violation of their rights once again.

Table 4.54: **Private Hospitals giving Appointment order**

Appointment order	Private1	Private2	Private3	Private4	Total
Yes	4	13	13	19	**49**
No	42	23	11		**76**
Total	**46**	**36**	**24**	**19**	**125**

Table 4.55: Fear of Termination

Fear of Termination	Hospital Sector		Total
	Govt.	Private	
Yes	30	85	115
No	95	40	135
Total	**125**	**125**	**250**

A very substantial percent of private nurses fear termination as they have no idea about the terms and conditions of their appointment, and there is no regulative mechanisms existing to protect them from such inhuman terms of employment. Almost as a consequence, it leaves them at the mercy of their employer and that acts against all their priorities.

Table 4.56: **Inspections by Governmental Agencies**

Name of the visiting Agency	Hospital sector			
	Government		Private	
	Yes	No Response	Yes	No Response
Health Dept.	53	72	52	73
Labour Department	49	76	52	73
Nursing Council	20	105	53	72
Other agencies	Nil	Nil	Nil	Nil

The above table clearly shows that, there is no proper system of inspections carried out by responsible agencies. At least, the nurse professionals are left with no communications about the visits, even if it is carried out as reported by some of the respondents. The frequency of the visit is also reported as very low and that shows the absence of any effective monitoring system in this sector, adding to the instabilities and insecurities experienced by the workforce of this sector.

Equal Opportunity and Treatment in Nursing Employment

The seventh parameter linked with DWA is the equal opportunity and treatment in employment. This parameter cuts across all the contexts of identity, be it national, sexual, linguistic, cultural and so on. The informal sectors all over, are widely characterized by several segregations and it is this aspect that the DWA is attempting to overcome. Studies like that of Sreelekha has convincingly, shown that the Malayalee nurses population in Delhi, is experiencing a number of hazards characterizing, questions of ethnicity, class and gender. The situation in other regions need not be much different at all, as the nurse population is subjected to differential treatment in one way or another. In Kerala, for instance, there is a clear segregation of the male gender from entering the nursing sector, although, there was an increased demand from the male nurse graduates in between. Most of the managements, are openly refusing it, saying that, they are responsible for the increasing unionization of the nursing sector. They also attribute the recent strikes and protest movements

among the nurse population to the role played by the male nurses who were recruited recently.

Table 4.57: Classification of Respondents based on Gender

Gender	Frequency	Percent
Male	35	14.0
Female	215	86.0
Total	**250**	**100.0**

Not deviating from the history profession of Nursing, a higher percent of 86 are female nurses. What is worth mentioning again is the fact that the 14% included in this study is in no way a small number as the proportion of male nurses as such is very low, in comparison to the females irrespective of the sectors. Qualitative data, collected from the interviews conducted in this study also, clearly support this argument as there is a declared preference for female nurses in private sector. Although, the female nurses welcome the entry of male nurse colleagues, as that could at least provide a little more security and support to their work. During the interviews, it was highlighted by many that, the entry of male nurses have become an important aspect, considering the adoption of more and more technical and mechanical instruments in this sector. Presence of the male colleagues would be useful also in performing tasks which requires more physical strength. Many female nurses, also reported that, they are struggling with terrible health problems like back pain and varicose vain problems as they are getting physically exhausted due to long hours of standing and walking along with even lifting the patients while shifting them for different treatment related needs.

Interestingly enough, the major reason provided by the management for the non recruitment of male nurses is that they may start the union activities, which in itself is a right of the work force, according to the DWA.

However, there is still an intriguing problem in the context of the public sector also, as the number of male nurses is very insignificant over there also. The union activities

are, however, permitted here. This is where, the problem point to the gendered context of the care profession. As statistics from different parts of the world demonstrate, care work is often categorized as women's work. It is also considered by many as a low status job, a 'dirty job'. Concerns of equality of opportunity, of payment, of treatment etc., all have limited value here. Equally important is yet another fact that, there is an established preference for young nurses, in comparison to the aged, as this also helps the management to reduce the salary expenditure in a big way, although, it may result in reducing the quality of care. The age distribution table below will reaffirm this argument much more clearly.

Table 4.58: Age interval

Age Interval	Hospital Sector		Total
	Govt.	Private	
21 to 25	44	27	71
26 to 30	34	61	95
31 to 35	12	28	40
36 to 40	8	5	13
41 above	27	4	31
Total	125	125	250

More than 93% of the nurses in the private sector fall under the 35 years of age, whereas 72% in the public sector is under the same age level. Although, the public sector is having some representation of the experienced, in this sector, it is terribly absent in the private sector. The situation in Kerala, do not fall much beyond the routine statistics found all over the world in these areas. If the DWA is to be put into practice, then it would require more active regulative processes, expediting of legal policies ensuring equality of treatment, in recruitment, payment, and of course opportunities and monitoring.

Safe Work Environment in Nursing Sector

Nursing is not generally considered as an employment sector with possibilities of fatal accidents and injuries. Still, there are questions of safety and occupational challenges, like for instance, risky work situations, risky work timings and possibilities of contractual diseases and illnesses. Whether there are any precautionary measures taken to cover these possibilities is a parameter taken seriously by the DWA. The present research has also explored it and the results are as given below.

Table 4.59: Serious accidents on duty

Serious accidents on duty	**Hospital Sector**		**Total**
	Govt.	**Private**	
Yes	24	8	32
No	94	113	207
No Answer	7	4	11
Total	**125**	**125**	**250**

In line with many types of occupational hazards nurses experience, there are a few of them who met with serious accidents while on duty. Among them only a marginal number have got any compensation from their employer. What is more challenging for the nurses are the types of harassments they face while they are on duty. This happens mostly during the night shifts and that adds up to their agonies.

Table 4.60: Harassment during night shifts

Harassment during night shifts	Hospital Sector		Total
	Govt.	Private	
Yes	33	32	65
No	73	63	136
No response	19	30	49
Total	**125**	**125**	**250**

Even though the number who report harassment is not so big, still the data does not rule it out in the job. This has its own relevance considering the fact that, the nurses are not provided with any infrastructural provisions, even during the night shift to protect them from any such challenges. Unlike in other professions, the nurses will have to attend patients(/clients) during odd hours and they may not even have the assistance of many senior staffs to help them out in case anything happens. As the interviews have revealed, most of them have no other choice, and instead consider it as just a part of their responsibility. The sizeable number who was not willing to respond to this question is also a relevant aspect to be considered here.

Table 4.61: Person from whom they experienced harassment

Person whom they experienced harassment	Hospital Sector		Total
	Govt.	Private	
Patients	17	19	36
Patients' Relatives	24	30	54
Hospital staff	6	10	16
Others	3	0	3
Not revealed	93	93	186
Total	**143**	**152**	**295**
*due to multiple responses the total is greater than the no. of respondents			

The table above, more or less completes the story untold in the previous table. Irrespective of the sector it is commonly from patients, patients' relatives/by-standers etc that they face the harassments. While 93 from each sector are not ready to reveal the source of harassment, this can only attributed be to the social/gendered stigma involved here. As a representative of a private management confided in an interview, in this study, 'nurses are the ones who are mostly in contact with public and patients in a hospital. Hence they are the ones who have to bear the brunt of patients, and most- patients misbehave and sometimes even shout at them for issues which are not even a part of their duty, like for instance the issues as non functioning of the television remote or the improper functioning of the room air conditioner.

Table 4.62: Type of harassment

Type of harassment	**Sector**		**Total**
	Govt.	**Private**	
Verbal	28	29	57
Emotional	2	5	7
Physical	1	1	2
Sexual	0	0	0
Not revealed	97	93	190
Total	**128**	**128**	**256**

*due to multiple responses the total is greater than the no. of respondents

Dominant form of harassment is verbal abuse, although, there is still a majority who are not ready to reveal the way they were harassed.

Table 4.63: Person involved in Verbal Harassment

Harassment from	Sector		Total
	Govt.	Private	
Superior Nurses	21	12	33
Subordinate staff	5	1	6
Hospital Authorities	9	15	24
Patients	28	26	54
Patients' Relatives	28	35	63
Not Revealed	79	81	160
Total	**170**	**173**	**343**

*due to multiple responses the total is greater than the no. of respondents

The major threat for nurses, irrespective of their sector of employment, is in the form of harassment is from patients and their relatives or by-standers. Some disclose the harassment from Superior nurses too.

Table 4.64: Types of Risks faced by the Nurses

Nature of risks	Govt.		Private		Total
	Yes	No	Yes	No	
Risky work situation	77	48	45	80	250
Lack of Personal Protective equipment.	69	56	84	41	250
Lack of Precaution towards communicable diseases	86	39	98	27	250
Non immunization	68	57	81	44	250

The govt. nurses feel that they have risky work situation because of the type of cases they handle in the govt. run hospitals. The limited number of availability of personal protective equipments, lack of precaution towards communicable diseases, non

existence of periodic immunization, etc are the major risks they face. Because of the nature of the job they do nurses should definitely be immunized against such diseases which are easily communicable.

Social security

DWA places a lot of value in social security provisions to the work force in the unorganized sector. This is clearly a reflection of its commitment to provide a healthy livelihood context for the workers who are not having any protective benefits of an organized sector. As it was evident from the variables discussed above, the workers in the informal employment sector generally do not enjoy much stability and security of employment or any other alternative protective coverage. In such contexts, the workers are very likely to face a lot of uncertainties in the later course of their lives. This is the situation that DWA wanted to overcome by proposing schemes to ensure a livelihood option for the workers. How far, it is integrated in this context is what is looked at in the tables below.

In India, almost all workers in the public sector are entitled to pension. They are also entitled to several other emoluments at the time their retirement. Benefits like Provident Fund also help them quite substantially at this stage. These advantages are largely denied to the labour force in the informal sector. While everyone in the govt. sector, are enrolled in both the pension scheme and provident fund scheme, the private sector nurses have very low enrollment rate. The table below clarifies it further

Table 4.65: Pension provision in the private sector

Pension	Private1	Private2	Private3	Private4	Total
Yes	2	4	1	6	13
No	44	32	23	13	112
Total	**46**	**36**	**24**	**19**	**125**

As the table shows, the large majority of respondents here are outside these benefits. The small number who have these schemes have availed it on their own through

private insurance schemes. The situation is the same with regard to their medical benefits also

Table 4.66: Provision of Medical Insurance

Medical insurance	Hospital Sector		Total
	Govt.	Private	
Yes	41	18	59
No	84	107	191
Total	125	125	250

A large majority of the nurses again do not have any medical insurance coverage irrespective of the sector. The government hospital nurses are better off – 41 out of 125 saying they have joined the personal medical insurance schemes.

Table 4.67: Provision of Subsidized Medical Care from the Workplace

Subsidized medical care	Hospital Sector		Total
	Govt.	Private	
Yes	79	6	85
No	46	119	165
Total	125	125	250

In govt. sector, the nurses are entitled to medical reimbursement benefits, whereas, in the private sector there exists no such consideration and during the interviews it was even revealed that, they do not even get any attention at all if they are sick. They will have to follow the same procedure of doing the registration as an outpatient making the same amount of payment as an outsider.

Once again the statistics do not support the DWA programme at all. The work force in the private sector is still not covered under most of these schemes and this can indeed lead to a miserable state of security of life. Already, it was seen that, most of them are denied of even a decent salary and most of them come from a poor socio economic background. Hence, the chances of decent livelihood is apparently much beyond their reach and only the implementation of protective policies and programmes would result in any turn of events. The growing number of protest movements and the repetition of strikes in the nursing sector all have to be seen against this background.

Social Dialogue, Workers' and Employers' representation

The informal sector of employment is widely criticized for its opposition to the trade union activities. The DWA, however, puts it up as a very important parameter to safeguard a decent work environment. At the same time, DWA has conceived it more in the form of a dialogue ensuring the representation of the workers as well as the employers.

Table 4.68: Nursing Union Membership

Nursing union	**Hospital Sector**		**Total**
	Govt.	**Private**	
Yes	94	29	123
No	31	96	127
Total	**125**	**125**	**250**

The government and private nurses are totally different from each other in their approach towards trade unions. When 94 of them are members in trade union from government sector only 29 from the private sector has joined the union. The reasons are quite debatable, although, it is apparently linked to their fear of displeasure of their management. The management is not at all in favour of the unionization and the fact that they do not even appoint male nurses, out of their concern that they may initiate the union activities is a clear evidence of that.

A separate table on the private hospital will show how the situation is different from hospital to hospital in the private sector.

Table 4.69: Union Membership in Private Hospitals

Nursing union	Private1	Private2	Private3	Private4	Total
Yes	0	3	24	2	29
No	46	33	0	17	96
Total	**46**	**36**	**24**	**19**	**125**

The table shows significant variation in union membership across the private hospitals. While the nurses in the first two hospitals are largely without the union membership, the third one is an exemption to this. The fourth one again is not so much unionized either. In fact, the extent of unionization is indeed expanding as the recent strikes and protests by the nurses have demonstrated. Over the last six or seven years, there were several protest movements organized under the banners of different unions. Some of them have been effective enough to bring about some bit of improvements in the condition of nurses in Kerala and even outside. Still, there are issues to be tackled. Many a times the promises made to the leaders of nurse agitations are ignored later by the authorities. Even in the recent past, there was a strike organized under the banner of United Nurses Association, organized in front of the Kerala Secretariat, on 25th of February, 2016, which was attended by a significant number of nurses as it is evident from the photographs below.


STOP

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കരളലിവില്ലാത്ത
അധികാരമേ,
കണ്ണു തുറക്കൂ..
നീതിയായ
കൂലിക്ക്
വേണ്ടി
നേഴ്സുമാർ
സമരത്തിലേയ്ക്ക്
una
സെക്രട്ടറിയേറ്റിന് മുന്നിൽ
ഫെബ്രുവരി 25 മുതൽ
ജാസ്മിൻഷ
അനിശ്ചിതകാല
നിരാഹാരത്തിലേയ്ക്ക്
UNA UHSA UNSA UNTA UNPA UWA UNA PRAVA
HOUSE PLOT FOR SALE

This movement was a much publicized one and the strike, which was planned as an indefinite hunger strike was called off within 10 hours, claiming that the government has accepted all their demands. But, there are no decisions announced ever since. The interactions with some of the participants in the strike later revealed that, the UNA which was the prime organizer has gone through a division and it has split apart on political lines. This is not a welcome movement as the nurses in the private sector as such are not organized enough and any further division would only lead to more and more weakening of the movement. Anyhow, the fact that this protest movement was attended by thousands of nurses, who work in various regions in Kerala, clearly depicts the fact that, they are a much aggrieved labour segment and are in need policy interventions, regulative measures to ensure their rights as labourers.

Unfortunately enough, majority of them in the private sector, do not seem to be free enough to mobilize themselves, clearly out of the large scale insecurities of their employment they face from their managements. Some of them have also confided in the interviews that, they do not have much faith in the existing unions as they are quite politicized. The issue is more about the lack of any proper dialogue, especially the absence of any scope of a dialogue between the managements and the labourers. The labourers are seriously under surveillance. Some of the nurse respondents from one of the private hospitals, where the study was conducted, even showed us the presence of surveillance camera kept inside the hospitals at several points. According to them, those cameras are kept there to monitor the nurses, to see if they are where they are supposed to be? To see, whether they are taking rest or doing their work? To see whether they are sitting or standing while on duty? Obviously, they live in a sort of fear, fear of losing their job, fear of termination, fear of denial of an experience certificate. Their answer to the question of whether they have ever been part of any collective bargaining process, the answer was mostly in the negative. This is quite an anomaly in the history of Kerala, where labour radicalism is a widely discussed reality

Table 4.70: Collective Bargaining

Collective Bargaining	Hospital Sector		Total
	Govt.	Private	
Yes	18	8	26
No	107	117	224
Total	**125**	**125**	**250**

Amongst the nurses only very few represent them on a bargaining table. They are somehow insulated against it. Their response to the participation in strikes are also equally negative.

Table 4.71: Participation inStrike

Strike	Hospital Sector		Total
	Govt.	Private	
Yes	47	30	77
No	78	95	173
Total	**125**	**125**	**250**

Table 4.72: Discuss their problems with the employer

Discussion with employer	Hospital Sector		Total
	Govt.	Private	
Yes	68	44	122
No	57	81	128
Total	**125**	**125**	**250**

It is generally seen that majority in the private sector do not have discussions on their job related issues with their respective employers, while the government sector is little better in this regard. But this is still not the case with almost 40 percent nurses

Table 4.73: Employer asking concerns

Employer asking concerns	**Hospital Sector**		**Total**
	Govt.	**Private**	
Yes	39	42	81
No	86	83	169
Total	**125**	**125**	**250**

In continuation with the earlier table here the nurses responded to the question whether there employers do ask the nurses about their problems if any or opinions on ways to improve their work situation, they answered largely in the negative.

Table 4.74**: Family questioning unionism**

Category	**Hospital Sector**		**Total**
	Govt.	**Private**	
Yes	67	6	73
No	58	119	177
Total	**125**	**125**	**250**

Majority of the families of the nurses in the private sector are against unionization. This is again a clear depiction of the nature of insecurities of job that this sector reflects and also the level of dependence that the families have on their profession in spite of the minimum levels of benefits attached to this job

Table 4.75: Role of the Union

Union helpful	Hospital Sector		Total
	Govt.	Private	
Yes	73	93	166
No	52	32	84
Total	**125**	**125**	**250**

However, on their own they would like to see that nurses organize into a powerful union context. Because, there is hardly any other prospects for them in front of them. At the same time, they have fear in joining unions as that may result in loss of their job. Obviously, they are in a serious dilemma. This is where, the need of interventions emerge. Regulative measures are indeed required. In the absence of that, the nurses may miss out on this parameter of social dialogue, participation will decline, and invisibilities will increase.

Section 2

Section II

This study was originally conceived within a mixed methods approach as the research context comprises different types of respondents, who probably reflect the multiple dimensions of the problem under study significantly different from one another. Accordingly, qualitative methods were also employed and this section of the data interpretation is primarily a transcription of the data generated through the qualitative interviews. The section is also in a way an attempt to address the objectives, reflecting the qualitative character of the topic, especially the questions of Gender and the dynamics of management perspectives on the nursing profession, which are more of descriptive and interpretive nature. A total of five in-depth interviews were carried out and as the respondents are very particular about their anonymity and confidentiality of identity, their names are avoided and pseudonyms are used to refer to them. The respondents include persons from both, the private and public sectors as well as experts who have themselves, taken up efforts to evaluate and thereby address the dynamics of health care sector. Also it was attempted to collect some qualitative insights from the point of view of a couple of nurse professionals belonging to the different sectors.

Case 1-Ajitha

Ajitha (*pseudonym*) – is a nursing professional (in administrative wing) with considerable years of service in the Nursing profession and she is presently heading the office in charge of nurses in a government sector.

Asked about the issues existing in the sector, as a person concentrating on the administration wing , Ajitha was quick to respond and point out the *lacunae's in the existing system* .The grave reason cited was the move of Indian Nursing Council in 2012 –relaxing the norms for starting nursing educational institutions. In the backdrop of shortage of Nurses, the Council diluted the provisions for opening nursing educational Institutions. Though it was the need of the hour then, in the long run this has led to mushrooming of substandard educational institutions diluting the very quality of students passing out each year from many of those institutions.

Whatever may be the reasons, Ajitha finds it difficult to accept the change whereby entrance exam as qualifying mark for joining nursing degree has been given up since the last five years. Also she is unwilling to accept the decision to lower the minimum mark of the qualifying exam. In her view, all this are seriously affecting the quality of this profession that is bound to provide quality care for the patients. Ajitha's concept of nursing is that it is a profession that demands utmost quality and dedication from those who join this profession.

As far as private institutions are concerned, she feels that a proper coordination between the Nursing Education Department and Nursing Service Department of Hospitals is to be maintained properly at any cost. Only then will the students get proper exposure and guidance during their study period. Unfortunately, that is not happening at the moment. This in her view is a direct result of the aforementioned relaxation in norms. The most visible impact of this relaxation is what she calls a '*demand – supply imbalance'*; which is, in her opinion, the main reason because of which the nurses are paid less everywhere. It is this increased supply of nurses and decreasing demand which is leading to unemployment, underemployment and poor working conditions in the nursing sector. She finds the declining demand for Indian nurses in foreign countries, Libya, Syria, Jordan etc and increased demand for Philippine nurses in Arab countries, all a reflection of this dilution of quality in our nursing training, adding fuel to fire.

Coming to the administrative side, the fact that nursing posts are not created in Institutions as per the direction of High Power Committee and Nursing Councils, also merit attention. As per the statistics available, the annual requirement of Nurses within Kerala, is just around, 10000 in number, whereas the actual supply is more than 27000. Citing statistics, she says, during the year 2012-2013, around 10-12 thousand nurses got registered Kerala Nursing Council, from the nursing schools operating in Kerala itself. In addition to this was the registration of 17000 nurses educated from outside Kerala.

The two most important issues faced by nurses demanding urgent attention according to her are; Low salary & Allowances and the unlawful and exploitative practice of trainee system:

"Low salary is one of the greatest ills of this sector. Salary is never in proportion to either educational qualification or experience. They are too low paid. Salary both in Government and Private sectors should be revised taking into consideration their quantity of work as well as quality of work required. So is the case of Allowances- they are not paid risk allowance and other mandatory allowances, although everything is mandatory as per several policy decisions."

What is required is a *'Costing Study' (An estimation of expense incurred by a patient and its share for doctors and patients. This will ensure that they are paid in proportion to income of the management and does not remain underpaid)* She vehemently opposes the unlawful and exploitative practice of 'trainee system' and considers it as the major factor behind the exploitation of nurses everywhere, and especially in Kerala. Under this system, they are appointed as trainees for about two years with only menial wages. In reality they don't need any such system because if a nurse has undergone proper studies and did their degree in a quality institution for sure they will be experienced. From the first year of nursing course onwards they are exposed to clinical training. What happens is that the private hospitals appoint trainees but do not give any training. They work as staff nurse and carry out all responsibilities, only difference is in pay. For this exploitation to be curbed she demands that the Council should specify the maximum percentage of trainees that a private management could appoint.

She also draws our attention to the case of Nursing Students Stipend (in Government sector), which is in her view a kind of anomaly that exist here. While a large number of nurse trainees are terribly exploited in the private sector, even after completing the studies, their counterparts in the government sector are enjoying a provision, wherein, they are well paid and free to leave as and when they find better prospects. What she refers to is the case of B Sc nursing students in the government sector, on completion of their course is supposed to undergo one year compulsory service in the government hospitals. During this period they are entitled to get rupees 13,900/- as stipend. At M Sc level the stipend is Rs 18,500. There service will be in clinical supervision and teaching. They too are free to leave in between as it is optional only. Indeed, there is a serious discrepancy, when compared to the nurses in the private

sector. To get this much of salary, a nurse in the private sector may have to complete a minimum of five to ten years of service. This claim is, however, not so much reflected in the present study, as many nurses who have joined the medical college under this category, were even unaware of their salary status. Some even answered that they do not have any salary.

A cross comparison of career enhancement opportunities for staff nurses in public and private sector is also made by Ajitha. While in private sector there is no such provision for acquiring higher qualification, while in service; in Government sector a quota is fixed for them in all Government owned nursing colleges. But still the enrolment ratio remains too low owing to the fact that the additional qualification is never considered to be a criterion for any hike in salary or chances for promotion. Ajitha, here comes out with a creative and practical way to tackle this issue. Higher qualification should be made mandatory for staff nurses just like the doctors in order to acquire promotions.

Commenting on the unionizing of Nursing profession, she supports the idea of responsible unionizing. *'It should be responsible and activities should be through proper channel and for justifiable demands. Similarly management shouldn't consider union activities as dangerous to the future of the institution. Managements should become sensitive to the rights of workers in their institution and find solutions for their problems also. As reported in Balaraman Commitee report, the issues such as low pay, lack of overtime payment, overload of work, worksite harassment etc should be dealt with by maintaining proper dialogue between the parties and if that does not happen, it is important that we resolve them even if it is through unionization."*

It is Ajitha's strong view that, keeping the nurse professional satisfied with their working conditions is a must for the health care system of any country. As otherwise, it will only damage the public health status and in the process would lead to a terrible loss of nation's manpower and national income. The patient safety should be our priority at any cost. According to her, good working environment, better infrastructure facilities, better salary, availability and supply of good quality equipments, positive feedback, provision of perks and other allowances, guidance and support from supervisors, adequate support staff, maintaining prescribed nurse patient ratio and

facilities for knowledge updating are the major factors adding to the job satisfaction of Staff Nurses.

Looking forward, Ajitha keep hoping for a leadership with willpower, who could implement the written laws of our land. Special mention is made about the possible role of State Nursing Council- which is entrusted with the responsibility of implementing the laws and regulations in this field. According to her, the council has immense power and authority, but how far is it utilized is a question!

In between, attention is also drawn towards the different Bills pending in the legislature- like the Clinical Establishment Bill**.** Realizing the shortcomings, Kerala Government appointed a committee in 2010 to modify the act. And so was modifications suggested, however it still remains as an act awaiting sanction and approval by the legislature. Hence an urgent amendment of RNMC Act is the need of the hour. She points that the council is still functioning on the basis of outdated laws and rules- formulated years back. They have the authority for quality checking, imposing fines etc. But the fine so imposed is still the amount fixed years back and so outdated.

For a wholesome improvement in health care sector she also feels the need for passing of Clinical Establishment Bill by the State legislature. At present hospitals comes under the shops and establishment Act. The same has been implemented in the Central sector but pending at the State level, maybe, due to pressure from many Private Hospital managements.(as understood from media reports, she says)

Another insightful observation by Ajitha was that unlike earlier times, we need to get rid of the compartmentalization of this profession as one suited only for the females. She finds it the need of the hour to welcome more and more male nurse professionals, because of changing trends in the medical field, as increased use of technical and mechanical devices in hospitals for the treatment and medical care of patients. It is learned through experience that in such areas as critical care, emergency department and psychiatry department, the male nurses outshine female. The contribution they could offer in shifting, lifting patients is highlighted. At the same time she finds that 'when it comes to such soft areas as Geriatrics, pediatrics etc the inborn nature of females is an added advantage'. Basing herself on the above considerations, she goes on to argue that *a 'judicious mix of both gender'* is required in the profession and it is

the authorities who have to do the division of labour keeping in mind the above facts. No more should it be considered a female only profession. She was also of the opinion that the private managements have almost opted out from recruiting male professionals in this sector, fearing unionization. This has become like a trend in Kerala, and only through a legal procedure we can overcome this hassle now.

Moving on to the question of societal response and dignity of the Profession, she is happy that overtime, change has occurred in the way society view this profession and professionals. The stigma towards this profession was an offshoot of some practices within the field, wherein the nurses are very often forced to do non nursing work, due to the insufficiency of supporting staff. This, in turn, creates a feeling that nurses are the ones who are supposed to do all sort of work, which the attendees or assistants are required to do.

Ajitha, although, a representative of the managerial sector now, she is apparently well aware of the way this sector is working now. Her views are visibly reflective of the problems looming large in this system. There are several insights that could helps us in finding an answer to many of the issues, identified in the present research too.

Case 2 : Sajitha

Sajitha (pseudonym) is a Managing Superintendent of a private hospital in Trivandrum. She clearly represents the management perspective when compared to the case above. At the same time, she is also able to think aloud reflecting the status of the profession of nursing, in terms of its overall character, especially the changes happening in this sector. She finds sea of changes in the societal attitudes and stigma shown towards the nurses. She recalls that, in the early days, it was quite difficult for female nurses even to get a decent marriage alliance. The reason quoted being that they are interacting and dealing with a good number of patients who include males and that made people to view them with suspicion regarding their character and morals. This is no more the situation, says Sajitha. The reason, she found relevant for this change is that nursing has turned out to be a job with lot of prospects and as a profession it is having chances to go abroad, that too along with attractive offer of

salary. As a result, there is a huge rush in the nursing colleges seeking admissions, and that is why there are more nursing colleges in Kerala, at present.

However, she agrees to the fact that nurses are facing much stress and strain at work even at present. This is however, not due to the problems of the hospital management, Rather, she attributes it to the changes in the attitude of the patients and other groups who visits hospitals. In her words

> *"An attitudinal change of patients and relatives are visible over the years. Nowadays the general awareness of people have increased and naturally they have started demanding for services. They, no longer consider nurses with awe and respect or as 'angels'; but just like any other profession, where one provides different services on making a payment. That means, the service dimension attached to nursing profession in earlier days has fast disappeared and it is more seen as a profession or just another career."*

How come only the nurses are responsible for this change, is, however, left unanswered by Sajitha. Obviously, this change from being a service sector to a commercial establishment is not in anyway, because of the way the nurses conduct their profession. It is more of a change from the above and that is what is pointed out by many committees including the Balaraman Committee and it is the same understanding that is coming out from this study also.

But, Sajitha, also admits that, this has increased the stress issues for Nurses. It is the nurses who are mostly in touch with the patients and bystanders, and they are the ones who are mostly answerable to them. Even for such technical, non medical matters as improper functioning of air conditioner or television remote, the patients complain and criticize the nurses who frequently visit them."

As a nursing Superintend, Sajitha shares her experience that she is the one who is accountable to the Management and therefore, all that she is concerned is about the performance of nurses. This is the context, where she has to be so strict with the nurses, which they attribute as harassment. She is critical of the tendency of Doctors also for it. Many a times the doctors give instructions to nurses over phone and when anything goes wrong the doctors simply skip by saying that they haven't given such instruction and naturally nurses can't question back.

As far as appointing of male nurses are concerned, as a management representative, Sajitha brings out a number of reasons for avoiding them. In her view, the male nurses are difficult to manage, they are not submissive as female nurses, they raise questions and demand more facilities, and more significantly they often lead to unionization. They are found not complying to the rules and regulations of the hospital such as, not to use mobile phones during duty hours; don't strictly comply to duty hours, take more break time etc. Often they develop love affairs and this affects the hospitals work and reputation also.

Sajitha, cites an ethical reason also for this omission. As most of the doctors in her hospital are males, for a male doctor to examine female patients a female nurse should be present there. So naturally we need more of female nurses. Also female patients won't feel comfortable with male nurses. The irony, here is, whereas there is no ethical and moral issue in a female nurse taking care of a male patient, the same is not considered ideal for a male nurse. Hence, if a male nurse is to attend a female patient then another female nurse has to accompany them, which means an additional financial burden for management, claims Sajitha.

However the reasons she cited for hiring of female nurses were more conflicting. It is seen that the management prefer young, fair and beautiful nurses, because they have a *pleasing* personality, and therefore, even if any issue emerges, the patients ignore that more often, if they are attended by female nurses! At the same time, she do believe that the nurses today are not compassionate and soft hearted as nurses used to be in the past, and they are having an ' I don't care' attitude, Rather than service, they are more concerned with salary and other such benefits. They are not even ready to work overtime; many are using their duty time for personal needs; like preparing for IELTS examinations, or always looking for a hospital with little better salary etc. The response of Sajitha to the question of factors affecting Nurses' job satisfaction, were the speedy recovery and well being of the patient and not infrastructure and material benefits.

Obviously, there are lots of views expressed here, which are highly contradicting in nature. Still the fact is, Sajitha is representing a private management and she cannot, therefore, absolve herself of the role they play in undermining the working conditions

of the nurses in this sector. To defend herself, she can only pass it to the changing attitude of the nurses themselves. The anomaly is that, the nurses in the private sector are not at all getting a decent salary, and in that case how can one attribute the attitude of nurses as salary oriented. Also it is a fact that, the patients are complaining not about the care given by the nurses, rather it is about the exploitative attitude of the hospitals, especially the rising expenses that they are being charged by the hospital administration.

It was noticed during the study that the norms stipulating in service education for staff nurses are often violated by Private Hospitals. The same issue was brought to notice to Sajitha and the reason she cited was lack of interest from the side of nurses. She says, " *these lazy nurses want to have trainings during their duty hours only, and that is why the management refuses it*"

Moving on to the issue of lack of infrastructure, she vehemently and harshly opposes that as merely accusations. Her claim is that the nurses are provided with enough facilities everywhere. However, the fact is that, the nurses in the same hospital had reported to the team of this research, that there is only a single chair for about 5 staff nurses who are present at a time in nursing station, and the researchers had personally seen that too. Interestingly, Sajitha, herself contradicts her position, when she further observes that " *the profession demands the nurses to stand and not to sit. And only the wards in charge is supposed to sit and all the rest should be always be vigilantly attending to patients in the ward. She goes further and says that, it is their duty and nature of work that they have to stand and so why should we provide chairs and in the process turn them lazy?"*

Regarding the prevailing high Nurse patient Ratio also, she is fast to respond that, it is much better in her hospital. At a time there will be around five staff nurses, three student trainees, and one nursing assistant in a ward. At least there will be 6 'nurses' at a time in ward. And maximum they need to take care of is only 16 beds. So the nurse – patient ratio is about 6: 16. And hence no question of extra work load in this hospital, she adds. But the, fact remains, most of them are hired straight from their own nursing school, and they work for cheap money. They work there for an experience certificate and the casualty is the 'quality of care', pointed out by Ajitha, in the first interview.

Asked about the occurrence of diseases as part of their work, she shared a totally insensitive attitude by saying that *"It is their irresponsibility and negligence that leads to diseases. All equipments are provided but they don't use it properly"* Her response to the query regarding health issues resulting from the nature of their work, is equally abusive*"they should resign and* go home." Almost as a consequence, many nurse professionals in the hospital had reported complaints about the several physical ailments like back pain and Varicose Vain, apparently due to continuous standing. In fact, the team of researchers was even advised by the nurses to look at the cameras installed in the walls, which is according to them kept only to monitor their movements.

Regarding the unionization of the profession, Sajitha vehemently opposes it on the claim that if a nurse is good at work then naturally she will get benefits. And it is when they don't work well and want benefits that they go for unionization!. Sajitha, is just the one private management representative whom we managed to interview. All others whom we contacted refused to be interviewed. The quantitative data we have collected from the other private hospitals were all pointing to a lot of similarities in their working condition, although, in some hospitals, the situation is a bit different. Hence, it is almost possible to draw an inference that the attitude of Sajitha could be the same as that of the other managements elsewhere. The interview conducted with one nurse professional, who is also an active member of a nurses union is also supporting this inference.

Case 3: Mr Rajeev

Mr. Rajeev (pseudonym) is working as a staff nurse in a project funded by a council of medical research at a Government hospital in Thiruvananthapuram. He hails from a middle class family at Kottayam and his father was a government employee. He chose this profession with personal interest. He gives prominence to the satisfaction he gets from caring and helping a person who is ill. This 32 years old male nurse has secured his diploma in General Nursing from Bangalore. He studied there for three years and also has work experience as staff nurse in several hospitals. For the past five years he is working as staff nurse in the present project. His duty hour is not hectic as compared to other staff nurses. Apart from project related duties he has one day

clinical duty. Earlier he had a salary of around Rs.23,000 but now he has only Rs.16,000/-. Interestingly, his wife is also a nurse and she works in another private hospital in Trivandrum

Recollecting his academic experience at Bangalore he says, “The income of my Father helped me in my nursing studies without any loan. But I know other students who took loan for their studies. They are facing huge financial problems afterwards as they never get a decent salary anywhere in Kerala”. Also he says that, the quality of nursing education at Bangalore is very poor. The inexperienced faculties are appointed and they are taking classes for the nurses. The nursing students are not given proper practical and theoretical knowledge. Majority of the students are not equipped with the sufficient nursing skills during their training period. He himself admitted the fact that he acquired the nursing skills only after starting working as a nurse.

As a person who studied in Bangalore he knows that he has no enough skills in nursing, he was well aware that he may not get a good job here in Kerala. So along with some other friends he went to Pune. This nursing job was arranged by a Kerala agency located at a remote village in Pune. The salary was fixed as Rs.3000/- but after reaching there the salary was refixed as Rs.2500/- saying, he has only poor knowledge in Hindi language. Although, he worked there for only six months, with in that time he managed to acquire a lot of practical skills in nursing. He says that, the colleagues in that hospital were A.N.M staff and they had good practical knowledge and that helped him.

After coming from there he got appointed in a private hospital in Kerala. Though salary was low he was happy working there as it is his home land. Here again, new issues came up. He faced harassment from a male doctor. Rajeev says that, he was the only male nurse in that hospital. This doctor from North India has an attitude that only female nurses are good enough. He always used to shout at Rajeev even in front of patients for no reason. At one time the doctor verbally abused him in front of patients beyond the limit. Rajeev really felt so bad and on that he registered a complaint to the authorities, who made some enquiries based on the incident. After that incident, Rajeev worked there for two more years, but he only by personally avoiding the doctor who insulted him.

After two years he left that hospital and joined for a specialization course in Cardio Therapy and Vascular Diseases. The course was for two years and more than the theory, practical sessions were prominent. This helped in upgrading the skills. But there he faced some other kind of problems from superior female staffs. He says that one female nurse often used to irritate him. She always complains about his nursing skills. Also he shared another experience he had during his second year. While attending a post operative ward patient at the cardiac unit for the first time, one superior female staff assigned him to receive patients but he was new to this ward and he didn't know how to do all that. But he somehow managed to do this with the help of other staffs around and he prepared the report of patients. Later when the female nurse came and checked the records and she started to shout at him pointing out his inability to create a report of the patient. He said he is new to this kind of case and he had created one report by enquiring from other staffs. But she never accepted his statement and went on to shout. Eventually he lost his patience and replied her saying that he is an inexperienced person and don't know how to prepare the report. But as an experienced person she should correct him instead of shouting. Then the lady became normal and he apologized for her behaviour if it has hurt him. But after that he didn't face any problem from that senior nurse.

He says the male nurses who are working in this profession are having a lot of struggles. As of his own personal experience, so many people including females, are often asking him, "*why are you doing a job of cleaning and collecting human excreta?*" He says this is a clear reflection of the general attitude of people towards the nursing profession. The people don't know what the nursing profession really means. However, Rajeev also adds, whenever, he attends a patient, he had never faced any problems from them. He keeps a friendly nature with the patients and creates a rapport which helps him to deal with the patients without any troubles. As a male nurse he is satisfied with his job in a cardiac section.

Rajeev is of the opinion that the social situation is not so much favourable to the nurse professionals. He believes that it has to be changed at any cost. He recollected one comment by a highly reputed and experienced doctor regarding the nursing students demand for increase in stipend. What the doctor said was that, "If you want to have higher salary you should go for MBBS, there is no need for giving higher wages to

nurses". Thus the nurses are treated as second class or lower class employees within the medical profession itself. The attitude of patients is also not different as they too represent the same society.

As per his experience, the possibility for a male nurse to get employed is tough. One of his nursing friends has been trying to get an appointment for a long time, but he is avoided by everyone, in the name of being a male nurse. And he is now working as a medical representative. More than 80% of the qualified male nurses are now working outside the nursing profession. The majority of these persons depend on the pharmacy sector for employment. The hospital authorities are reluctant to appoint male nurses in private hospitals, fearing that, their exploitative policies will get exposed once the male nurses get into their hospitals.

He holds the view that the private hospitals have rules and regulations of their own, they change them according to their interests and nurses are always victims of that. Nobody is daring to talk against the private hospitals because they may be terminated or their experience certificate and relieving letter may be denied. Union is good but the political agenda behind it is currently making the nursing unions ineffective. Rajeev is not a member of a political union. Rather he has joined a non-political nursing union.

His life partner is also a nurse in another hospital. So he feels good to manage work and life. But she is also having several problems including low salary and lack of leave benefits etc. He concludes by saying that, without good doctors nobody goes to a hospital but no one cares about the nurses. No one ask who the nurse is. So such kind of a situation exists and this is being utilized by the hospital authorities. It is not just that nurses are getting less salary, more disturbingly there is no consideration for the work they are doing. No respect is shown towards the nurses. This has to change.

Case- 4: Pooja

Pooja is a senior faculty in the field on nursing education. As a faculty in Nursing Education field she too has a lot of concerns about the nature in which the nursing sector is transforming of late. Just as the first respondent in this section, Pooja has also closely followed the dynamics of this system, and has also got some significant suggestions for the improvement of this system.

Pooja has serious concerns over the way quality of nursing education is coming down. Giving up of the entrance exam is cited as a reason for this. However, an advantage she does mention is that, the students from remote rural and tribal areas, who could never afford the entrance coaching and other shortcut methods to get into nursing profession, are now able to get admission directly. In her opinion, there are also several other systemic issues which require immediate attention to save this sector from further disorientation. For instance, there is a need to give recognition to specialization in the field of nursing. She adds, "Among nursing students a good number of specialty courses are offered. But rarely there are any opportunities in their specialization field. Whatever be their specialization they will be appointed merely as a staff nurse. Varied specializations, such as Cardiology, Neurology, Public health Nursing is offered right now. Students with specialization in Public Health Nursing can really do a lot of good in improving public health. But now all those posts are under the designation of Multi-purpose health workers – JPHN, ASHA workers and so. Actually additional posts need to be created to suit the expertise of those with MSC degree and specialization. Their knowledge and expertise should be used for the good of the public."

Thus she demands creation of additional Posts in the field matching the qualification and specialization of Nurses. As of now in PHC's- 3 posts of Nurses and in CHC's 7 posts for Nurses exist. The opportunities as Primary care practitioner, Family health Practitioner, Gerontology Nurse Practitioner etc need to be created, who, in her opinion could do a lot in Promotional and Preventive areas, especially with regard to Life style diseases. If they are appointed and their services provided to public, the quality of health care could improve a lot and also reduce unemployment rate. Pooja, suggests the creation of the post of Nursing instructors- those with B Sc nursing degree- can be appointed in hospitals for providing guidance to nursing students. Also when not having guidance work they can be asked to do clinical work as well. Nowhere in Kerala is such a practice followed. It exists in other places like the Vellore Hospital.

Pooja opines that nursing profession is an arena of exploitation mainly due to the fact that it is female majority one. Although, being a faculty she is also of the opinion that, it is the females who express much aptitude to this profession, basically due to the

caring nature of females! However male nurses are considered as an asset in such areas as emergency and critical care. The example cited is that of the functioning of *108 Ambulance under KEMP (Kerala Emergency Medical Project),* wherein major chunk of nurses are males whose quality of work and presence of mind are applauded often.

Here again, what is coming out is the gendered logic that surround this sector of employment. Of course, these are possible questions of debate. At the same time, Pooja is pointing towards issues which requires close analysis as the sector as such is seriously disoriented and indeed in need of policy reorientation

CASE-5: Anamika

Anamika is a supervisory grade official in the Government Sector. She is a person with immeasurable years of experience in this sector of employment, both as a nurse and also as a person in supervisory charges guiding young nurse professionals. When asked about, what makes nursing profession distinct, Anamika straightly started reflecting on her own experience as a Staff Nurse and said:

> *"Unlike many other areas of work, this profession is not one dealing with files in which some delay, postponement and compromises are possible. Herein work and action is time bound. This is a life saving profession and naturally demands timely attention without delay. This in turn demands dedication beyond time and stipulated working hours. One should be ready to work even if duty hours are over; when the situation demands.*
>
> *This is an area where zero error is expected. No excuses or errors can be entertained. Once an IV fluid is given to a patient you can't take it back. The profession demands utmost attention and dedication. All the 5 senses should work at a time. One is not expected to be gloomy or not concentrated during duty hours; due to some personal issues. Once into duty, they should be physically and mentally present there."*

She adds, there is no need to glorify the above peculiarities and portray Nurses as 'angels on earth'. In fact in her opinion that is becoming like the background for many of the suppressions and exploitations in this field right now. The following interview

excerpts conveys in exact terms, the dedication and commitment of a Nurse that Anamika is having in her mind

> *'Once on duty and we wear the Uniform we forget everything else and are totally into our work. Maybe similar to the way Khaki uniform gives an orientation of service and responsibility to a Police official .Only if we aim for 100% perfection we can provide at least 80%. So, personal involvement is the greatest demand of this profession."*

With regard to the gender element, Anamika strongly believes that this profession has a gender element. She favors that this is a profession best suited for ladies. Men can never replace women in this sector because the kind of love, compassion and care that a lady provides is exceptional. That is nature's law- the element of Mothers love and care is an important element here. However, she is not against the idea of male nurses coming into this sector. Instead, she finds male nurses to be most important in those instances where more physical tasks are involved like when it is required to move a bulky patient from one place to another etc. But they are not that caring and compassionate as female nurses who have an inborn instinct for it.

In the particular hospital where Anamika works, there are only 11 male nurses, although the total nurse strength is more than 200, all of them are appointed in wings as pediatrics and also their posting is avoided in such wards as gynecology and labour room. As far as duty time is concerned the authorities find male nurses more adjusting and also there is no security issue in sending them out for some emergency or so. They are considered more useful at the time of conducting various programmes and dealing with technical matters. Considering these benefits, Anamika suggests to have 1: 3 male female ratio among nurses.

> Interviewee also recalled the issues of stigma that was once considered a part of this profession. In the olden days, people used to believe that once into this profession you lose all morality and dignity. Especially because, you take care of people of opposite sex. Adding to this was the way people look at night shifts. However, over time, she finds considerable change, maybe due to the fact that women are working in many other jobs involving night shifts such as in IT sector. So 'night duty' is not that much an issue now.

Another major change cited was that, now common man are more informed and demanding. It is a common sight that on getting the diagnosis report the patient or relatives instantly google and try to know more on it, gain some knowledge and keep an eye on the medicine given. If they feel any medicine is unwanted they suddenly intervene and question. Such tendencies are often causing much headache for nurses and doctors. Anamika opines that technology if not used with care lead to new and unnecessary issues also. A serious problem related to it is that they face in their profession is the misuse of Camera Mobile phones. Many use it without much sense and capture images of others within the hospitals and that leads to issues. Another trend is that if the patient who is inside the hospital has any minor complaint or grievance they suddenly call their bystanders standing outside. They soon become violent and create unnecessary issues.

A major concern she shared was the rising risk element of this profession owing to newer and serious communicable diseases which were unheard so far are cropping up. Often nurses come to know that their patient has some communicable disease only at a later stage. The major communicable disease that nurses dealt with was TB. Another area of risk was physical attack from Mental Patients. Now the number of communicable and serious diseases like HIV has increased and there exists no coverage against this for nurses. The sad plight is that no risk allowance is provided to nurses in Government sector. But she adds with utmost sense, it is all a part of this profession and nurses should take it as a challenge and take sensible precautions while dealing with patients, without compromising on their responsibilities. Although, she is an administrative office, still she also agrees that, nurses are indeed facing several problems in their service. She briefs it as follows

Time related issues:

"*The peculiar challenge emerging from the nature of this job is handing over and taking over of duty. Only if the nurse in next shift comes on time, then the one on duty can take leave. In that case if for any reason the nurse who should take over duty is late; this leads to complaints and issues raised by the handing over nurse. So being there for duty on time is a serious requirement on the side of nurses. And if a nurse is late by half an hour for three days it will be considered a casual leave. May be it is*

for genuine reasons that they are late. But we can't do anything on humanitarian grounds, as these are written rules. This often leads to dissatisfaction among nurses. In fact the stress faced by the supervising nurse is equally high, because, although, she is aware of the situation she is still unable to do anything in such circumstances."

Unexpected demand for leave:

"*For many reasons nurses may ask for leave suddenly- maybe for unavoidable reasons. But in this hospital we don't have much standby nurses who could substitute them. In that case we may be forced to substitute it with a nurse who is not that used to in that particular ward (eg: labour room) This affects the quality of work and maybe minor issues arises thereby."*

When asked about the reported tendencies of not providing sufficient chairs for the duty nurses to sit, her reply was; '…they should be provided, they are humans. Besides they have to write reports and other medical details, for which they need a chair and a table.' As a supervisory grade official, Anamika is seriously dissatisfied with the nurse patient ratio. She alleges that the staff pattern is not revised periodically. However authorities manage the work load using PG students, nurse trainees, House surgeons etc.

Work personal life imbalance is reported to be too high especially because of the night shifts. In case, husband too has a job having night shifts, looking after children will become a big issue and that can cause much stress for them. Even otherwise, she says, most husbands are dead against night shifts. Not being able to avail public holidays is another issue. Because of this, when other members of the family are at home, nurses, are generally not able to be with them. Not having time and chances to spend with family during festivals, death, birth, marriage etc, still remain as a problem She claims that her hospital is providing sufficient in-service education (Continuing Nursing Education) once in every month, as one day training from 8.30am to 4.30pm.The areas covered are Clinical, Community and Management. It is reported that one day orientation is given to all fresh nurses who joins the hospital. The hospital is also taking up a good number of initiatives in serving the leisure and recreation needs of Nurses, opines Anamika. The provisions available are; Arts and Music club, Annual Staff Tour, Health Club- Yoga, meditation classes and so on.

Considering the rampant exploitation in the field, especially in the private sector, she supports unionization which is in existence in government in the form of service unions as NGO Union, NGO Association etc. Still, she concludes by pointing to the areas demanding immediate attention as those of Salary, Allowance, Staff shortage, high nurse: patient ratio, Low Pay and Night duty allowance and the like.

Chapter 5

Findings, Conclusion and recommendations

Findings Conclusion and Recommendations

The present research was initiated with the overall objective of finding out the general context of work and the consequent character of the status of nurses in the different sectors in Kerala. This exploration was done based on the parameters of the 'decent work agenda' of ILO to see how far those variables hold good for the community of nurse professionals in Kerala. Along with this, an attempt was also made to look into the comparative variations across the public and private sectors in terms of these parameters, and to see how far the sector is upholding the values of equity and rights?

The analysis of the quantitative data, along with the excerpts from the qualitative interviews, which are provided in the two sections of the chapter above, clearly gives a variety of insights on all these issues. Although, it is not totally one dimensional, at the same time there are visible violations of the decent work agenda prevalent across both the sectors and also characterizing significant discrepancies across the sectors on almost all the ten criteria of DWA taken up for investigation. The section below makes an attempt to recapture these violations briefly, so as to reach at the conclusions of this study.

The first parameter of opportunities of employment is itself, under a problematic state as there is a clear imbalance in the supply-demand logic. Although, the waiting period of nurses to get an employment is still not so long as the data reveals, at the same time, their inablity to secure a decent salary and other benefits show that, they have no bargaining power at all. The fact that, a large number of the nurses in the private sector are appointed as trainee nurses, that too with a minimum salary, if not no salary even, shows that it is just a replacement of the 'bond' system, which used to exist here before. Even though, the designation is changed, there is hardly any change in the practices. As the interviews have also revealed, the 'trainee system' is the worst exploitative aspect that continue in this sector and regulative measures are needed so badly to curb it. Coming to the context of public and private sectors separately, it is

indeed so visible that, this practice is more exploitative in the private sector. It is, in effect, even diluting the quality of health care offered by those institutions.

When it comes to the next parameter of adequate earnings and productive work, there is a fundamental variation between the public and the private sectors. Compared to the private sector, nurses in public sector have significant advantages in terms of the salary benefits. Nevertheless, the nature of nurse patient ratio existing in the public sector, which was in some cases even reported as 1: 60 and at times as 1:120, is indeed a source of concern for anyone, who is sensitive to the rights of the work force in any segment. The situation in the private sector is of a different nature. Here, the nurses in all categories are generally underpaid, and in some instances like in the case of 'trainee nurses' they are not even paid a single rupee. This along with an extremely small salary system allows them to keep the nurse patient ratio at a low rate when compared to the public sector. Another significant insight in this context is that, while the practices across different public sector hospitals have some common features, the practices in private sector, vary from hospital to hospital. There are hospitals, where the management is totally insensitive to the rights of nurses as a worker, and in some instances even as a human being. Coming to the question of workload, the public sector is seriously constrained by the shortage of staff matching with the ever increasing number of patients. This issue indeed merits more analysis and that would follow in the pages below.

The issue of decent work time is another very relevant aspect to look at, as in the nursing sector as a whole, it appears that, there exist no possibility of any norm of 'decent work time.' Every nurse, who became part of this study, literally, didn't have any time to spare for us, and most of them sounded helpless, saying, they may not be able to finish their job if they spend time with us, for the study. This is a reality that the research as such had to cope with, as the nurses as a group are running against time every day and is finally get defeated at the end of the day or night, whichever shift they are assigned with. Every single duty that they complete ends by minimum thirty minutes late. Sometimes it crosses even an hour or two. That is why, their hours of work is much beyond the scheduled hours. There are nurses who have reported it as exceeding fifty hours per week. In fact, for a substantially big number it is reaching up to sixty hours even. The fact of the matter is that, this excess time is not just an

excess of a couple of minutes or hours, it is in effect, long distance run ran in the same pace as that of hundred meters race. Because, for them everything is urgent, every patient is in need of care. In the public sector, a couple of members from the team of this research once decided to accompany them to get a firsthand knowledge on their job. However, they couldn't complete the race, opted to withdraw in the middle, as it was found physically impossible. What is, most disturbing in this context is the attitude of the private sector management, who do not even consider it important to offer them a chair to sit in between. They do not even seem to be aware of the hard work these nurses are engaged in. The irony is that, when these nurses were asked about the amount of time they have as break time, they could not even relate themselves with this question. The reason is simple. They do not have it. In fact they do not even have a specified time to eat their food. The question on the way they spend their leisure time is answered even more surprisingly. The general answer they gave was that, they eat their lunch or food at that time. Eating food is leisure to most of them, not at all considered a physical necessity.

Coming to the issue of combining work, family, and personal life, there is hardly any deviation in direction from the above parameters. The nurses' profession is a 24 hour responsibility and it is difficult to capture their experiences in terms of six hours or eight hours terms. They are on duty right across the whole week and the festivals and family celebrations have little space in their personal or family lives. They miss out most such occasions and the end result is a 'neither here' 'nor there' situation. Their duty time remain largely undefined till now. In spite of the repeated recommendations made by various commissions, which looked into this issue, the hospitals, especially in the private sector, are not able to evolve a defined pattern so far. The hours of work vary from hospital to hospital and most importantly it still exceeds 50 hours. Most of them, report that they do not get much time to spend with their family even during the festivals or family celebrations. Obviously, the work is intervening with their family life and even personal life.

The parameters of the works that should be abolished, Stability and security of work are also found apparently missing the DWA standards in nurse's lives. Every nurse is a victim of undefined nature of their work, irrespective of the sector of their

employment. This is the reason why nursing is considered a ‘dirty job.’ All of them are doing works that are not simply the work of a nurse. They are made to do the jobs of attendants’, nursing assistants’ and even that of the sweepers. Dusting, cleaning, preparation of patient’s beds, giving sponge baths, shaving, all were reported as their jobs. It is this list which is responsible for the stigmatization of ‘nursing as a dirty profession’.

In terms of the security of job, there is however, a difference between the private and public sectors. While the public sector enjoys more security in employment, the case of private sector is indeed different. They do not have any security; they live with the fear of losing their job any time. The fact that, the private sector does not have nurses belonging to the higher age groups clearly reflects this unstable nature of their job. This sector is after young girls who are, as they themselves say, more pleasing and of course more obedient. There were reports of rejection of nurses who returned back from their maternity leave after their delivery. They were not even paid for during that period. Some received the salary for that period, (that too just about 70%) from their ESI membership. The management has no responsibilities towards them.

The question of equality of opportunity and treatment is again out of context for the nursing profession. The hospitals of all sectors do show a preference for the female nurses. They form the major chunk of nurses everywhere. The private hospitals, go a step further, and recruit only the young girls. The considerations behind are neither the quality nor the qualification they possess. It is their gender and their age that matters. Male nurses are not at all considered as favourable. The reasons cited are indeed debatable. They are quite ideological as well. It includes the dimensions of gender, class, age and so on.

Safe work environment is not a reality for the nurses. The risks attached with night shifts are the most important references in this regard, and the problems of harassment they experience from patients or their relatives are also adding to this. Another concern that they share is their health based insecurities, as they are exposed to several risky diseases and illnesses, which are communicable in nature, without any

precautions. The near total absence of periodic immunization programmes and the absence of other medical support schemes are also affecting their morale in a big way.

The presence of social security provisions and the opportunities for dialogue with the authorities or among themselves is again found lacking more visibly in the private sector of nursing. In comparison, the public sector is comfortably positioned with regard to both the parameters. The insecurities of employment, along with the discriminations based on age, gender etc is leaving the nurse segment in private sector almost totally at the whims and fancies of the managements, who are highly insensitive to the agonies that the nurses suffer from. A large majority of them are unorganized and they are apparently threatened against it or are monitored. The possibilities of such movements are also thwarted with steps like the near total rejection of the male nurses are all pointing to this dimension only. The unions functioning in this sector are struggling hard to mobilize the support of the nurses. The hassles are plenty, ranging from, the qualifying degrees to the nature of recruitment policies. The near total dependence of the family on the meager salary that these nurses earn, do not give them the required freedom to risk their job, even if it is terribly underpaid. The membership in any union is not an easy option for them. They need some assurances for that to happen. The present working environment does not provide that.

Recommendations of the study

This research, being an evaluative study on the status of nursing profession, based on the Decent Work Agenda, has primarily revealed that, the DWA parameters are almost completely absent from this sector. In this context, it is quite important that, a study like this should lead to some suggestions as to how to bring about certain much needed changes in this sector. Based on the findings and the conclusions arrived at through the analytical evaluation of the data gathered from different types of respondents of this study, the researcher would like to put forward the following recommendations to the policy planners. The suggestions are put up under three categories. The first deals with the private sector. This will be followed by the public sector. The last part will deal with the policy needs in common

Private sector

1. Every nurse, working in any hospital should be provided with an appointment order, carrying the name of designation to which the appointment is made, with specific definition of the nature of his/her work like a proper description of duty timings, number of hours of work per week, holidays per week, number of night shifts, number of annual leaves and a clearly stated detail about the salary, increments, and other allowances.
2. This appointment order should be signed by both the management and the nurse who is appointed and a copy of this should be filed in the hospital and that should be made available for inspection by either the labour or health ministry, on demand
3. The first and foremost suggestion is to take the steps to keep a register containing the names of all the category of nurses working in private sector, with their designation. It should be made available for verification by the labour department, once in every year.
4. Make it a responsibility of the management to get them all registered under the ESI scheme, even if they are working as a trainee, so that they will all have the basic recognition of their status as a worker.
5. The ratio of nurses in different categories like, trainee staff nurses, staff nurses, head nurses and nursing superintendants has to be strictly followed.
6. Their salaries should be based on their designation plus years of service, irrespective of the place of service.
7. The salary for the private hospital nurses should be fixed based on the recommendations of Balaraman Committee. But the annual increment should be re- fixed to a minimum 5% of the basic pay.
8. The trainee nurses should strictly be provided with the basic salary fixed for the staff nurse and should be provided with an annual increment too.
9. The basic salary of the staff nurse should be fixed including the annual increments based on his/her service anywhere as a trainee nurse or staff nurse.
10. The entry cadre of the ANM nurses and B Sc nurses should be different and the salary should also differ accordingly, so that the B Sc graduates should be provided with additional monetary advantage for their qualification.

11. The Working time management should be more in the interest of the nurses, and if the time exceeds the duty hours, it should be strictly calculated at the end of every month and the nurses should be compensated for the overtime work on an hourly basis
12. For this, the electronic punching options can be adopted. Or if it is not feasible, then the hospitals should maintain their attendance register, in which separate columns should be given to register the time of duty also.
13. Night duty allowance should be made mandatory, and under no circumstances the nurses should be asked to do more than one night duty in a week.
14. Medical insurance should be provided to all categories of nurses, with a fifty/fifty share from the management and the nurses
15. Compulsory periodic immunization should be given for the nurse professionals
16. Every nursing station should have seating facilities and the nurses should not be restricted from sitting when they are inside the nursing station.
17. Every category of nurses should be allotted with minimum thirty minutes of break in between their duty, during which time, they should be allowed to rest in the rest room, alternatively.
18. The private hospitals with nursing schools/colleges should be strictly advised to keep visibly different uniforms for the different categories, and uniform allowance should be provided to all the nurses other than students.
19. Every nurse professional should get the benefit of pension, based on the total year of his/her service.
20. Every private hospital should ensure that the male, female ratio of nurses is kept as 1:4 or in a manner that one male nurse should be allotted in every nursing station.
21. The nurses should not be restricted from taking membership or joining a union or professional association. In every hospital, the management should provide a designated space for associational/recreational activities for the nurses.

Public sector

22. Take urgent steps for the recruitment of more staff nurses in accordance with the ever increasing number of patients depending on the public sector hospitals.
23. The nurses in the public sector should be provided with an additional incentive in the form of nursing fee
24. For this a nominal fee should be charged from patients at the time of admission demarcated as nurses' fees, considering the invaluable service they render towards the maintenance of public health of Kerala. This will help in creating a public awareness about the value of their services and in the process will also contribute to the eradication of stigma attached to this profession.
25. In addition to their salary, they should also be properly rewarded for the additional work they perform within their stipulated duty time itself, due to the really unmanageable nurse, patient ratio they manage every day.
26. They should be rewarded with a decent overtime allowance for every additional hour of their work
27. The public sector nurses should be duly recognized for every additional qualification they attain by giving minimum one increment.
28. The nurses in this sector should be given one hour break in between their duty, considering the physical and mental stress they experience throughout their duty time.
29. Decent Night shift allowance has to be ensured for the nurses.
30. The working hours of senior nurses in this sector should be reduced to six hours.
31. The senior nurses should be given two days as weekly holidays, to help them combine their family and work lives.
32. The number of staff nurses in the CHCs and PHCs should be increased.
33. As far as possible, the nurses in the public sector should be posted to the hospitals near their home.

Common Recommendations

34. Periodic inspections of departments of health, labour, and nursing council should be made mandatory.

35. The leave provision for all categories of nurses should be as per the government norms.
36. No differentiation should be allowed on this.
37. Nursing council should initiate a one month long staff development programme for nurses, it should be given in batches throughout the year
38. Every nurse in any sector should compulsorily undertake this one month refresher programme, every five years, to update their skills
39. All the steps should be taken to expedite all the Bills related with the nursing services, pending in front of the legislature immediately.
40. The Clinical Establishment Bill must be passed by the State legislature urgently.
41. The hospital sector should be kept out from the shops and establishment Act, and it should be strictly be under a mechanism, that caters to the service character of this profession.
42. Implementation of all government norms should be strictly brought under legal observation.
43. The educational loan for nursing should be made available interest fee to encourage the enrollment of students for this profession.
44. The admission procedure for nursing should be strictly monitored.
45. All institutions running the nursing training should be brought under strict and standardized norms.
46. The Balaraman Committee report should be implemented immediately.

Concluding Remarks

In short the insights that comes out from this research is substantively pointing to the enormity of struggles that characterize this otherwise glorified profession. Not only that the nurses are denied of their rights to decent work agenda, they are severely affected, both physically and mentally, with the inhuman work conditions that they are subjected to. Altogether, the situation is leading them to yet another phase of agitations. The recently organized hunger strike in front of the Kerala Secretariat, although, attended by a large number of nurse professionals, cannot expect to significantly result in any turnaround as the largest segment of these professionals are still without any opportunity of organizational movement. They are dominated with

the fear of insecurity of job, as many work without even an appointment order or any other valid documentary prescriptions of the terms and conditions of their job. Most of them remain in service on the whims and fancies of their employers and they have nothing better to dream at the moment. The decent work agenda needs more powerful machinery for intervention and in the absence of that, the nursing profession will remain at the margins without any prospect of a better future.

REFERENCES

Abraham, Binumol (2004) 'Women Nurses and the notion of their 'Empowerment', **Discussion Paper, No. 88**, Kerala Research Programme on Local Level Development, Thriruvananthapuram.

Aravind, I. (2014, July 26). Kerala's nurses: Taking care of the world. Retrieved November 10, 2015, from http://www.business-standard.com/article/beyond-business/kerala-s-nurses-taking-care-of-the-world-114072501466_2.html

Balaraman Committee Report (2012) Unpublished Report.

Biju, B.L. (2013). Angels are Turning Red: Nurses' strikes in Kerala. ***Economic and Political Weekely,*** *XLVIII* (52), 25-28.

Decent work Indicators ; ILO Manual, First version (2012) Geneva, Retrieved November 10, 2015, from http://www.ilo.org/wcmsp5/groups/public/---dgreports/---integration/documents/publication/wcms_229374.pdf

Decent work country programme 2013-17; **ILO & Government of India** (2013) Delhi.

Government of Kerala. (2013). ***Health Policy of Kerala*****: 2013.** Retrieved on November 10,2015, from http://dhs.kerala.gov.in/docs/draftpolicy.pdf

Government of Kerala (2012) **Economic Review 2014.** Accessed from http://spb.kerala.gov.in/images/er/er14/Chapter4/chapter04.html

George, Sheba M. (2000) ' "Dirty Nurses" and "Men who Play" ', in **M. Burawoy** (ed.), **Global Ethnography: Forces, Connections, and Imaginations in a Postmodern World,** pp. 144-74. Berkeley: University of California Press

George, Sheba M. (2005) When women come first. Gender and Class in Transnational Migration. Berkeley, University of California Press.

Health at a Glance (2014) Thiruvananthapuram, Directorate of Health Services, Government of Kerala, Public Information Cell.

Joseph, Ammu (1999): 'Girls and Women in Kerala: Some Less Acknowledged Facts' in **M A Oommen (ed.),** ***Rethinking Development: Kerala's Development Experience***, Vol II , Delhi: Concept Publishing.

Jeffrey and Jeffrey (2008) 'Money itself Discriminates: Obstetric Emergencies in the Time of Liberalisation', ***Contributions to Indian Sociology***, 42(1): 59–91.

Kerala considering sops for capacity building in nursing sector'. (2015, April 16). Retrieved November 5, 2015, from http://www.business-standard.com/article/current-affairs/kerala-considering-sops-for-capacity-building-in-nursing-sector-115041601407_1.html

Kodoth, P., & Varghese, V. (2012). 'Protecting Women or Endangering the MigrationProcess: Emigrant Women Domestic Workers, Gender and State Policy.' **Economic and Political Weekly**, *XLVII* (43), 56-65.

Veerakumar committee Report, Labour Department (2013)

Oommen M. A (1999) (ed.), Rethinking Development: Kerala's Development Experience, Vol II, Delhi: Concept Publishing.

Oommen T. K (1964) 'Vedana Mattunnavarude Vedhana' (Pain of Pain Removers), Malayala Monorama, 25 October, Kottayam

Oommen, T. K (1978). Doctors and Nurses, Delhi: Macmillon Co. of India. 1978.

Nabae, K. (2003, June 27). 'The Health Care System in Kerala - Its Past Accomplishmentsand New Challenges .' Retrieved November 6, 2015, from https://www.niph.go.jp/journal/data/52-2/200352020010.pdf

Nair, Sreelekha. (2010). 'Nurses' Strikes in Delhi : A Status Question.' **Economic and Political Weekly,** *XLV* (14), 23-25.

Nair, Sreelekha. (2011): 'Multiple Identities and Migratory Dynamics of Nurses' in **S. Irudaya Rajan (ed.) Migration Identity and Conflict India Migration Report 2011**, New Delhi. Routledge, pp 203-219

Nair, Sreelekha. (2012): **Moving with the Times: Gender, Status and Migration of Nurses in India**. New Delhi, Routledge.

Nair, S & M. Percot (2007) 'Transcending Boundaries: Indian Nurses in Internal and International Migration'**, Occasional Paper No. 7**, New Delhi, CWDS.

Percot, Marie and Irudaya Rajan(2007) "Female Emigration from India: Case Study of Nurses" **Economic and Political Weekly**, 42 (9-10), pp 318-355.

Percot, Marie (2006) 'Indian Nurses in the Gulf : From Job Opportunity to Life Strategy', in**Anuja Agrawal (ed.) Migrant Women and Work,** New Delhi.Thousand Oaks Publication : 155-176.

Roberts, W. & Rajan , I. (2007). 'Nurse emigration from Kerala: 'Brain circulation' or 'trap'?' Retrieved on November 7, 2015, from https:// www.academia.edu /2335246/

Sampath, G. (2016, February 20). 'Labour in the twenty-first century'. *The Hindu*, pp. 13.

Thomas, P (2006): "The International Migration of Nurses", **International Nursing Review**, Vol 53, pp 277-83

Thimothy, Rakkee & Sasikumar S.K (2012) **Migration of Women Workers from South Asia to the Gulf.** New Delhi, V.V Giri National Labour Institute.

Walton-Roberts, M and Rajan, I.S (2013) ***Nurse emigration from Kerala: 'Brain circulation' or 'trap'?*** **India Migration Report 2013**, New Delhi. Routledge.

Questionnaire

Nursing as 'Decent Work': Questions of 'Rights' and Gender Equity in Care Profession

Date:-

Hospital Name :-

DEMOGRAPHIC DETAILS

1.Age : ……..Years

2.Gender : Male ☐ Female ☐ Others (specify):☐

3.Marital status:

Single ☐ Married ☐ Widowed ☐

Separated ☐ Divorced ☐

4.Religion Hindu ☐ Christian ☐
Muslim ☐ Others(specify):☐

5. Caste SC ☐ ST ☐ OBC ☐ Others(Specify) ☐

FAMILY DETAILS

6.Number of members in the family- .... nos

Sl.No	Relation with You	Occupation	Educational qualification	Income (in Rs)-Per month

7. To which category do you belong? APL☐ BPL ☐

EDUCATIONAL DETAILS

8. Nursing Qualification

M.Sc Nursing ☐ BSc Nursing ☐ GNM ☐ Others ☐

9. Nature of the Institute from which you secured the Nursing degree:

Government nursing college ☐ Private nursing college ☐
Co-operative nursing college ☐ Any other specify ☐

10 .Is the institute located within Kerala? Yes ☐ No ☐

11. Year of Passing out:

12 .Have you availed any education loan for your Nursing Studies? Yes ☐ No ☐

1 If Yes, what was the loan amount?
2 What was the duration of the Loan Period?
3 Year of taking Loan-
4 Time by which you have to close it.-
5. Have you repaid it completely? ☐ Yes ☐ No
6. If no, what is the pending amount?
7 Are you forced to work; because you need to pay it back at the earliest?

Yes ☐ No ☐

13 .Do you have any Educational Qualification other than Nursing?

JOB PROFILE

14. Who among the following influenced your decision to join the nursing profession?

Self ☐ Family ☐ Friends ☐ Others ☐

15 Did anyone object to you at the time of joining this profession/studies ☐ Yes ☐
No If yes, who ?

16. What do you think is the reason he/she objected?

17 Why did you finally chose to join this profession?

Passion ☐ Economic Reasons ☐
Job Prospects ☐ Prospects abroad ☐
Prospects in India ☐ Others(specify): ☐

18 On completion of your course how long did it take for you to attain a job?

……Year/s…….Month/s…….. Days

19 . Details of Your Work Experience as a Nurse

Name of the Hospital you worked with	Govt./ Pvt. Sector	Duration of Service

20 If worked in more than one hospital , what was the reason for change?

Transfer ☐ Termination ☐ Low Salary ☐
Poor working conditions ☐ Any other ☐

21 .Your entry grade Designation in Nursing Profession

☐ Sister grade1 ☐ Sister grade2
☐ Head Nurse ☐ Nursing superintendent

☐ Deputy Nursing superintendent ☐ Any other

22 .Your Present Designation

☐ Sister grade1 ☐ Sister grade2
☐ Head Nurse ☐ Nursing superintendent

☐ Deputy Nursing superintendent ☐ Any other

23 .In this hospital, which department are you posted at present?

☐ Critical Care /Casuality ☐ Operation Theatre
☐ General wards ☐ Other (specify)

24 .Number of Beds in this hospital? --

25 .Number of Doctors? --

26 .Have you worked outside Kerala? Yes ☐ No ☐

If yes, details :
A) Place B)Type of institution: Govt / Private(tick mark)

C)Designation D)Duration : E)Monthly Salary:

F)Reason for leaving :

27 .Have you worked outside India? Yes ☐ No ☐

1 . If yes, details :
A)Place B)Type of institution Govt/Private

C)Designation D)Duration : E)Monthly Salary:

F)Reason for leaving :

28 .Have you worked in sectors other than nursing after completing your nursing studies?
☐ Yes ☐ No

ADEQUATE EARNING AND PRODUCTIVE WORK

29 Nature of Employment
Permanent ☐ Contract ☐ Internship ☐
Other ☐

30 Current Salary/Stipend (per month) in Rs:

31 Are you satisfied with your current salary/ Stipend? Yes ☐ No ☐

32 Have you got any in-service training related to nursing during the last 12 months?
Yes ☐ No ☐

33 If Yes,
a. From whom _____ b. On what----------?

DECENT WORKING TIME

34.Working Time - Day ……am to ……pm
Evening ---------- pm---------- pm
Night- ……am to …….pm

35.Duty hours ……..hours a day

36.What is the total duration of allotted time for break during this duty hours?

.....

37 .Type of shifts you work and its duration : ☐ Day -……hrs Evening ……hrs ☐
Night…….hrs ☐

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours of Work							

38 On an average how many hours do you work a week? ……

39 .Specify the number of (Sunday to monday)
a. working days in a week : ……
b. off days in a week: ……

40 Do You have Night shifts?
Yes☐ No ☐
If Yes,
1. How many Night duties per Week?
2. What is the criteria/on what basis are night shifts assigned?
3. Last month how many night duties did you have? ……..
4. Do you have enough facilities (like proper rest room) for night shifts?
Yes ☐ No ☐
5. Have you experienced any sort of harassments during night shifts?
Yes ☐ No ☐
If yes from whom? Patients ☐ Patients Relatives ☐
Hospital Staff ☐ Others, specify ☐

6. What type of harassment? : Verbal/Emotional/Physical/ Sexual/Others/None
7. Do you have adequate security and protection during night duties?
Yes ☐ No ☐

41 .Do you work overtime?
Yes☐ No ☐
If Yes, is it:
Forced ☐ Voluntary ☐
1. Reason (specify) :

2. Do you get additional payment for overtime duty?
3. If yes, specify the rate: …..Rs

COMBINING WORK, FAMILY AND PERSONAL LIFE

42 .Where do you stay?

At Home ☐ Hostel ☐ Paying Guest ☐ Accommodation

43 . Mode of conveyance? Hospital Vehicle ☐ Public Transport ☐ Own Vehicle ☐

44 . Hours spent a day travelling to and from the workplace. :

45 .Is the commuting time affecting your family and personal life time?

Yes ☐ No ☐

46 .Who all do help in your household work?

Husband ☐ Mother /Father ☐ Mother/Father in law ☐
Servant ☐ Children ☐ All of them ☐
None ☐them

47 .Do you have any family members who need primary care (Kids, Old aged etc)?

Yes ☐ No ☐

If Yes,

1.Who takes care of them?

Husband ☐ Mother /Father ☐ Mother/Father in law ☐
Servant ☐ Children ☐ All of them ☐
None o☐em Paid Ser☐t

LEAVE DETAILS

48 .Which all categories of leave are available to you?

Casual ☐ Compensation ☐ Others(specify): ☐

49 . How many paid annual leaves do you have? :

50 Do you have provision for additional sick leaves? Yes ☐ No ☐

51.Do you have provision for Maternity leave in your Hospital? Yes ☐ No ☐

52 Duration of Maternity leave?

53 .Are you paid during the period of Maternity leave? ☐ Yes ☐ No

54 How much salary is given during Maternity Leave?

Full Wage ☐ 2/3 of Wages ☐ ½ of Wages ☐ No wages ☐

55 .Do you get time to spent with family during festivals/Celebrations/ family functions (Onam, Christmas,…)?

Very often ☐ Often ☐ Rarely ☐ Never ☐

56 Have you missed any important function of your family (Wedding, Birthday,…) due to your Job? ☐ Yes ☐ No

57 Are your family members supportive in continuing in this profession?

Yes ☐ No ☐

58 .Are you satisfied in your engagement with family as a Nurse? Explain ,please

Yes ☐ No ☐

59 .Is there any clash between your working time and your family needs?

Yes ☐ No ☐

.Are there any one else from your family in this profession?

1. If yes, who?:
2. How many years have they been in this profession?:

WORK THAT SHOULD BE ABOLISHED

61 .What is the nurse patient ratio in your hospital?

62.Is this ratio adequate ? ☐ Yes ☐ No

63.Do you get enough rest break during your work? Yes ☐ No ☐

64.Do you have safe and proper rest rooms and other facilities (for dress change etc.) ?

Yes ☐ No ☐

65.Have you signed a bond with this institution? ☐ Yes ☐ No

If Yes,

1 What kind of Bond?

2 Do you consider that bond as a burden? Yes ☐ No ☐

66.Are you satisfied with your job environment? ☐ Yes ☐ No

If no, why?

67.Are you forced to work in hazardous or vulnerable working condition?

Yes ☐ No ☐

68.Do you have proper safety measures while treating patients with communicable diseases?

☐ Yes ☐ No

69.Are you having any coverage of medical insurance provided by the hospital you work?

Yes ☐ No ☐

70.Were you ever forced to do any other work apart from nursing ? Yes ☐ No ☐

71.If yes, give the nature of those tasks

STABILITY AND SECURITY OF WORK

72.How long have you been in this hospital?

73.Do you have any incentives other than regular salary?

Yes ☐ No ☐

1 If Yes,

What are they? _____

74.Do you have any provision for Pension from the Hospital authorities or Govt. ?

Yes ☐ No ☐

75.Do you have any deposit in Pvt. Pension schemes or Life Insurance?

Yes ☐ No ☐

76.Do you have thefear that your work could be terminated any time.

Yes ☐ No ☐

77.Give the reasons why you feel so.

78.Have you experienced any termination in your earlier services ?

Yes ☐ No ☐

79.If Yes, was there any proper notification?

EQUAL OPPORTUNITY AND TREATMENT IN EMPLOYMENT

80 .Have you ever worked with a male nurse? Yes ☐ No ☐

82.Do you welcome the male nurses in to this profession? ☐ Yes ☐ No

83.Do you think that the entry of male nurses is good for this profession? ☐ Yes ☐ No

1)If yes, why?

2 If no, why?

84.Are there both male and female nurses in your present hospital? ☐ Yes ☐ No

85.Do male and female nurses have equal wages and opportunities?

Yes ☐ No __ ☐

If No, why?

86.Do you experience any kind of Discrimination from others? Yes ☐ No ☐

87.From whom?

88.Do you face any kind of harassment from ,

Male Colleagues	☐	Female Colleagues	☐
Superior Nurses	☐	Subordinate Staffs	☐
Hospital Authorities	☐	Others, specify	☐

89. Have you experienced any kind of harassment from Patients? ☐ Yes ☐ No

SAFETY OF WORK ENVIRONMENT

90 Do your hospital have adequate physical facilities for your work?

Yes ☐ No ☐

If yes,

1	A place to rest	Yes ☐	No ☐
2	Safe drinking water	Yes ☐	No ☐
	1. Toilet facilities	☐Yes	☐No
	2. Dress changing rooms	☐Yes	☐No
	3. Seating	☐Yes	☐No
	4. Dining space	☐Yes	☐No

91.Are you vulnerable to accidents and injuries during duty? Yes ☐ No ☐

92.Do you have proper measures (Gloves,…) to get protected from work related injuries?

Yes☐ No ☐

93 .Have you ever met with serious accidents while on duty?

Yes ☐ No☐

If Yes,

94 .Have you got any compensation or aid from hospital? ☐ Yes ☐ No

95 ,Do accidents happen quite frequently to the nurses in your hospital?

Yes ☐ No ☐

96.Did any Govt./Health authorities visit your hospital last year?

Yes ☐ No ☐

1. If Yes, What impact did it make? Explain

97 .Did hospital authorities provide preventive medicines or any other protective measures for you on joining this institution? Yes ☐ No ☐

98 .Do you have suffer from any serious health problems?

Yes ☐ No ☐

If Yes, What is it?:

99. Is it related with the duties that you are entrusted with?

Yes ☐ No ☐

SOCIAL SECURITY

100 Are you forced to work when you are sick? Yes ☐ No ☐

If yes, Who compels?

101 . Are there any schemes of long term care , like post retirement schemes? Yes ☐ No ☐

102 Are you protected under post retirement medical care ? Yes ☐ No ☐

103 What is your retirement age?

104 .Are you getting lump sum grant or any periodic payments? ☐ Yes ☐ No

INFORMATION ON GRIEVANCE REDRESSAL MECHANISM

105 . Do you have a grievance redressal mechanism in your hospital?

☐ Yes ☐ No

106 . If yes, what are they? ----------

107 .If yes, Are you satisfied with the grievance redressal mechanisms?

☐ Yes ☐ No

108 .Do you have any suggestions for improvement?, If yes please explain

SOCIAL DIALOGUE

109 .Is there any nurses union existing in your hospital? Yes ☐ No ☐

110 .Are you a member of any union? Yes ☐ No ☐

111 .Do any trade union help you in protecting your job and job benefits? Yes ☐ No ☐

112. Have you ever made any collective bargaining action to protect your or colleagues payment and employment condition in your hospital?

☐ Yes ☐ No

Explain if any?

113 .Have you ever took part in any strikes demanding the rights of nurses?

Yes ☐ No ☐

114 .Have you ever faced any disciplinary action from your employer for Union Activities and collective bargaining? ☐ Yes ☐ No

If Yes,Explain…

115 .Do you discuss your job related problems with your employer Yes ☐ No ☐

116 .Did your employer ever ask you about your concerns in the job? Yes ☐ No ☐

117.Do you face any problems from your family regarding your union activities or collective bargaining? Yes ☐ No ☐

If Yes, Explain

118.Do you feel that union activities are helpful in accruing your demands or improving you work conditions? ☐ Yes ☐ No

119.Do you ever take part in tri-party (Govt., Employer and Employee) meetings?

Yes ☐ No ☐