COURSE GUIDE

NSC201
FOUNDATION OF PROFESSIONAL NURSING PRACTICE I

Course Team Dr. Reuben Fajemilehin (Developer/Writer) - OAU
Mr. Olufemi Ayandiran (Co-developer/Co-writer) - OAU
Mr. Kayode S. Olubiyi (Co-developer/Co-writer) - NOUN
Prof. (Mrs) O. Nwana (Programme Leader) - NOUN
Mr. Kayode S. Olubiyi (Coordinator) - NOUN



NATIONAL OPEN UNIVERSITY OF NIGERIA

© 2021 by NOUN Press
National Open University of Nigeria
Headquarters
University Village
Plot 91, Cadastral Zone
Nnamdi Azikiwe Expressway
Jabi, Abuja

Lagos Office
14/16 Ahmadu Bello Way
Victoria Island, Lagos

e-mail: centralinfo@nou.edu.ng
URL: www.nou.edu.ng

Printed 2021

ISBN: 978-978-058-320-0

All rights reserved. No part of this book may be reproduced, in any form or by any means, without permission in writing from the publisher.

CONTENTS **PAGE**

Introduction..... iv
What you will Learn in this Course…… iv
Course Aims..... iv
Course Objectives..... iv
Working through this Course..... v
Course Materials…… vi
Study Units..... vi
Textbooks and References…… vi

INTRODUCTION

Welcome to NSC 201 – Foundation of Professional Nursing Practice I is a four-credit units course for students who are pursuing BNSc. It is one of the courses meant to lay your desired foundation for choice of nursing as a course of study and profession.

The course consists of 4 Credit units (60 hours of instruction online; 48 hours of laboratory & Clinical Practice). This is a second year first semester con-current BNSc degree programme courses.

The course comprises of the bedrock of acquisition of necessary elementary skills amidst health care reforms. The changes in response to social, political, economic factors as well as health technology and advances in health care system call for reform in the delivery of health care have greatly influenced the setting where nursing is practiced coupled with the recipient of care itself.

WHAT YOU WILL LEARN IN THIS COURSE

The overall aim of this course is to introduce you to the ability to assess the patient, skills of the nurse regardless of the practice setting. All settings where nurses provide care, eliciting complete history and using appropriate assessment skills as critical to identifying physical and psycho- emotional problems concern experienced by the patient. The course will provide you with a broad base understanding on Nursing and what made up nursing as a profession.

COURSE AIMS

The aim of the course is to give you a better understanding of the fundamental of nursing profession. The aim of the course will be achieved by:

- Providing you a comprehensive historical development of Nursing
- exposing you to the concept of Nursing
- helping you to understand the various factors that affect health and human environment
- giving you insight into fundamentals of Nursing practice

COURSE OBJECTIVES

To achieve the aims set out above, the course sets overall objectives. In addition, each unit also has specific objectives. The unit objectives are always given at the beginning of a unit; you should read them before you start working through the unit. You may also want to refer to them during your study of the unit so as to check on your progress. You should always

look at the unit objectives after completing a unit. In this way, you can be sure that you have done what was required of you by the unit.

Below are the wider objectives of the course, as a whole. By meeting these objectives, you should have achieved the aims of the course as a whole. On successful completion of the course, you should be able to:

- define History and state the stages of nursing development in Nigeria
- describe the events that occurred in the past that positively moved Nursing forward to the present date
- explain the nature of Nursing
- explain the importance of nursing to health and human environment
- examine the role of the nurse as a teacher, counselor, caregiver, manager and researcher
- explain what is integrated approach of health, wellness and illness
- describe physical assessment and diagnostic measures in care of patients
- explain the problems militating against nursing development
- proffer solutions to these problems.

WORKING THROUGH THIS COURSE

To complete this course, you are required to read the study units, as well as other related materials. Each unit contains self-assessment exercises, and at certain points in the course, you are required to submit assignments for assessment purposes. At the end of the course, you are going to sit for a final examination. The course should take you about fifteen weeks, in total, to complete. Below you will find listed all the components of the course, what you have to do and how you should allocate your time to studying the course.

You will be expected to read every module along with all assigned readings to prepare you to have meaningful contributions to all sessions and to complete all activities. It is important that you attempt all the Self- Assessment Questions (SAQ) at the end of every unit to help your understanding of the contents and to help you prepare for the in-course tests and the final examination.

You will also be expected to keep a portfolio where you keep all your completed assignments.

Specifically, each unit has activities and videos that will guide your ability to learn the health history and physical assessment skills.

COURSE MATERIALS

The major components of the course including the following:

1. Course guide
2. Study units
3. Textbooks and references
4. Assignment file
5. Presentation schedule

STUDY UNITS

There are thirteen study units in this course as follows:

Module 1	**Nature of Nursing I……**	**1**
Unit 1	Historical Development of Nursing I……...	1
Unit 2	Historical Development of Nursing II…….	7
Unit 3	Concepts of Nursing……	18
Unit 4	Nursing as an Art and a Science……	26
Unit 5	Nursing as a Profession ……..…	33
Module 2	**Nature of Nursing II……...**	**42**
Unit 1	The Role of the Nurse……	42
Unit 2	Nursing Care Deliver……	49
Unit 3	Nursing and Society ……..	58
Unit 4	Nursing and Human Environment……..	68
Module 3	**Health and Human Environment……**	**80**
Unit 1	Concept of Health and Illness……..	80
Unit 2	Health and human needs I……..	91
Unit 3	Health and human needs II……	103
Unit 4	Health Promotion…….	

COURSE REQUIREMENTS AND EXPECTATIONS OF YOU

Attendance of 95% of all interactive sessions, submission of all assignments to meet deadlines; participation in all CMA, attendance of all laboratory sessions with evidence as provided in the log book, submission of reports from all laboratory practical sessions and attendance of the final course examination.

You are also expected to:

1. Be versatile in basic computer skills

2. Participate in all laboratory practical up to 90% of the time

3. Log in to the class online discussion board at least once a week and contribute to ongoing discussions.

5. Contribute actively to group seminar presentations.

EQUIPMENT AND SOFTWARE NEEDED TO ACCESS COURSE
You will be expected to have the following tools:
1. A computer (laptop or desktop or a tablet)

2. Internet access, preferably broadband rather than dial-up access

3. MS Office software – Word PROCESSOR, PowerPoint, Spreadsheet

4. Browser – Preferably Internet Explorer, Mozilla Firefox

5. Adobe Acrobat Reader

NUMBER AND PLACES OF MEETING (ONLINE, FACE-TO-FACE, LABORATORY PRACTICALS)
The details of these will be provided to you at the time of commencement of this course.

DISCUSSION FORUM
There will be an online discussion forum and topics for discussion will be available for your contributions. It is mandatory that you participate in every discussion every week. Your participation links you, your face, your ideas and views to that of every member of the class and earns you some mark.

MAIN COURSE

CONTENT **PAGE**

Module 1	**Nature of Nursing I……**	**1**
Unit 1	Historical Development of Nursing I……...	1
Unit 2	Historical Development of Nursing II…….	7
Unit 3	Concepts of Nursing……	18
Unit 4	Nursing as an Art and a Science……	26
Unit 5	Nursing as a Profession ……..…	33
Module 2	**Nature of Nursing II……...**	**42**
Unit 1	The Role of the Nurse……	42
Unit 2	Nursing Care Deliver……	49
Unit 3	Nursing and Society ……..	58
Unit 4	Nursing and Human Environment……..	68
Module 3	**Health and Human Environment……**	**80**
Unit 1	Concept of Health and Illness……..	80
Unit 2	Health and human needs I……..	91
Unit 3	Health and human needs II……	103
Unit 4	Health Promotion…….	115
Module 4	**Fundamentals of Nursing ……..**	**127**
Unit 1	Vital Signs I……	127
Unit 2	Vital Signs II……..	146
Unit 3	History Taking and Physical Examination	168
Unit 4	Diagnostic Measures in Patients Care……	182
Unit 5	Providing Safety and Comfort……	201

MODULE 1 NATURE OF NURSING I

UNIT 1 HISTORICAL DEVELOPMENT OF NURSING I

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Significance of the Study of History
    3.2 Pre-Nightingale Development of Nursing
    3.3 Florence Nightingale Era (1820-1910)
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further reading

1.0 INTRODUCTION

Where are we coming from? What developments have brought us to the present state? What problems were encountered during the journey? What factors have facilitated or obstructed our movements? When we delve into the events of the past for one reason or the other, we are concerned with history, with past events. There are many advantages to the study of history. It provides foundation for the present and the future. It helps us to plan strategies for a smooth transition. It provides us with the knowledge of persons and resources that had supported and strengthened our course over the past years. This is a general phenomenon of any development in life.

There are two dimensions to the study of history, the process and the content. In this unit you will be studying the content of the historical development of nursing. The events that occurred in past that positively moved Nursing forward to the present date. You will learn the contents of the events in chronological order. The discussions shall cover the following periods: Pre-Nightingale Era; Nightingale era, Pre and Post First World War; Pre- and Post-2nd World War; and the modem times. United Kingdom, North America and Nigeria shall receive the most attention. The content enumerated shall be presented in two units (Units 1 & 2).

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- explain the significance of the study of history
- summarise the development of nursing in Pre-Nightingale Europe and the UK
- identify the major areas of society and of nursing that Florence Nightingale's impact was felt.

3.0 MAIN CONTENT

3.1 Significance of the Study of History

Try to recall a history course you had at High School or the historical aspects one of courses you had in your school of Nursing. There was the course titled History which dealt with the process of reviewing events. There are subjects such as History of Political Movements in Nigeria; History of the Church Missionary Society in Nigeria; History of Education - all these examine the content of events. By the same token, when we talk about the historical development of Nursing, we are concerned with the content of development over a period: and how one developmental state influences the subsequent stages. What is the significance of history in nursing? History allows us to link the past with the present. It shows the achievements at each milestone. Knowledge of history serves as reference points for future.

You will now study the development of nursing during the different era stated in the introduction.

3.1.1 Pre-Nightingale Development of Nursing

Nursing was distinguished in its early history as a form of community service and was originally related to a strong instinct to preserve and protect the family (Donahue 1985). The desire to keep people healthy and provide comfort, care and comfort for the sick were the initial focus of nursing. This focus has remained relatively the same over the centuries, but the practice of nursing has been modified because of societal influence and changing needs. Nursing has evolved into what we now know as modern nursing. Nursing is as old as medicine. Nursing and medicine have been interdependent throughout history. During the era of Hippocrates, Medicine was practiced without Nursing. While in the Middle Ages, nursing was practiced without medicine.

In ancient cultures, religious leaders assumed responsibility for health and medical care because causation of illness was tied to myths and religion. Hence nurses were seen to be below religious leaders. Nurses then worked under priests and physicians performing custodian and personal hygiene care. The physician directed nursing activities; except the role of midwifery where nurses had always been accepted. Throughout this period, nurses as known then did not participate in activities to promote health or teach the families how to care for the sick.

Under the influence of Christianity, nurses began to gain respect and the practice of nurses expanded. The order of Deaconesses, a group similar to today's public health or visiting nurses was one of the earliest records of Christian nursing. According to Dolen et al. (1983), Donahue (1985), the order's goals included meeting of the following needs:

- Feeding the hungry
- Giving water to the thirty
- Clothing the naked
- Visiting the imprisoned
- Sheltering the homeless
- Caring for the sick
- Burying the dead

Historically, men and women held the role of the nurse. The entry of women into nursing could be traced to AD 300 because of improvement in the social position of Roman women. Christianity taught that men and women are equal before God. There was an appeal to women to carry on God's work towards those who were in distress. The Benedictine Order comprising men was founded in the 6th century and this increased the number of women in nursing.

During the Middle Ages, the Crusades became a stimulus for expanding nursing and healthcare. Military nursing orders for men were formed, and hospitals were established. After the Crusades, and with the decline of the feudal system, large cities began to develop and grow. This extensive growth of cities resulted in associated health problems.

SELF-ASSESSMENT EXERCISE

Nigeria is experiencing a similar population shift from rural to urban. List five health hazards: that are associated with extensive population growth of cities.

Example of an answer: Overcrowding, poor ventilation; Hot and humid environment, poor sanitation, inadequate water supply, air, food and water contamination; disregard of personal and environmental hygiene, inter-personal feuds.

Because of the enormity of the health problems, secular groups were formed in addition to nurses, to meet specific health care needs in the Middle Ages.

In response to the serious health problems of the 15th to 17th centuries which were the consequence of societal factors, nursing responded by the founding of the Sisters of Charity in AD 1633 by St. Vincent de Paul. The Sisters cared for the people in hospitals, asylums, and poor houses. In addition, they cared for sick people in their homes, hence labelled 'visiting nurses'

The first supervisor of the Sisters of Charity was Louise de Gras, a widow of high social standing. She established perhaps the first educational programme to be associated with a nursing Order. She recruited intelligent, refined and compassionate women. The programme included experience in the care of the sick in hospitals as well as home visits. The sisters of Charity were introduced in America in 1809, but their name was later changed to Daughters of Charity. The 18th Century saw further growth of cities in Europe including the United Kingdom; and consequently, increase in the number of hospitals, and more roles for the nurses. Nursing skills and knowledge were generally passed on by experienced nurses because there was still little formal education for them.

While nursing in continental Europe, especially in Germany was beginning to make progress, the same could not be said of the UK. Hospitals in the UK were built in response to similar health problems, but the 'nurses' came from the low social status, lacked responsible leadership, and were illiterate.

3.1.2 The Florence Nightingale Era (1820-1910)

Florence Nightingale went to study with the sisters of Charity in 1853, and was later appointed superintendent of the English General Hospitals in Turkey. During this period, she instituted major reforms in hygiene, sanitation, and nursing practice, thereby reducing the mortality rate at the Barracks Hospital in Sentari, Turkey from 42.7% to 2.2% in 6 months (Woodham Smith, 1983). Florence Nightingale was a proficient bedside nurse with a great concern for the soldiers she nursed. Her ward round at

night with the lamp earned her the title "The Lady with the Lamp". Organised nursing began in the mid-1800s under the leadership of Florence Nightingale, before her era nursing care was done by paupers and drunkards and persons unfit for any type of work.

Florence Nightingale's beliefs about nursing form the basic foundation of the practice of nursing today. Her religious convictions and experience in nursing during the Crimean War influenced her approach and beliefs about the care of the sick. She came from the upper social class, educated and possessed a good communication ability as judged by her various letters and book, *Notes on Nursing: What It Is and What It Is Not.* She travelled widely and had the ability to deal with government and politics. Florence Nightingale possessed many outstanding qualities. By today' s terminology, she would be called an epidemiologist and statistician. She was a researcher, a politician and a caring nurse of the sick and the well. Her philosophy of nursing practice reflected the changing needs of society. She saw the role of Nursing as having 'charge of somebody's health' based on the knowledge of "how to put the body in such a state to be free of disease or to recover from disease" (Nightingale, 1860).

Considering the role women were expected to assume during her time, Florence could be regarded as an activist of some sort. She was the one who vehemently objected to the female Victorian role of indolence and marriage and viewed the development of nursing as a "respectable livelihood and constructive utilisation of women". She saw activities as being based not only on compassion, but also on observation and experience, statistical data, knowledge of sanitation and nutrition, and administrative skills (Fitzpatrick and Wholl, 1983). The greatest achievement to the world of nursing was the establishment of the first organised programme for training for nurses: The Nightingale Training School for Nurses at St. Thomas' Hospital in London in 1860 AD. Professionalisation of nursing commenced from henceforth and nursing began to be accorded some respectability in society. Educated ladies from respectable social background were selected for training. A distinct body of knowledge was developed for nursing; and this was based on observed societal health needs.

4.0 CONCLUSION

The writings of Florence Nightingale which are over a century old remain the reference points for all aspects *of* nursing development today. Her focus of nursing was directed at the client, sick or well; the environment for nursing, the knowledge and expertise required by the nurse, and the interactions of these parameters towards the achievement of desired

goals. Florence Nightingale's thrusting forces were Religion, Science, and Society. Could there have been a better combination to initiate change and sustain progress?

5.0 SUMMARY

In this unit, you have learnt that the importance and advantages of studying history and the historical development of nursing in particular were examined. Contributions of various individuals and groups to public health and the care of the sick and less privileged in societies in Europe and the UK were highlighted. The extra-ordinary contributions *of* Florence Nightingale to Nursing, society, and science were fully discussed.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain 'historical development' in the context of nursing history.
2. Briefly summarise the place of nursing in pre-Nightingale Europe.
3. Highlight the impact of Florence Nightingale on the following:
   -Victorian women -Nursing science -Nursing education -Care of the sick -Nursing management.

7.0 REFERENCES/FURTHER READING

Dolan J.A. et al., Nursing in Society: A Historical Perspective, ed 15, Philadelphia 1983 Saunders.

Donahue, M.P. Nursing: the finest art, an illustrated history, St. Louis, 1985, Mosby Year book.

Nightingale, F.: Notes on Nursing: what it is and what it is not, London, 1860, Harrison and sons.

UNIT 2 HISTORICAL DEVELOPMENT OF NURSING II

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Historical Development of Nursing in the USA.
    3.2 Historical Development of Nursing in Nigeria
        3.2.1 Religious Influence
        3.2.2 British Colonial Service
        3.2.3 Nursing education within the university system
        3.2.4 Nursing education in Nigerian universities
    3.3 Globalisation of nursing
4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

You will recall that unit 1 of this course dealt with the first part of the Historical Development of Nursing in Europe and the UK. The last part of the presentation focused on Florence Nightingale who heralded major reforms in nursing. The concept of nursing proposed and practiced by Florence Nightingale became the foundation for professional nursing, not only in the UK but in the USA and the British colonial territories.

The dominant functions of nursing have been modified as an inevitable consequence of changes in the social, economic, political, educational, and scientific-technological value in which the consumers and the practitioners of nursing meet. With the above changes and facilitation by information/communication media, nurse's all over the world are now in better positions to share ideas and strategies, and to move nursing forward globally. By the beginning of the 20th Century, the Florence Nightingale concept of nursing and the various implementation strategies have crossed oceans and seas to the USA and British colonial territories.

In this unit, we shall continue with the historical development as the events occurred in the USA and Nigeria. As in the previous unit, major developments shall be addressed.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- describe the historical developments of nursing in the USA and Nigeria
- discuss factors that influenced these developments
- explain factors that facilitated nursing education within Nigerian universities
- discuss the influence of globalisation of nursing-on-nursing development.

3.0 MAIN CONTENT

3.1 Historical Development of Nursing in the USA

Like the Crimean War in Europe, the Civil War in the USA stimulated the growth of nursing. The women in the American Red Cross played important nursing roles.

Clara Barton, founder of the American Red Cross attended to or cared for soldiers on the battlefields, cleansing their wounds, meeting their basic needs, and comforting them at points of death. The American Red Cross was ratified by the United States Congress in 1882 after 10 years of lobbying by Clara Barton. Dorothea Synde Dix, Mary Anne Ball (Mother Bickerdyke) and Harriet Tubman also influenced nursing during the civil war. As superintend- ent of the female nurses of the Union Army, Dorothea Dix organised hospitals, appointed nurses, and oversaw and regulated supplies to the troops. Mother Bickerdyke organised ambulance services, supervised nurses, and walked abandoned battlefields at night looking for wounded soldiers. Harriet Tubman was active in the Underground Railroad movement and assisted in leading over 300 slaves to freedom.

After the Civil War nursing schools in the USA and Canada started to pattern their curricula after the Nightingale School. Many nurses contributed to the development of nursing in the USA and Canada, but a few will be highlighted. Isabel Hampton Robb graduated from St. Catherine's School of Nursing, Ontario, Canada, a school which was patterned on Florence Nightingale curriculum. She became the first superintendent of the Johns Hopkins Training School, Baltimore Maryland. She contributed immensely to the professionalisation of

nursing through publications of nursing textbooks and formation of a professional nursing association that became the American Nurses Association in 1911. She was one of the original founders of the American Journal of Nursing. The textbooks she authored were:
Nursing: Its principles and Practice for Hospitals and Private Use (1894); *Nursing Ethics* (1900), and *Educational Standards for Nurses* (1907).

Advances were made in hospital care, public health, and nursing education in the early 20th century. Mary Adelaide Nutting, a member of the first graduating class of Johns Hopkins Training School was instrumental to affiliation of nursing education with universities. She became the first professor of nursing at Columbia University Teachers College in 1907.

The journey towards the placement of nursing education into universities was quickened in 1923 when the Rockefeller Foundation funded a survey of nursing education, popularly known as the *Goldmark Report.* The report recommended that nursing education needed increased financial support and suggested that the money should be given to University Schools of Nursing. Five universities benefited from the financial support. University schools of Nursing were able to expand, increasing opportunities for more nurses to have university education. As nursing education developed, nursing practice expanded. More clinical specialty programmes were started and so also were specialty nursing organisations that were concerned with quality care.

In 1965, the National Commission on Nursing and Nursing Education explored issues that included: the supply and demand of nurses, clarification of nursing roles and functions, education of nurses, and career opportunities available to nurses. The Lysaught Report, named after the study director called for clarification of nursing roles and responsibilities in relation to other health professionals; advocated greater financial support for nurses; and more career opportunities to attract nurses and retain them in the profession. (Lysaught 1970).

As nursing education and practice evolved to meet the changing needs of society, Nurses' code of Ethics also evolved. In 1926, American Nurses Association proposed its code of Ethics. The purpose of this code was to "create a sensitiveness to ethical situations and to formulate general principles which result in the formation of conscious and critical judgement resulting in action in specific situations" (ANA 1926).

As technology and needs of society changed, the code of ethics was revised to provide code of ethics for nurses with interpretative statements (ANA 1985) Nurses in the USA and Canada had made giant strides in the development of nursing. The resolve to move nurse's education into Universities and Colleges, and away from hospitals affiliated schools facilitated the: development of more nurse scholars who are committed to developing nursing science and theory. Developing science and theory in nursing involves generating knowledge from the nursing field and other disciplines. One method for creating nursing scientific knowledge base is through the development and use of nursing theory through the research process.

A significant milestone influencing the development of concepts and theory was the establishment of the Nursing Research Journal in 1952. The journal has encouraged scientific productivity and has helped to provide the framework for a questioning attitude that has set the stage for further enquiries into theoretical nursing (Meleis, 1985). These have produced theorists whose theories are influencing all aspects of nursing worldwide. Such persons are Peplau, Henderson, Roy, Orem, Johnson. Nurses in North America, particularly in the USA, have developed nursing to a truly professional status.

You have spent the past few minutes studying the historical development of nursing in the USA, the events that occurred and the persons responsible for these events. We have also seen how the social, economic, political, science and technological development of society as a whole affected the development of nursing in the USA.

Discuss one developmental factor with American society that facilitated the development of nursing.

3.2 Historical Development of Nursing in Nigeria

The following factors influenced the development of nursing in Nigeria. Religion, British colonial administration, inter-professional communication, and the world wars. Traditionally caring for the sick took place at home and care is given by women and family members. The concept of a nurse in the European sense was not part of the traditional community set up. It was considered to be the responsibilities of the families to care for their members both in health and sickness. But the midwife had been a constant figure in all traditional societies. Nigeria had and still has the traditional midwives who care for pregnant women from conception, through labour and delivery. Post-natal care is also given to

both mother and baby. Caring includes provision of basic comfort, feeding, bathing and also the care of other siblings in the family.

3.2.1 Religious Influence

When the missionaries arrived in Nigeria from the UK in the 19th Century, their objectives were to convert (evangelise), to educate and to provide health care. Hence you find the church, the school and the hospital/clinic clustered in the mission grounds. With trained missionary nurses, some of them products of Florence Nightingale School of Nursing or curriculum. They recruited young men and women mostly with primary school education for on-the-job training in nursing- procedures and skills. The emphasis was on skills training starting from simple to complex. It was purely task-oriented training. Initially, there was no organised curricula, hence no central certification. The missionary Nursing sisters provided physical, psychosocial and spiritual care for their followers. The health care. needs of the communities were constantly assessed and appropriate health care facilities were provided. The first set of nursing personnel in the country were those trained on the job by UK trained missionary Nursing sisters. These locally trained nursing personnel also imbibed the tenets of the Christian religion and served as local contacts for evangelism. The two McCarter sisters ran the mother and child health centers in Abeokuta and its environs, while Mary Slessor was known in Calabar for her work with abandoned twins.

3.2.2 The British Colonial Service

The British colonial service in conjunction with the Royal Niger Company provided health care services for their serving citizens and their families in Nigeria. Medical teams were also brought from the UK to run the medical services. The medical teams included professional nurses trained in the UK. Two parallel health care services were provided: one for those in the colonial service Administration and the other for the local Nigerians. Hence, there were the European and African Hospitals.

The nursing sisters in the Medical Teams also trained women and men on-the-job and supervised their work. They were taught a lot of task and skills but with little theory. These young women and men were referred to as 'probation nurses' and they worked under supervision, mostly in the African Hospitals. There was no formal curriculum, each Nursing sister taught from her experience. There was no certification as there was no controlling or Examination body.

After the Second World War, which ended in 1945, many Nigerian girls with High School Education traveled to the UK, to train as professional nurses. Upon their return, most of them were employed in the Civil Service. The working environment was hostile, and many found that they could not put to practice the knowledge and skills they had acquired in the UK. Some left nursing for other disciplines, but others persevered. As more nurses returned from the UK, they collectively resolved to improve the standard of nursing education and practice in the country. These standards pioneering nurses included Adetoun Barley who later became the first Nigerian Registrar of the Nursing Council, Francis Oguntolu the retired Director of Nursing, Lagos University Teaching Hospital; Kofoworola Pratt, first Nigerian Matron of University College Hospital, Ibadan; Oluyinka Sofenwa, retired Deputy Director of Nursing, University College Hospital lbadan.

First on the list of improving standards was the inauguration of the first Nursing Council for Nigeria and the appointment of an interim Registrar in 1947 -an expatriate.

The changes effected in nursing were facilitated by the political climate in the country. It was the period of negotiation for the country's independence from Britain. During this period there were plans for the improvement of health care. The Richards constitution which divided the country' into three regions (East, West and North) and the capital Lagos created a School of Nursing for each region located at Enugu, Ibadan and Kaduna, plus the one in Lagos. These schools started to function in 1949 with formal syllabus to direct the educational programme. Qualified nursing tutors were employed from the UK to direct the programmes. Preceptors were employed from amongst Nigerian nurses trained in the UK to supervise the practical training of students in government hospitals.

The Health Policy also stipulated those Nigerian boys and girl with good high School education be sponsored to study general nursing, midwifery and other nursing sub-specialties of National needs in Great Britain. This was a great departure from the traditional practice of training individuals with only 6 to 8 years of primary education. The new direction encouraged boys and girls with good high school education to choose nursing as a career.

The Health Policy also directed that a School of Nursing be established at the University College Hospital, Ibadan in 1952. It was patterned after the Nightingale School of Nursing at St. Thomas' Hospital London. Girls with good education also qualified for admission into the school. From

all indications, the government was bent on changing the poor image of nurses and consequently improving the quality of nursing. This was linking good general and professional education with qualitative nursing practice.

With the Nursing Council in place and the instrument of authority approved, the Council proceeded to set minimum standards for, nursing curricula in Schools of Nursing, clinical teaching facilities, and the minimum educational qualification for entry into the Schools of Nursing. The authority of the Nursing Council was felt more in nursing than in midwifery. This was probably due to the fact that midwifery services were less organised than the nursing services. Fewer of the highly trained professional nurses went into midwifery practice. Furthermore, midwifery practice was more controlled by nongovernmental organisations.

3.2.3 Nursing Education within the University System in Nigeria

The developments in nursing education in Canada and the USA started to influence nursing education development in Nigeria especially in the old Western Region. In line with its health manpower development and to meet its expanding health care services, the Western Region government embarked on a programme of sending qualified nurses overseas to train as Nurse Tutors. In 1960, the Canadian government offered to educate nurses at university degree level. In 1960, there were technical aids from the British and Canadian

Governments to prepare nurse tutors at diploma and degree levels respectively. Nursing administration and nursing clinical specialisations were not left out of the development; there were German and British technical assistance for those areas. The immediate post-independence period saw nursing in Nigeria enriched with new ideas from the USA, UK, and Western Germany. Impressed by the Professional performance of the nurses trained abroad, many men and women went to these countries for their nursing education. The return of the five graduate nurses from McGill University in 1962, was the turning point for university education in Nigeria. These graduates were deployed to different schools of nursing where through their interpersonal relationships, influenced students' attitudes to nursing. By 1966, twelve graduate nurse teachers sponsored by the Canadian government, had taken up appointments with the Western Region government and later with other governments and health care institutions. This crop of nurse teachers were able to impress on the governments, formal and nonformal groups the benefits of university education in nursing and especially at

the administrative and education levels. There was also a world-movement through Inter- National Nursing Organisations to move nursing education from hospitals schools to universities. The first stage was sourcing for funds, followed by staff development, then programme development, identification and negotiation with institutions and government, student's selection and admission.

These processes were embarked upon consequently. In 1965 the University of Ibadan after creating a Department of Nursing admitted the first set of 10 students into the post-basic Bachelor of Science (Nursing) programme with options in Nursing Education and Nursing Administration, and Clinical Electives in Medical Surgical Nursing, Material and Child Health and Midwifery, Psychiatric Nursing, and Community Health Nursing.

The Rockefeller Foundation provided the building, the World Health Organisation (WHO) provided fellowships for students and teaching aids and other teaching materials, and Boston University admitted students for post graduate studies. WHO also provided supporting staff for the first five years of the programme. The University provided the administrative support, pending the take-over after five years.

By the time the first set of students graduated many more nurses wanted university education. The number of applicants increased every year, even when financial support was no longer available.

In 1971, the University of Ife (now Obafemi Awolowo University) started a Faculty of Health Sciences with a philosophy of educating the health professions students together, since they were expected to work together in real situations. Based on this philosophy, a generic degree BNSc. was started in 1973. More and more nurses and individuals who want to become nurses want university nursing education. More universities now run the generic nursing programme. Those Nigerian nurses and other persons who spearheaded nursing education within the University system include the late, Professor Frida O. Adebo, Olufemi O. Kujore" Adetoun Bailey, Ayodele Tubi, Lola Alade, Stella Savage Vye. Okusoga, Late Grace Afamefuna, Adebisi Fabayo and Later Professor T.A.I. Grillo

3.3 Globalisation of Nursing

Florence Nightingale through her definition of nursing has shown the universality of nursing. She showed how the role of nursing is to utilise the laws of nature to facilitate health and recuperation from illness. Long before Maslow's hierarchy of human needs, Nightingale has called nurses'

attention to the manipulation of the elements in the environment in order to meet Man's health needs. Nurses in different countries have evolved concepts and theories from Nightingale's concepts.

Nurses, through research, are identifying global problems and issues that affect man and sharing or offering solutions. The communication media for the sharing could be by the printed materials in the form of journals, books; electronic materials and software; face-to-face communication as occurs at meetings and conferences. We can now access information on nursing issues from the Internet. Nursing is no longer a calling shrouded in secrecy. The ability to produce knowledge by the scientific process through the fastest possible means is a work of professional growth and development of the 21st century.

Globalisation of nursing is also fostered through communication among various national nursing associations and specialty nursing groups. At international conferences issues and/or phenomena of common concerns are discussed, for example the International Council of Nurses (ICN). The ICN is an organisation focused on 'Advancing Nursing World Wide'. In 1998 identified three key areas as crucial to the improvement of nursing and health. These are known as ICN Pillars and they are: Professional Practice, Regulation, and Socio-economic welfare. The International Classification for Nursing Practice (ICNP) and Leadership for Change are two significant ICN projects which come under the professional practice pillar, Negotiation in Leadership is a project which comes under the socio-economic welfare pillar.

EXERCISE 2

Access the Websites of:

i. International Council of Nursing (ICN),
ii. World Health Organisation (WHO),
Summarise the nursing roles within the organisations *Regional nursing organisations (RNO).*

The trend in the past 20 years is for nurses within a geographical location to corporately develop nursing. A typical example is the West African College of Nursing (WACN) which is also an agency of the West African Health Organisation (WAHO). It is concerned with the nursing and health needs of people in countries of W AHa. The West African College of Nursing (w ACN) is composed of five faculties offering fellowship programmes in specific nursing specialties Community Health Nursing, Nursing Education and Administration, Maternal and Child Health,

Medical Surgical Nursing, and Mental Health and Psychiatric Nursing. Its responsibilities include inauguration of the nursing and midwifery councils, with the appropriate instruments of authority, the establishment of better equipped secondary, tertiary and specialist and teaching hospitals and the provision of articulated health policy. The cumulative effects of all the above resulted in communication between Nigerian nurses outside, particularly in the UK, Canada, and the USA.

4.0 CONCLUSION

From the presentation in this unit, it is clear that nurses in North America, particularly in the United States, were the main force in the development of nursing. The immediate pre and post independent periods in Nigeria witnessed a formalisation of nursing education and nursing practice through government policies on health; the raising of the educational standard for entry into the nursing profession; the starting of formal schools of nursing in all the political regions and at the University College Hospital, Ibadan and other University Teaching Hospitals in the Nation; government support for deserving students to study nursing in the United Kingdom with scholarships, employment of many British trained Nigerians and British nurses into the health services whereby much higher quality of nursing education and nursing practice were demonstrated, and these serving as encouragement to well-educated persons to come into the nursing field.

5.0 SUMMARY

This unit examined the historical developments of nursing in the United States of America. Discussions showed you how the development has moved nursing to a high professional status.

It also examined the development of Nursing in Nigeria and the factors that influenced the historical development. Lastly, globalisation of information in nursing through various communication media are highlighted.

6.0 TUTOR-MARKED ASSIGNMENT

1. List three major areas of development of nursing in the USA during the first five decades of the 20th century.
2. Discuss the relationship between the development of the Nightingale Era and post Nightingale Era in the US.
3. Describe two factors that influenced Nursing history and development in Nigeria.

7.0 REFERENCES/FURTHER READING

Dolan, J.A. *et al. Nursing in Society: A Historical Perspective,* ed. 15, Philadelphia 1983, W.B. Saunders

Donahue, M.P. *Nursing* The *Finest Art, an Illustrated History,* St. Louis, 1985, Mosby Year Book.

Lysaught, J.P. *An Abstract for Action,* New York, 1970 McGraw-Hill Poller, P.A., Perry, A.G. *Fundamentals of Nursing: Concepts Process and Practice, (*3rd ed.). Mosby Year Book, St. Louis.

International Council of Nurses (ICN) http://www.ICN/ch/progrtam.htrn

UNIT 3 CONCEPTS OF NURSING

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Concepts of Nursing
        3.1.1 Florence Nightingale
        3.1.2 Virginia Herderson
        3.1.3 Hildegard E. Peplau
        3.1.4 Myra Levine
        3.1.5 Dorothea Orem
        3.1.6 Calista Roy
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

I hope that you have read and understood the course guide. You are therefore in a better position to appreciate how this unit (Concept of Nursing) fits into the course as a whole. Concept of Nursing focuses on the idea and meaning of nursing as a professional occupation. Different people express different ideas as to what nursing actually is. The unit will describe the ideas of nursing by six distinguished nurse leaders who had influenced the development of nursing worldwide.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- define the word 'concept' from the point of a general usage and from the point of nursing as a concept
- mention at least three concepts of nursing stated by distinguished nurse leaders from the time of Florence Nightingale to the contemporary time
- identify the common focus of nursing activity for concepts of nursing
- compare and contrast your concepts of nursing before and after the study of this unit.

3.0 MAIN CONTENT

3.1 Concepts of Nursing

The concept of nursing expresses the opinion of recognised practitioners of nursing as a profession. It is seen by some people as an art, and by others as a science, skill or as a calling. But, here, we shall consider the opinions of only six distinguished nurse leaders. These include:

-Florence Nightingale,
-Virginia Henderson,
-Hildegard E. Peplau,
-Myra Levine,
-Dorothea Orem, and
-Calista Roy.

These people have been specifically choosen because of the uniqueness of the statement each of them has made. You are expected to study at least three of the six statements from the point of view of uniqueness and focus.

EXERCISE 1

1. Think and state your concept of nursing that had influenced your decision to choose nursing as a career.
2. State the focus of nursing activity that could be derived from your statement.

Very often, the way a situation, a thing, or an event is conceptualised directs the type and focus of activity that would be engaged in it. For example, Imogene M. King's concept of nursing is that it is 'a process of human interaction between nurse and client'. This statement when examined shows that the focus is on communication whereby both nurse and client share information, recognise each other, agree on set goals and take actions for their attainment. This type of concept of nursing demands collaborative interaction aimed at attaining planned set of goals.

There is a thread of ideas which connect from one nurse leader to another. As we examine the concepts of nursing of different nurse leaders, we should look out for the linking ideas. The attempt to define nursing started before the 20th century.

3.1.1 Florence Nightingale

Florence Nightingale, the founder of professional nursing espoused nursing to be a profession for women, the goal of which is to discover and use nature's law governing health in the service of humanity. In addition, nursing was stated to be an art and a science, and required an organised scientific and formal education to care for those suffering from disease. Both sick nursing and health nursing are to "put the patient in the best condition for nature to act upon him". From this concept of nursing, it is possible to deduce the actions, activities, educational preparation and organisational support for the concept.

Nightingale concept of nursing dominated the development of nursing for nearly 100 years roughly from late 19th century to mid-20th century. It gave birth to the professionalisation of nursing.

The concept of nursing continued to receive attention of nurse leaders after Florence Nightingale. The dominant functions continue to be modified as an inevitable consequence of changes in the social, economic, political, educational, scientific and technological milieu in which the consumer and practitioner of nursing meet. Positions in the first half of the 20th century on the nature and contribution of nursing have resulted more often from deductive than from inductive reasoning.

3.1.2 Virginia Henderson

The relatively stable essence of nursing is captured in one of the most widely quoted concepts of nursing by Virginia Henderson:

The unique function of the nurse is to assist the individual, sick or well in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work is thus part of her function. She initiates and controls. She initiates and masters. In addition, she helps the patient to carry out the therapeutic plan as initiated by the physician. She also, as a member of a medical team, helps other members, as they in turn help her, to carry out the total programme whether it be for the improvement of health, or the recovery from illness or support in death.

Henderson proposed 14 activities contributing to health which nursing is responsible for -assisting the individual and suggested that existing or potential loss of the power to control or perform those activities signals the existence of a nursing problem. The 14 proposed components are:

1. Breathing normally.
2. Eating and drinking adequately.
3. Eliminating body waste.
4. Moving and maintaining desirable postures.
5. Sleeping and resting.
6. Selecting suitable clothes -dressing and undressing.
7. Maintaining body temperatures within normal range by adjusting clothing and modifying the environment.
8. Keeping the body clean and well-groomed and protecting the integument.
9. Avoiding changes in the environment and avoiding injuring others.
10. Communicating with others expressing emotions, needs, fears or opinions.
11. Worshipping according to one's faith.
12. Working in such a way that there is sense of accomplishment.
13. Playing or participating in various forms of recreation.
14. Learning, discovering, or satisfying the curiosity that leads to normal development and health and using the available health facilities. -(Henderson, pp 16-17, 1966).

The above components guide the selection of educational content and practice/intervention activities either in health or sickness.

3.1.3 Hildegarde Peplau

Hildegarde Peplau came into limelight in 1950s. She was one of the nurse leaders dedicated to the development of nursing as a recognised professional discipline, focusing much of her effort on the development of knowledge base to guide clinical practice. Peplau differentiated nursing and medicine by stating that physicians address themselves to within person phenomena, to dysfunctions, deficits, defects and the like, in relation to the organism. Physicians define the diseases of a person and prescribe treatment for them. In contrast to this statement, Peplau defines nursing as "a significant therapeutic interpersonal process which functions cooperatively with other human processes that make health possible for individuals".

Peplau's definition of nursing as a "nurturing force and educative instrument", represent her view of the facilitative nature of the discipline. Its primary purpose is the application of scientific principles in facilitating human health.; Initially, Peplau viewed nursing as an applied science and as a process which aids patients to meet their own needs and recover from illness. More recently, her conceptualisation of nursing is

that of a social and scientific force in the exploration and organisation of factors relevant to the maintenance of health.

Although Peplau considers nursing as a collaborative part of the health profession team, all the same, she sees a' unique focus for nursing as resting in the reactions of the patient or client to circumstances of illness or health problem. This is helping patients to gain intellectual and interpersonal competences.

Nursing activity is, more specifically, depicted as six identified roles which the nurse assumes at various times during inter-personal encounters with the patient. Details of the roles as components of Peplau' s Model will be discussed in subsequent units of this Course.

The next three nurse leaders produced their concepts of nursing during the last three decades of the 20th century. Previous ideas by earlier nurse leader were expanded upon.

3.1.4 Myra Levine

Myra Levine defines nursing as:
a human interaction -an exchange between individuals. Nursing is regarded as a sub-culture, processing ideas and values which are unique to nurses and which reflect society.

Nursing knowledge allows for a sensitive and productive relationship between the nurse and the individual needing care.

Levine, like Nightingale, place great emphasis on observation. Observation allows the nurse to evaluate the patient's condition as well as anticipate the patient's future course of events.

Levine sees Nursing as a human interaction between individuals and for which nursing has an extant body of knowledge.

3.1.5 Dorathea Orem

Dorathea Drem defines nursing as:

a human service that is different from all other human services. She indicates that nursing's special concern is man's need for the provision and management of self-care action on a continuous basis in order to sustain life and health or to recover from disease or injury.

Of those who preceded Orem, Henderson's and Orem's definitions/concepts appear to be closely related. Both focus primarily on the individual stress, assisting the individual with activities he/she can no longer do for himself/herself and extending the defined boundaries of nursing to include assisting the individual toward independence from nursing or assistance toward a peaceful death.

Nursing's special concern or uniqueness rests with the individual's need for self-care action and the provision and management of it on a continuous basis in order to sustain life and health, recover from disease or injury, and cope with their effects. Nursing is characterised as action and as assistance. For activities to be considered as nursing, they must be consciously selected and directed by the nurse toward accomplishing nursing goals.

3.1.6 Callista Roy

Callista Roy defines nursing as:

a theoretical system of knowledge which prescribes a process of analysis and action related to the care of the ill or potentially ill person. Nursing is concerned with the person as a total being, interacting with a changing environment and responding to stimuli present because of his/her position on the health-illness continuum. When unusual stressors or weakened coping - mechanisms make a person's usual attempts to cope ineffective, then, the person needs a nurse.

Nursing consists of both the goal of nursing and nursing intervention. Although the above statements of concepts of nursing originated from different nurse leaders, nevertheless they share at least one focus.

SELF-ASSESSMENT EXERCISE

1. Read each concept of nursing statement again, and identify one common focus.
2. You have decided to study professional nursing as a career.
   -State your idea/concept of nursing
   -Mention two factors that influenced your idea/concept of nursing.

You will recall, as pointed out earlier, that a concept of nursing directs and guides the nurse in her focus, choice of nursing activities and basis for model and theory development. For example, Nightingale's concept of nursing focused on the manipulation of the environment in line with the laws of nature. The concept environment is further broken down into

less abstraction, whereby we now have physical, psychological and social environment. As these are further broken into observable activities, they provide further direction for the intervention activities.
This process will be further developed in subsequent nursing courses.

SELF-ASSESSMENT EXERCISE

Think again of your own concept of nursing:

List five specific nursing activities that you can generate from it. The activities should be things you can do (for example, making a patient's bed, feeding).

4.0 CONCLUSION

In this unit you have been introduced to the concept of nursing. The unit started with a general introduction to the topic, followed by statements of specific objectives to be achieved at the end of the interaction. The definition of concept as a general term was discussed and followed by definition of 'concept of nursing'.

The concepts of nursing of six renowned nurse theorists were presented. The importance of concepts in the derivation of nursing activities, as foundations for nursing models and nursing theories was mentioned. Exercises were given to assist you to monitor your learning.

5.0 SUMMARY

In this unit, you have learnt about concepts, and concepts of Nursing. Definitions from selected nurse theorists were made for illustrations, starting from Florence Nightingale who is regarded as the founder of Modem Nursing. This Unit serves as a theoretical foundation for the subsequent Units in this and other nursing courses.

7.0 TUTOR-MARKED ASSIGNMENT

1. Define the term *concept* in the context of its general usage, and state briefly how concepts evolve.
2. Define a concept of nursing and describe the roles concepts of nursing play in the development of nursing.

7.0 REFERENCES/FURTHER READING

Chin P.H. Jacobs, M.K. (1983). *Theory and Nursing: A Systematic Approach.* St. Louis: C. V. Mosby.

George J.B. (1990). *Nursing Theories: The Base for Professional Practice.* New Jersay Appleton and Lange.

Henderson, V. (1966) *The Nature of Nursing.* New York: The MacMillan Co.

UNIT 4 NURSING AS AN ART AND A SCIENCE

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Definitions
    3.2 Nature of Nursing as an Art and a Science: Historical development
        3.2.1 Nursing as an Art
        3.2.2 Nursing as a Science
4.0 Conclusion
5.0 Summary
6.0 References and other resources
7.0 Tutor-marked assignment

1.0 INTRODUCTION

Historically, the practice of nursing concentrated on groups of activities identified, organised and practiced in such ways that the sick would have succour and comfort. These activities are based on the natural needs of man for survival. These natural needs are air, water, food, excretion (elimination), stimulation, exercise, rest, sleep, comfort, safety, love and belonging, self-esteem, and self-fulfillment. Nursing initially was equated with mothering; hence activities were centred on these parameters. The focus of nursing historically centered on the sick and the injured that were unable or incapable of providing for themselves the natural needs which Abraham Maslow later identified as basic human needs.

Nursing, as a human service, designed activities and skills (tasks) that facilitated recovery from sickness and injury. The skills constituted nursing knowledge; hence the memorisation of the various skills formed the process for learning nursing. The consumers also view competent performance of the technical skills as the focus of nursing. The greater the automaticity with which a task is performed, the higher the competency rating.

This initial interpretation of the art of Nursing was very narrow. It assumes that this task oriented nursing does not require an understanding of why the tasks are necessary, how they work, or what the effects will be. This view assumes that nursing has no knowledge base of its own, nor

does it need one. The skills are regarded to be essentially manual and technical and reflect the knowledge of other disciplines, especially medicine. Hence the common expression: "Nursing is tied to the apron string of medicine". This might have been true for much of the pre-and early Nightingale era. 4 Nursing as a science, on the other hand, views nursing as an intellectual process and activity. "

In current professional nursing art and science are not discrete entities. They are on a continuum of interpersonal interaction, which has specific goals and involves particular kinds of activities/tasks. A universally accepted process is applied in the practice of nursing science. Some aspects of this topic have been discussed in units 2 and 3 and will also be expanded in unit 8, *Nature of Nursing as a Profession*. We will now 100 at the objectives to be accomplished on completion of this unit.

2.0 OBJECTIVES

By the of this unit, you will be able to:

- define the concepts art and science as in general usage
- describe the historical development of art and science in Nursing
- enumerate at least two factors that influenced the art and science of nursing
- discuss the application of art and science in the content and process of nursing.

3.0 MAIN CONTENT

3.1 Definitions

- Art is defined in general terms, most of them applicable and are applied in Nursing. The Oxford Advanced Learner's Dictionary defines *Art* as,
- Skill acquired by experience, study, or observation.
- An occupation requiring knowledge or skill
- The conscious use of skill and creative imagination; A skillful plan
- The faculty of carrying out expertly what is planned or devised.
- An ability or skill that can be developed with training and practice.
- *Science* is defined as Possession of knowledge as distinguished from ignorance or misunderstanding.

- Knowledge attained through study or practice
- Something that may be studied or learned like systematised knowledge. Knowledge covering general truths or the operation of general laws
- especially as obtained and tested through scientific method.
- Such knowledge concerned with the physical world and its phenomena; A system or a method based or purporting to be based on scientific principles.

The realisation of these definitions may not be fully experienced by you at the end of the study of this unit. But, as you progress in your nursing studies, each definition will unfold with a variety of nursing situations. You need to keep this foundation information in constant perspective.

EXERCISE 1

Select one definition each from the Art and the Science. Think of your past experiences in nursing (education, practice/care, management), March the definition with narration of your experience.

3.2 Nature of Nursing as an Art and a Science: Historical Development

3.2.1 Nursing as an Art

Nursing as an art encompasses the organisation and care of the clients' environment communication, general care of clients, and performance of clinical procedures and miscellaneous nursing skills. All these are performed with the application of Levine's four conservation principles which are: conservation of energy, Conservation of Structural Integrity, conservation of Psychological Integrity and Conservation of Social Integrity. These principles consider the clients, Nurses, families, community members, and other health professionals.

Historically, the practice of nursing concentrated on groups of activities identified, organised, and practiced in such ways that the sick would have succour and comfort. Nightingale described two different types of nursing, sick nursing or "nursing proper" and healthy nursing, which required an organised, scientific, and formal education. Nightingale meaning of nursing activity was a departure from the previous common belief that nursing is a collection of tasks or procedures requiring some skills, and are initiated and directed by others, particularly physicians whose functions they exist to assist. So, there were no independent

nursing functions. Because they required skill, some training was necessary. But competent performance did not require an understanding of why the task is necessary, how it works, and what the effect would be. Nursing had no knowledge base of its own; its skills were essentially technical.

Nightingale saw nursing proper as both an art and a science that require organised scientific formal education. She perceived nursing as being distinct from medicine, asserted that nursing concern was with the client who was il1, rather than the illness which was the focus of medicine. Although nurses were to carry out physicians' orders, they were to do these only with an independent sense of responsibility for their actions. talking about Nursing as an Art, one needs to examine the various activities in nursing, of goals of securing comfort and succour to the clients be it in health or sickness. Nightingale in her book *Notes of Nursing* discussed various activities of the nurse and how these could be artistically organised that the goals of care are achieved. Safety, comfort, pleasing to the sense, are essentials of a nursing activity, which are to be directed towards the environment as well as the client.

The basic nursing focus, activities and procedures identified by Nightingale and taught to her students of St., Thomas Hospital, School of Nursing London, are still the Nursing Arts of professional nursing today. Why? Because the process has consistently focused on clients personal and universal needs in the context of the human environment. However, the process of arriving at needs had been greatly influenced by knowledge and the scientific method: Nightingale emphasised the importance of observation and documentation in the nurse-client interactions.

SELF-ASSESSMENT EXERCISE

1. You are asked to apply a bandage dressing to the forearm and wrist of a client who sustained a soft tissue injury. Describe your activity in terms of Nursing as an Art.
2. List two factors that have aided your skill development of a chosen nursing care task.

3.2.2 Nursing as a Science

In the bid to achieve the professional status nursing has striven hard in the 1st 100 years to fulfill the characteristics of a profession. A very important requirement for professional status is that the profession has a theoretical body of knowledge leading to defined skills, abilities, and norms. Nursing knowledge has been developed through nursing theories.

Theoretical models serve as frameworks for nursing curricula and clinical practice. Nursing theories also lead to further research that increases the scientific basis of nursing practice.

Although the outward and visible signs of nursing care are what the nurse does for, with or on behalf of a client, her actions are based on a series of intellectual processes that are not directly visible. Together these intellectual activities and nursing actions are called the nursing process. Essentially, the nursing process is a systematic method of problem solving applied to nursing situations and based on scientific method. Other non-systematic problem-solving methods such as intuition, experience, tradition, trial and error are used in nursing. But the reliability under is often low.

The purposes of the nursing process are to meet the general objectives towards which the nursing care of all clients is directed. The objectives may include:

- Personalising the care of each client.
- Ascertaining, supporting, and maintaining client's capacity for meeting the physiological, psychological, social and spiritual needs, as well as recognising the client's strengths and limitations
- Protecting the client from threats to his safety comfort and wellbeing
- Supporting, comforting and sustaining the client and to ease his suffering during all phases of illness.
- Assisting in the restoration of the client to the fullest capacity of which he/she is capable.
- Considering the client's family members and friends as persons with legitimate interest and roles to play in his well-being
- Assisting the client and the family in planning for the required care.

For these general objectives to be achieved, there must be a complementarity between the type of problems presented by the clients and the goal the nurse pursues in an effort to help the client meet an otherwise unmet need (patient problems). It is at the point of intervention that nursing art manifests. The relevance, quality quantity and organisation of the art as an outcome of a scientific process that confirms nursing care as scientific and nursing as a profession. In addition to the process knowledge from relevant disciplines would be consulted and utilised.

4.0 CONCLUSION

In essence Nursing as an Art and as a science could be described as two faces of a coin. Just as the task, skill or procedure is an outcome of a scientific process, the task, skill, or procedure may become a source for scientific investigation. The emphasis on nursing as an art without obvious intellectual activity might have been responsible for the view that nursing is just a collection of tasks and procedures, which requires some skill and therefore some training. The competent performance does not require understanding of why the task is necessary, how it works, and what the effects would be. But the intellectual activity of nurses by the application of the scientific process, clinical judgement based on knowledge, and research in nursing and publications in nursing journals continue to strengthen the professional image of nursing.

5.0 SUMMARY

In this unit, you have examined nursing as an art, and as a science. Definitions of the concept's art and science in the broad general usage were presented. Discussion of each concept from the professional perspective was presented, and the relationships in terms of the scientific process and practice of nursing were also presented.

6.0 TUTOR-MARKED ASSIGNMENT

1. Define the concepts art and science.
2. Explain briefly the development of (i) nursing as an art (ii) nursing as a science.
3. Explain how nursing as an art and nursing as a science could be considered as the two faces of a coin.

7.0 REFERENCES/FURTHER READING

Benner, P. From *Device to Expert: Excellence and Power in Clinical nursing practice,* Men! Park, Calif, 1984. Addison-Wesley.

Benner, P., Tanner C: *How Expert Nurses Use Intuition.* Am. J. Nurse 87 (1): 23,1987.

Clark, J. *Nursing: An Intellectual Activity,* International Nursing Review 39, 2, 1992.

Donahue, M.P. *Nursing:* The *Finest Art, an Illustrated History,* St. Louis, 1985, Mosby Year Book.

Fitzpatrick, J, & Whall, A. *Conceptual Models of Nursing: Analysis and Application.* A Prentice-Hall Puolishing and Communications Company, Robert J. Brady Co. Bowie Maryland,1983.

Henderson, V. The *Nature of Nursing*, The MacMillan Company, New York 1969.

Nightingale, F. *Notes on Nursing: What It Is and What It Is Not.* Gerald Duckworth & Company Limited London 1970.

Petter, P.A. Perry, A.G. *Fundamentals R.X. of Nursing: Concepts, Process and Practice (*3rd ed.). Mosby Year Book, St. Louis.

UNIT 5 NURSING AS A PROFESSION

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Definition
    3.2 Characteristics of a Profession
    3.3 Progress of Nursing Towards Professional Status
        3.3.1 Elements of Professionalism in Nursing
        3.3.2 Education
        3.3.3 Theory Development
        3.3.4 Specific Service
        3.3.5 Autonomy of Decision Making and Practice
        3.3.6 Accountability
        3.3.7 Code of Ethics
        3.3.8 Professional Organisations
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further reading

1.0 INTRODUCTION

You will recall that the science and art of nursing are important contributors to the professionalisation of Nursing. In this unit we shall discuss the nature of nursing as a profession. Take a few minutes off to review your last lesson before starting on todays. It will help you to appreciate the close inter-relatedness of the two units.

You should start this unit by first reviewing the objectives. Are they clear? Consult your tutor if you need clarification. You should now go to the topic and identify the three main concepts. Two of the concepts have received attention in previous units. Which two concepts are these?

- Nature
- Nursing

Do you still remember their definitions? Write them again into your notebook compare them with your study notes.

The third concept in today's topic is *profession*. The unit topic for today is nature of nursing as a profession. So it can be concluded that the lesson for today is addressing whether the inherent characteristics of nursing make it a profession.

The discussion will start with the definition of 'profession' as a general concept; some disciplines that are usually referred to as professions will be identified; how nursing in its practice and development has been progressing towards the attainment of an ideal profession will be examined and attempts 19 made by nursing in Nigeria towards professionalism will be highlighted.

You will be requested to respond to tutor-marked assignment and exercises in the text to help monitor your progress, and a Tutor -Marked Assignment (TMA) will serve as the summative evaluation for the unit, References to further reading and resources are also provided.

The following unit objectives indicate what you should accomplish at the of this unit.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- define 'profession'
- enumerate the characteristics of a professional discipline
- discuss how nursing is progressing towards the ideal professional status
- identify the efforts being made towards realisation of professional nursing status in Nigeria.

3.0 MAIN CONTENT

3.1 Definition

You might have read and heard discussions about some occupations being referred to as professions. How about the occupations such as accountancy teaching? There are many more. Although the occupations mentioned many others are distinct in emphasis and activities, they share the recognition being professions. What then does being a profession mean? Is your dictionary with you? Check the dictionary meaning of the word 'profession'.

The Webster New Collegiate Dictionary states a few definitions, but those found to be most relevant are Profession being:

1. A calling requiring specialised knowledge and often long and intensive academic preparation.
2. A principal calling. Vocation or employment.
3. The whole body of persons engaged in a calling.

Do you have similar statements in your dictionary? Remember! That I mentioned that there are a few statements, but that those quoted appear to be the most relevant composite. The statements can be reconstructed to read: "Profession is the whole body of persons engaged in a principal called, vocation or employment requiring specialised knowledge and often long and intensive academic preparation".

It is worth noting that unlike many concepts, *profession* is not defined with a single statement but with a construct. Hence it is from the construct or characteristics that the meaning can be inferred. To construct is to make or form by combining parts. Which means that all parts are necessary for a meaningful whole. Some authors have also offered descriptions of the concept -profession. Let us examine the one described by Etzioni (1961). He describes professions in terms of the following primary characteristics.

SELF-ASSESSMENT EXERCISE

List five occupations that are of professional status applying the definitions/constructs.

3.2 Characteristics of a Profession

The primary characteristics of a profession as described by Etzions (1961) are as follows among others:

- It requires an extended education of its members as well as a basic liberal foundation.
- It has a theoretical body of knowledge leading to defined skills, abilities, and norms.
- It provides a specific service.
- Members of a profession have autonomy in decision-making and practice.
- The profession has a code of ethics for practice.

EXERCISE 2

Can you find similarities in the two sets of characteristics of a profession and an occupation? Try to match them.

3.3 Progress of Nursing Towards Professional Status

Most occupations do not acquire the elements of a professional status over-night. It is a gradual developmental process. Hence in reality, any specific occupational group might be placed or ranked along a continuum ranging from 'non-professional to professional status, according to the degree which the occupational group manifested the elements of professionalism. In Nursing, the bid for professional status started with Florence Nightingale reforms. It has taken nursing over a century to travel to its present profession status.

Let us examine the occupation of Nursing. It is a professional occupation Having been part of the development in nursing for over fifty years, a witnessed and participated in various development, I want you to know that nursing is not simply a collection of specific skills and the nurse is not simply a person trained to perform specific tasks only. Nursing has come a long w to becoming a profession.

No one factor absolutely differentiates an occupation from a profession; b the difference is important in terms of how nurses practice. When we say that a person acts professionally, we are implying that the person is conscientious in actions, knowledgeable in the subject, and responsible to self and others. Therefore, when one examines both the various descriptions of a profession one would see that nursing clearly possesses to some extent, the characteristics. However, nursing is still evolving as a profession and faces controversial issues as nurses strive for greater professionalism.

3.3.1 Elements of Professionalism in Nursing

If one says that Nursing is a profession, then it is necessary to discuss the activities that support such an assertion.

3.3.2 Education

Nursing requires that its members possess a significant amount of education The issue of standardisation of nursing education is a major discussion today in the wide world of nursing. Most nurses agree that nursing education is important to practice and that it must respond to

changes in health care created by scientific and technologies advances. The race for education for nurses started by Florence Nightingale in the 19th Century in the United Kingdom and Germany had moved to different parts of the world where it has developed and is still developing. Nurses in North America and Canada started the movement of nursing education into universities, and this movement is influencing nursing education in practically all countries of the world. It is a universal agreement that education is important to the type of practice that would meet today's client's needs. As discussed in Unit 2, *Historical development of nursing*, nursing in the USA has led the world in lifting nursing education to unprecedented heights by relocating nursing education from sole apprenticeship system in hospitals to universities. The American Nurses Association (ANA) in 1984 directed that professional nurse require the Bachelor of Science in Nursing before practicing nursing. Many universities offer higher degrees in nursing making it possible for nurses to undertake research and develop nursing theories. Research facilitates the development of new knowledge and modes of nursing practice. Continuing education programmes are available for older nurses.

In the UK, the Royal College of Nursing and the UKCC embarked on various advanced and continuing education programmes inside and outside the universities. Universities and other higher institutions of learning offering nursing courses at degree levels have risen by over 60 percent the past twenty years.

In Nigeria, the Nursing and Midwifery Council of Nigeria, the National Association of Nigerian Nurses and Midwives and the Ministry of Health have been working towards the improvement in nursing education through curricular reviews, support for undergraduate and graduate programmes in nursing, and the enabling legislation.

3.3.3 Theory Development

As nursing emerged as a profession and with the quality of education improving, nursing knowledge began to develop through nursing theories. Theoretical models serve as frameworks for nursing curricula and clinical practice, nursing theories also lead to further research that increase the scientific bases of nursing practice. A theory is a way of understanding a reality, and in this general sense all practicing nurses use the theories they have learnt.

You have come across the word's 'model' and 'theory' in Concepts of Nursing, where they were mentioned in passing. They will be discussed in detail in Units xv and XVI (Theories in Nursing).

3.3.4 Specific service

A profession is expected to provide a specific service relating to identified needs of clients. The clients also recognise the need for the service being rendered Nursing has always been a service profession, although usually viewed as a charitable one. The nurse is no longer primarily limited to the hospital environment but has increasingly moved out into the neighbourhood and community in identifying health care needs and planning and executing appropriate interventions.

In addition to effecting change, nursing is offering an increasing member of services to society. You will recall from discussion in unit 2 that service' the major emphasis of practically all the definitions of nursing. In unit Historical Development of Nursing you learnt how the focus of activities' the-Nightingale and post-Nightingale era was service to humanity. You should review the Units again.

3.3.5 Autonomy in Decision Making and Practice

Autonomy is the quality or state of being self-governing. Have you experienced autonomy before? When you had to look after your own affairs without someone looking over your shoulders, think of how you felt. The same applies to Nursing. Autonomy means that a person, group or organisation' reasonably independent and self: -governing in decision making and practice.

It has been difficult for nurses to attain the degree of freedom enjoyed by other professionals. Until recent times, physicians, hospital administrators and others directed nurses in the health care delivery system because they could not understand why nurses require autonomy. Thank goodness for increased clinical competence and better education preparation. Nurses are increasingly taking on independent roles in nurse run clinics, collaborative practice, and advanced nursing practice.

In Nigeria nursing autonomy remains a thorny issue. The tradition of the physician holding tightly to the reins of control is evident. This is an area of conflict between the two professions. The genesis of this has been the great disparity in the educational level, the nurses' being much lower. The 10 educations of the nurses did not prepare them for self-confidence and assertiveness. With the upgrading of nurses general and professional

education inclusion of liberal arts subjects in the professional education, and the gradual relocation of nursing education into institutions of higher learning, the nurse is beginning to gain control of their profession. Nurses are becoming more self-confident and assertive. The quality of education is having this effect on nurses. Other health care professionals are also beginning to appreciate the new qualities in nurses. Communication and Interpersonal Relationships are becoming positive.

3.3.6 Accountability

Like it is in normal life, the greater the autonomy one has the greater the responsibility and accountability. Accountability simply means being answerable for one's actions or deeds. For the professional nurse however, accountability means that the nurse is responsible, professionally, and legally for the type and quality of nursing care provided. The nurse is accountable for keeping abreast of technical skills and the knowledge required for performing nursing care. A nurse is accountable to self, the client, the profession, the employer, and society. For example, if a nurse injects a drug into the wrong site, she will be accountable to the client who received the drug, the physician who ordered it, the nursing service that set standards of expected performance, and society that demands professional excellence. To be accountable, the nurse acts according to the Code of Ethics. Thus, when an error occurs, the nurse reports it, and initiates care to prevent further injury.

The nursing profession in most parts of the world regulates accountability through the process of nursing audits and setting of standards of practice. In summary professional accountability serve the following purposes:

- Evaluates new professional practices and assesses existing ones: Maintains standards of healthcare.
- Facilitates personal reflection, ethical thought, and personal growth on the part of the health professionals and
- Provides basis for ethical decision-making.

In Nigeria nursing area, accountability has not received the attention it deserves. This analysis is not confined to nursing alone, it is a public problem that thrives because clients hardly exercise their rights. Human Rights issues are now topical, and the general population is becoming enlightened about their rights. Human Rights, Accountability and Standards of Nursing practice how feature prominently in nursing curricula and in practice manuals. Nurses are now more knowledgeable about nursing Standards, Nursing Audit and Human Rights than a decade

ago. There is a general political will towards the implementation of these concepts.

3.3.7 Code of Ethics

In all human cultures, there are ethical codes that govern interactions between people and the environment-physical, psychological, social and spiritual. Most cultures inculcate into their offspring values and ethical behaviour characteristic of their groups. So at the professional level, the values and codes of ethics of the profession must be internalised. Many countries have developed their Codes of Nursing Ethics, guided by the Code of Nursing Ethics from the International Council of Nurses (ICN). Write on a sheet of paper one Ethical statement in your culture. Compare it with the Ethical Principles below. Is there one with similarity in meaning or characteristic?

Nursing operates under a code of ethics, which defines the principles by which nurses' function. In addition, nurses incorporate their own values and ethics into practice. The discussion on ethics will be brief here, as a Unit solely on ethics will be discussed in *Foundation of Nursing.* It is being mentioned here as a requirement for professionalism. Only the ethical principles will be highlighted.

High on the list of ethical principles is Respect for autonomy, followed by normal efficiency; beneficence; and justice. The secondary principles include veracity, confidentiality, and fidelity.

Check the definitions of these primary Ethical principles from your 'Test' Potter and Perry 1993 p. 278.

Which other profession would use the ethical principles in their professional discourse?

3.3.8 Professional Organisations

Members of a professional group are required to form formal professional associations that are to deal with issues of concern to those practicing in the profession. In Nigeria, there is the National Association of Nigeria Nurse and Midwives (NANNM). The mandate is to improve the standards of nursing education of nursing practice; foster a higher standard for nursing, and to promote the professional development, general and economic welfare of nurses and midwives. NANNM is affiliated to the International Council of Nurses (ICN) whose aims are to promote National Association of Nurses, improve standards of nursing

practice, seek a higher status for nurses, and provide an international power base for nurses.

Some specialty areas such as preoperative, Orthopedic, Intensive Care, Public Health, Ophthalmology, Association of Nigeria Nurse Educators, also formed Associations that seek to improve the standards of practice, expand nursing roles, and foster the welfare of nurses within the specialty areas. In addition, some of these professional organisations present education pro- grams and public journals. The Nigeria Nurse, Nigerian Nurse-Educator Journal, are examples of publications.

4.0 CONCLUSION

As any occupation of discipline approaches professional status, there occur important internal and structural changes and changes in the relation of the practitioners to society at large. A useful way of discussing these changes is by reference to the criteria of professionalisation. The traditional focus of nursing is service to society. The elements of professionalisation have greatly influenced the direction and development of nursing, and invariably the quality of service to society.

5.0 SUMMARY

You have learnt from this unit the definition of the concept profession as shared by many professional occupations. The basic characteristics shared by professions are highlighted. Professionalisation in an occupation is a gradual and continuing process. You have learnt the process of professionalisation in Nursing and how this has influenced the direction of, and quality of care. How professionalism is influencing nursing in Nigeria was discussed.

6.0 TUTOR-MARKED ASSIGNMENT

1. Define 'profession'.
2. Enumerate the six basic characteristics of a profession.
3. Discuss the role education plays in the professionalisation of nursing generally and Nigeria in particular.

7.0 REFERENCES/FURTHER READING

Baly, M.E. (1975). *Professional Responsibility*, Aylesbury, England: HM+M Publishers Ltd PP 12-13.

Etzioni, A.(196l). Holer, KK, Musser, DB, "Nurse Characteristics and Professional Autonomy," *Image J. Nursing School* 26:201,1994.

Potter, P.A. & Perry, A.G. (1997). *Fundamentals of Nursing. Concepts, Process and Practice* St. Louis: M. Mosby- Year Book Inc.

MODULE 2 NATURE OF NURSING II

UNIT 1 THE ROLE OF THE NURSE

CONTENT

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 The Nurse as a Teacher
    3.2 The Nurse as a Counsellor
    3.3 The Nurse as a Caregiver
    3.4 The Nurse as a Manager
    3.5 The Nurse as a Researcher
4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

The last two units examined the nature of nursing as a science and as an art and as a profession. By this, the foundation you require for the assumption of your role as a nurse has been laid.

A nurse is anyone who has undergone the prescribed type and length of training and certified by the Nursing and Midwifery Council of Nigeria to practice nursing. A nurse may be prepared as a generalist or a specialist as midwifery, psychiatry or community health nursing. Nursing then is primarily assisting the (sick or well) in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would have done unaided if he had the necessary strength, will or knowledge (Henderson, 1966).

There has been changing scene in nursing practice with the polyvalent care provider adaptation in response to changes in the society, thus the need for expanded nurse's role beyond patient care in the hospital environment. In addition to scientific and professional knowledge, nurses are acquiring skills for community mobilisation, co-ordination of resources (managerial role), and education to enhance care practice and research.

The decision to shift nursing focus from curative care, medically circumscribed and hospital based orientation and be involved in all aspects of decision-making was taken at the International Council of Nursing in 1983. Against this background, this unit will examine the role of the nurse as a teacher, counselor, caregiver, manager and researcher.

You will be expected to observe nurses in your receptor area playing these roles while you can also role play the same as part of your clinical demonstration.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- describe the changing roles of the nurses and effects on health care delivery
- discuss the managerial process required by a nurse manager identify the polyvalent role of a nurse in a changing society.

3.0 MAIN CONTENT

3.1 The Nurse as a Teacher

A nurse offers her services to a client and assists the individual in the performance of those activities leading to healthy living through teaching and observation.

A nurse as a teacher at both hospital and community level explains the concept and facts about health and illness to clients, demonstrates procedures such as self-care activities (wound dressing, treatment of pressure areas, changing of position, etc.); reinforces learning or client behavior and evaluate progress in learning. The ultimate goal is to provide knowledge that will lead to change of attitude and practice. The nurse-teacher may be formal or informal in her teaching. It may be planned or unplanned (as it depends on wherever it is required).

Appropriate methods matching clients' capabilities with needs and incorporating other resources such as the family in the process. Health education is a major activity when a nurse truly demonstrates the teaching role. As a role model in hygiene and interpersonal relationship, she/he instructs on self-care, teaching, in areas of ante-natal care, exercise, administration of insulin and urine testing by diabetic patients. Health

behaviour and risks are identified and preventive measures are packaged to help clients.

Nurses should understand the culture and values of the people to foster and j promote cooperation and understanding. As she teaches, she also listens and, observes the effect on the client to establish therapeutic nurse-patient relationship.

SELF-ASSESSMENT EXERCISE

1. What are the 3 main activities of a nurse-teacher?
2. What does a nurse teacher intend to achieve afterwards?

3.2 The Nurse as a Counsellor

The nurse is faced daily with issues that have psychological influence on her clients. A nurse counselor puts herself in the place of the client (empathic), creates a conducive atmosphere to discuss thereby getting into root cause of the expressed problem, dissolve doubts and fears which are the underlying issue that may affect client's recovery.

A nurse counselor sees beyond her client's expression; observes clients' attitudes, looks, involves the relation in the care of the client and establish healthful relationship. Health is perceived in bio-psycho-social realms whereas physical care provides health to the physical and social areas, psychological/mental health is often neglected. Couple will require counseling on marital harmony, family planning, identifying the predominate symptoms of a maladaptive lifestyle and re-integrating a psychiatric patient to the life in the community. A nurse counsellor ought to be sensitive to his/her client's needs, commend him/her when there is an improvement and encourage her to keep it up. The ultimate aim is to assist client to willingly accept treatment for an identified problem in order to recover early and live a healthy life. The nurse counselor also keeps records.

SELF-ASSESSMENT EXERCISE

1. List 4 qualities of a nurse counsellor.
2. Now go back to 3.1 and 3.2 to see (of any) the difference(s) in the identified role. Discuss with your colleagues.

3.3 The Nurse as a Care Giver

This is the conventional role of a nurse as expressed in the definition of nursing by Henderson (1966), (see Units 2 and 5). Nursing as demonstrated by Florence Nightingale (1860) is the act of caring not only for the sick, but also the well. The commitment of a nurse to patient's care is total (physical, mental, social) wellbeing thereby providing holistic care.

A nurse helps the client regain health through the healing process, addresses the needs of client, restore emotional and social wellbeing, sets goals for client and family for care. Even at the primary health care level, the nurse as a care giver cuddles a child, 'lay hands or touch' as in nursing a sick child or adult with fever, immunisation, ante-natal care, care during labour and after delivery.

A nurse care giver possesses scientific knowledge with which she uses her judgment in assessing client's needs, plan appropriate nursing care, implement and evaluate in order to make decisions. The nurse as a caregiver is health oriented, continuity of care through referral among other health and social agencies is also included. She is available in the 3 (three) tiers of health care primary, secondary and tertiary. Nurses shifting period covering the 24 hours provides closest contact with a multidimensional role in the maintenance and promotion of health, prevention and curing of disease, rehabilitation and advocate better nursing care for the clients/patients.

3.4 The Nurse as a Manager

The nurse manager co-ordinates the activities of nursing as well as other members of healthcare working with her in the provision of total clients' care. The tools employed include planning, organising, directing, coordinating, budgeting and the reporting. The nurse in the performance of her daily professional work employs these tools unknowingly. For example, a nurse on morning shift organises the daily schedule, monitors and supervises them and report at the end of the shit to ensure continued care by the incoming nurse. The nurse manager plans her time, resources (human and materials), engages everyone around her in one thing or the other and supervises them to ensure the ultimate interest of the client.

The utilisation of the management process by a nurse makes her an adviser to the community, individual client, interactions with various organisations, consultations on perceived needs, evaluation of task

performed based on set goals and objectives, and professing solutions to identified problems.

3.5 The Nurse as a Researcher

Nursing has moved from being task oriented to knowledge oriented. Research is a quest for new knowledge pertinent to an identified area of interest through application of the scientific process. Nursing has embraced research in her practice thus becoming self-regulatory and self-determining.

A nurse researcher identifies, investigates, and analyses clients/patients problems/needs. She sets out plan for care, implement and then evaluate. Findings are communicated in writing and applied to a whole group or class of clients. The process of research helps the nurse to provide care on a one-to-one basis focusing on every patient as an individual requiring an individualised care (see Nursing process in Unit 17). NOTE: A nurse researcher is a participant observer. A nurse researcher through her holistic approach coupled with the research skills uses an interdisciplinary team in providing comprehensive care to the clients.

EXERCISE 4

1. List the 5 steps required by a nurse researcher.
2. Quickly recap the identified changing roles of a nurse discussed in this unit.

4.0 CONCLUSION

The nursing role is multidimensional despite her expected role of maintenance and promotion of health, prevention and curing of diseases and rehabilitation, the nurse still functions as an advocate interceding for patients to obtain health services from various community health agencies.

The nurse interprets patient's needs to his family to carry them along as well as articulating the services of all disciplines in the health care. The decision making *of* a nurse helps her to employ different skills for effective care. The scope and range of nursing responsibilities become enlarged, specialties in nursing as depicted by the changing roles of nurses will assist greatly, support new and promising methods of delivering health care services more effectively.

5.0 SUMMARY

What you have learned in this unit concerns the role of the nurse as a teacher, counselor, caregiver, manager and researcher. I believe it has served to further your interest in nursing while you are set to assume the polyvalent care giving role expected of you.

6.0 TUTOR- MARKED ASSIGNMENT

1. Briefly discuss (not more than half a page) the 5 roles of a nurse in a changing society.
2. Identify and comment briefly on the managerial skills/process required by a nurse in-charge of the outpatient department of Christoffel Specialist Hospital, Ejule.

7.0 REFERENCES/FURTHER READING

Anderson, E.R. (1973). *The Role of the Nurse: The Study of Nursing Care,* White Friars Press Ltd. London Services 2 No.1.

Feurst, et al. (1974). *Fundamentals of Nursing:* The *Humanities* Philadelphia Toronto (5th ed.).

Henderson, V. (1966). *The Nature of Nursing,* New York, Mac Milan Publishing Co. (15th ed.).

Isenalumbe, A.E. (1985). The Role of the Nurse in Meeting the Special Health Need of Women in Our Community. Paper delivered at a seminar at International Nurse, Week, Benin City March 12-18 1985. lsenalumbe, A.E. The Nurse as a Polyvalent Care Provider. Paper delivered in a conference *of* the Graduate Nurses Association of Nigeria. Enugu 11-18 March.

Mustapha, R.O. (1993). Nursing -An inevitable health care service required by all. Paper presented at the International Nurses Week, Ilorin. Pearse, F. (1980) *A General Textbook of Nursing (*12th ed.). EB~, London.

Hockey L. (1980). *Research and Nursing Care. A General Textbook of Nursing,* ELBS (20th ed.). London.

Potter, P.A. & Perry, A.G. (1993). *Fundamental of Nursing: Concepts, Process and Practice:* J.B. Lippincott Co. St. Loius, (3rd ed.).

Fashina, F.M. (1975). "The Changing Role of the Nurse" *The Nigerian Nurse* Vol.7 pp. 16-17.

Usman, D.S. (1985). "The Role of the Nurse in Health Care Delivery" *The Nigerian Nurse.* Vol. 15, No. 11985 pp. 13-16.

Santhosh, M. et al. (2000). *Role of Nurse in Primary Health Care Primary Health Nursing (PHN) Handbook of the Indira Gandhi National Open University,* New Delhi, Berry Art Press.

UNIT 2 NURSING CARE DELIVER

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Definition of Care Delivery System
    3.2 Types of Client Care Delivery System
        3.2.1 Case Management
        3.2.2 Functional Nursing
        3.2.3 Team Nursing
        3.2.4 Primary Nursing
    3.3 Strengths and Weaknesses of Nursing Care Delivery systems
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Delivery of nursing care is a means to achieve the goals of a healthcare organisation. The effective delivery of nursing care requires efficiency in an organisation that promotes high productivity and staff adequately. Clients are usually placed in various categories to help in determining staffing needs based on the kind and amount of care needed. When clients with similar conditions or treatments are grouped together, special equipment needed in the care of these clients may be kept in one department, thus eliminating duplicating; however, there is danger that the clients will become so stereo- typed that their individual needs are ignored. Some of the categories that are being used are based on:

- the amount of care needed, e.g. self-care or manorial care, partial care, or complete or intensive care.
- Age, e.g. pediatric or geriatric.
- diagnosis of condition being treated, e.g. cardiopulmonary or bums.
- therapy being given, e.g. dialysis, chemotherapy.
- sex, sometimes on religious grounds. population of clients.

In Nigeria, a combination of these categories is used. Classification of clients guides the staffing pattern and the assignment pattern used for

nursing care delivery. The philosophy and the goals of the health care organisation also influence the staffing and assignment patterns. Visit a local government and a state government hospital and identify the categories being used in the organisation of the care of clients. How do the categories compare to those discussed above?

The discussion that follows will identify the major nursing care delivery patterns commonly used in Nigerian healthcare institutions. You will be required to visit healthcare institutions to discuss the implementation of each pattern of nursing care delivery.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- define 'nursing care delivery'.
- list the major categories used in determining nursing care delivery system.
- describe the four common nursing care delivery systems
- recognise the application of each system in client carte settings
- discuss the strengths and weaknesses of anyone nursing care delivery system.

3.0 MAIN CONTENT

3.1 Definition of Nursing Care Delivery System

Client care delivery refers to the manner in which nursing care is organised I and provided. It is organised at the unit level. The type of client care delivery system used in a healthcare organisation reflects the organisation's philosophy; it also depends on such factors as organisational structure, nurse staffing, client population, and client's health problems and nursing care needs.

EXERCISE 2

i. Define 'nursing care delivery'.
ii. List 3 factors within a healthcare organisation that could influence client nursing care delivery.

3.2. Types of Client Care Delivery Systems

In this unit four systems will be discussed. They are:

- Case management nursing
- Functional nursing
- Team nursing
- Primary nursing

3.2.1 *Case management*

This is the first and oldest approach to client care. It involves a 1 to 1 nurse client ratio, with the one nurse responsible for caring for one client and providing all, the client, care required while on duty. The nurse responsible for the care reports to a head nurse, charge nurse, or nurse manager. Although this approach to client care is expensive it continues to be used in critical care units and in other life-threatening situations. Depending on the education or philosophy of the nurse, either task oriented or client-centered care may be given. The care given by the nurse is not fragmented during the time the nurse is on duty. Staffing for case management considers the acuity of clients and the standards of care that the organisation wants the nursing personnel to provide.

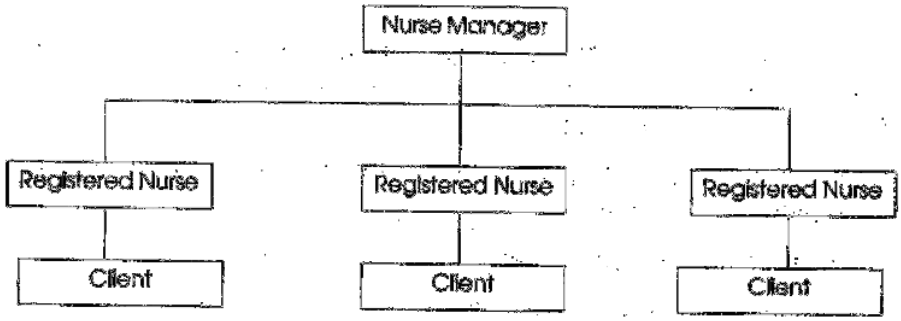


Fig. 1: Structure of Case Management Nursing

3.2.2 Functional nursing

This is fragmented approach to care, and it focuses on tasks and procedures, and emphasises efficiency, division of labour and rigid control. It reflects a bureaucratic, centralised organisations. Tasks are assigned to various personnel based on complexity and required skill, e.g. nursing aides might bathe clients, while nursing assistants might provide certain treatments, and registered nurses would administer medications. Each staff member is responsible only for assigned tasks while on duty. The charge nurse is responsible for coordinating the activities of the unit, and reports to the nurse manager~ in some cases a nurse manager may act as the charge nurse.

Although functional nursing may be useful during times of critical staff shortages job satisfaction may be reduced and client dissatisfaction may increase because the nurse and the client do not see the effects or impact of the total client care. The nurse sees the client through a series of tasks which the client might consider disturbing. The diagram below shows the structure of functional Nursing. Note the interaction network between the nursing personnel and the clients.

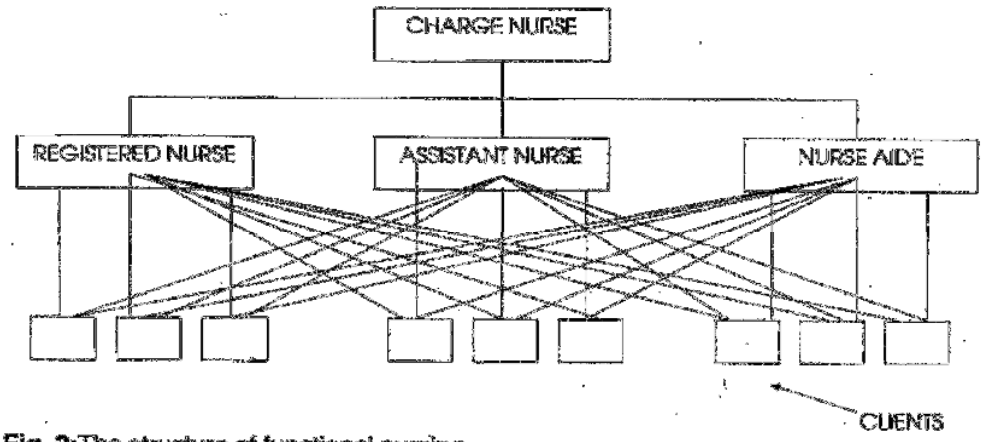


Fig. 2: The structure of functional nursing

3.2.3 Team Nursing

Team Nursing is a method of assigning client care used when the teams would be composed of nursing caregivers with diversities in education and abilities. **It** is based on the beliefs that:

- Every client has the right to receive the best care possible with the available staff and time.
- Planning nursing care is basic in providing this care,
- All nursing personnel have the right to receive help in doing their job, and
- A group of caregivers with the leadership of a professional nurse can provide better client care than those same people working as individuals.

The following concepts guide the practice of team nursing:

- Leadership of the team must be provided by a registered nurse who accepts responsibility for making decisions about priorities of clients' needs and for the planning, supervision, and evaluation of the nursing care.

- Team leaders should also examine how their philosophy affect their implementation of team nursing; as those who are task-oriented will continue to practice this kind of nursing, while those who are more client-oriented will find team nursing one method of implementing their philosophy.
- Effective communication is needed to ensure continuity in the delivery of planned nursing care.
- The team leader must use all the techniques of leadership/management
- Team members must accept the leadership of the team leader.
- The practice of team nursing should be limited by a fixed procedure.

Team nursing may be used throughout the day, evening, and night shifts of any client unit. The size of the unit and the number of registered nurses and other staff members will determine the number and the size of the teams.

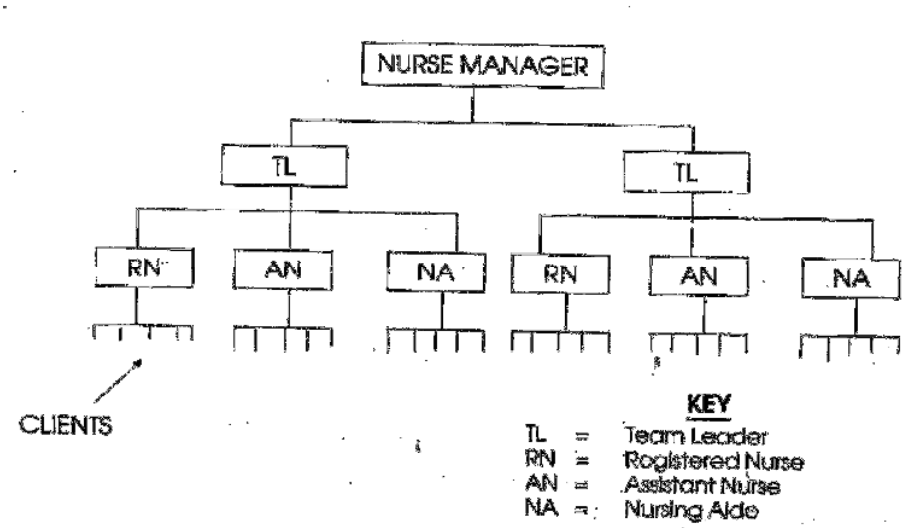


Fig. 3: Structure of Team Nursing

3.2.4 Primary Nursing

This is the last type of nursing care delivery for this unit. It is a method of delivering nursing care in which a registered nurse is responsible and accountable for the care of a client 24 hours a day. The responsibility includes assessing, planning, implementing and evaluating the nursing care from the time the client is admitted to the nursing unit until the client is discharged from the unit.

The concept of primary nursing was developed in 1968 under the direction of Marie Manthey at the University of Minnesota Hospitals. It was designed to return the Registered Nurse to the role of giving direct client nursing care, which would improve the quality of nursing care.

The focus of nursing is client-centred, and promotes continuity of care planning, care giving, and evaluation. Changes in the care plans are the responsibility of the Primary Nurse. The primary Nurse usually selects the number of clients she can manage, but in some health care institutions, the head nurse assigns the clients to the Primary Nurse. The Primary nurse gives the care while on duty, wl1ile an associate nurse carries on while she is not on duty. Primary nursing gives the opportunity to utilise and synthesise all the cognitive, psychomotor and affective skills needed to assess the patient's status and prescribe nursing care.

The primary nurse coordinates the care and thus must be cognisance of available resources. An associate nurse administered care in the absence of a primary nurse. A nurse can be an associate nurse for some clients while serving as a primary nurse for other clients. The associate nurse must be a registered nurse (RN).

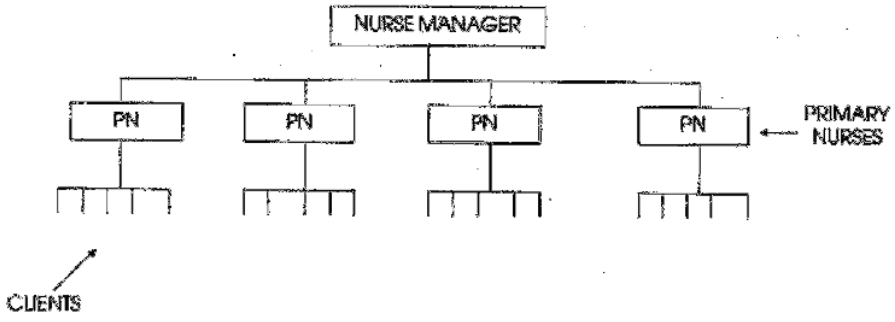


Fig. 4: Structure of primary nursing

3.3 Strengths and Weaknesses of Nursing care Delivery Systems

In 3.2, the four common nursing care delivery system were described and illustrated, situations where each could be utilised were mentioned, we now proceed to highlight the strengths and weaknesses of each system.

Types of Client-Care Delivery Systems: Strengths & Weaknesses

Delivery system	**Description**	**Strengths**	**Weakness**
Case management	• Based on holistic philosophy of Nursing • Nurse is responsible for care and observation of specific client's • Involves a one-one nurse-client ratio	• Improve nurse's responsiveness to client's changing needs • Improve continuity of care • May increase nurse's job satisfaction	• Increase personnel cost
Functional nursing	• Based on task-oriented philosophy of nursing • Nurse performs specific tasks according to charge nurses work schedule	• Reduces personnel and care costs • Supports cost controls	• Fragment's nursing care • May decrease staff job satisfaction • Decrease human interaction with client • Limit continuity of care
Team nursing	• Based on group philosophy of nursing six or seven professional and nonprofessional personnel work as a team to supervised by a team leader	• Supports comprehensive care • May increase job satisfaction • Increases cost effectiveness	• Decreases contact with client • Limit continuity of care
Primary nursing	• Based on comprehensive, personal	• May increase job satisfaction	Increases personnel cost initially

	philosophy of nursing. A nurse is responsible for all aspect of care from assessing client condition to coordinating client's care for specific client • Involves a 1 to 4 or 5 nurse care ratio and care methods assignment	• Improve continuity of care • Allow independent decision making • Supports direct nurse client communication • Encourages discharge planning • Improve quality of care • May improve cost effectiveness when comparing AN. NA'	Requires property trained nurses to carry out system's principles Restricts opportunity for evening and night shift nurses to participate

SELF-ASSESSMENT EXERCISE

In the light of the information in 3.1 and 3.2 discuss your findings in terms of similarities and differences.

4.0 CONCLUSION

You have learnt that the philosophy of nursing held by an individual nurse, or a health care organisation often determines the choice of nursing care delivery system which is also influenced by other factors such as organisational structure, available nursing staff, population of clients and the nursing needs of clients. You must have noted that the ultimate is the utilisation of a delivery system that would achieve the goals of nursing care, which is high quality care.

5.0 SUMMARY

In his unit you have examined four common types of nursing care delivery systems-care management functional, team and primary nursing. Factors that influence choice were highlighted, and the characteristics and assignment patterns of each discussed and illustrated with diagrams. The strengths and weaknesses of each system were also listed. The ultimate in nursing care is identifying and fulfilling clients' nursing needs at a high-quality level, utilising the most appropriate nursing care delivery

system. Nurses should be mindful of extraneous factors that might interfere with the achievement of high-quality nursing care, even when a seemingly appropriate delivery system has been chosen. Therefore, nurses must identify these extraneous factors and incorporate them into the total plan. No nursing care delivery system is stagnant in terms of knowledge, psycho-motor and effective skills. Therefore, nurses must make continuing education as an important aspect of their professional life.

6.0 TUTOR-MARKED ASSIGNMENT

1. a) Define 'client nursing care delivery system'.
   b. Discuss briefly four factors that may influence the selection of a type of nursing care delivery system
2. a) List four common types of nursing care delivery system.
   b) Describe the strengths and weaknesses of any two under the headings: Delivery system, description, strengths and weakness.

7.0 REFERENCES/FURTHER READING

De Young, L, *Dynamics of Nursing.* St. Louis, C.N. Mosby Co., 1985 Hegyvary, S.T., *The Change to Primary Nursing.* St. Louis, C.V. Mosby Co., 1982.

Kron, T, & Gray, A, *The- Management of Patient Care: Putting Leadership Skills to Work* Philadelphia, Wiz, Saunders Co. 1987.

Sullivan, E.J. & Decker, P.J., *Effective Management in Nursing*. Reading, Mass: Addition Wesley Publishing Co. 1988.

Sullivan, M.P., *Nursing Leadership and Management: A Study and Learning Tool.* Spring- house Corporation, Pennsylvania, 1990.

UNIT 3 NURSING AND SOCIETY

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Demographic Changes
    3.2 Technological Advances
    3.3 Increasing Consumer Knowledge
    3.4 Human Rights Movement
    3.5 Women Liberation Movement
    3.6 Professionalism in Nursing
    3.7 Cultural and Societal Influence on Nursing
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

The society is a system whereby people live together in organised community. It is dynamic with its attending challenges.

In the last lecture, the relationship of nursing to other sciences and technology was established thus as the society is changing so much nursing. Throughout history, nursing has responded to society needs and ceases to remain static/practicing solely on tradition with threats to her existence and relevance.

In this unit, we shall examine Nursing and the Society with the trends influencing Nursing practice. The overall effect will be considered vis-à-vis Nursing adaptation to the challenges posed by the societal trends.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- examine the societal changes and nursing practice
- discuss the current societal trends and influence on nursing practice
- identify the place of Nursing in the society.

3.0 MAIN CONTENT

3.1 Demographic Changes

Demography is the statistical description of population using birth, death migration, emigration, life expectancy, marriage and divorce rates. Population in every society increase daily, which accounts for more people in need of health services with greater demand on health practitioners (Nurses inclusive). Urban shifts, peculiarities in the health care of older persons and youths which forms 75% of the population, increased divorce rates and weakened family ties requires nursing assistance to family and other social problems with health implications. These include incidence of chronic long-term illness, e.g. AIDS, Cancer, mental disorders and alcoholism, epidemics, etc.

Nurses therefore must explore new methods for providing care and establish practice standards in new areas.

Activity 1

a) What is the population of Nigeria today?
b) List three problems of over population.

3.2 Technological Advances

The ongoing scientific research has continued to uncover new knowledge at a faster pace. With the advent of computer and other management information systems, societal values and quest for services have been tailored towards this e.g. canned foods, drinks and additives. Scientific advances closely associated with health illness, organ transplants, family planning methods and sophisticated diagnostic sets such as C. T. Scan machine, Ultra sound machines and Electrocardiograph machines. In the social sciences, great strides have been made in attempting to understand and predict human behaviour, which is an important area for nursing.

Nurses as agent of change uses the knowledge of values, attitudes and prejudices, social mobility, ethnic, social and cultural backgrounds to design patient care. Empirical knowledge of practice is no longer adequate as nursing programmes are increasingly teaching scientific principles that will guide the practice for all possible circumstances.

SELF-ASSESSMENT EXERCISE 1

Mention four (4) advancement in communication/technology that can facilitate Nursing Care in a Hospital set up.

3.3 Increasing Consumer Knowledge

There has been an increase in health information on consumable items thereby encouraging consumer movement aimed at getting quality health to the worth of their money. The society made up of consumers is demanding health care with high quality. Nurses as consumer of someone's product in the society with high expectations, is expected to support the clients right in the quality and cost of health care being offered.

3.4 Human Rights Movements

Human Rights movements is a non-governmental organisation which seeks to address outright violation/negation of human rights to life, expression, association and religion that is considered as morally right or wrong in our relationship with others. The movement is concerned for the poor, lonely, neglected and oppressed.

Nursing respects the rights to good care for all and recognises the right to life, advocates clients rights with recognitions of special needs of some groups: the dying, hospitalised, pregnant women, to ensure that quality care is provided without sacrificing their rights. Nursing holds the key to maintenance of human individualistic concern for people and their health problems hence it must be zealously enlarged.

3.5 Women Liberation Movement

Women today are taking steps to free her for independent action. Nursing traces its origin in the society to orders with unquestioned obedience to superiors. Nursing is predominately made up of women and this reveals the role of a nurse as a mother surrogate to nurture those who were ill and helpless.

SELF-ASSESSMENT EXERCISE

a) Who is the mother of modern nursing?
b) When was she born?
c) What was her major role?

Women in the society today seek for social, economic, political and educational quality with men. The Women-In-Nursing (WIN) is one of such group which joining forces with non-nurses strives for equality in the society and changing nursing care practices.

3.6 Professionalism in Nursing

Nursing in Nigeria has evolved through several philosophical eras in the last decade. Having passed through the Nurses' Ordinance of 1947/1959, Registration of Nurses Regulation of 1962 and the legal status of as a professional cum trade union organization, trade Union Decree 21 and 22 of 1978, Decree 54 of 1989 and recently amended decree 54 of 1992. One common phenomenon that prevailed in all these has been that of uplifting the image of nursing.

This progress is attributed to the recognition accorded nursing by the society due to unique and essential contributions made. The emergence of professionalism in nursing has produce a self-regulatory, self-determining and a body of scientific knowledge of a group of people who can assume responsibility and accountable for their action.

3.7 Cultural and Societal Influence on Nursing

The range of human behaviour is dramatic and diverse and through many thousands of years, the human being has survived because of the remarkable ability to adapt to a variety of problems and situations. Human beings have demonstrated concern for their welfare, health, and for their very existence. The responsibility of nursing is to assist human beings in their adaptation bid through promotive, preventive and restorative nursing activities. One major way by which the human being copes is through his/her cultural practices -his norms, values, mores, understanding and the likes that he shares with others in his group. This is man's culture. In this session we will discuss how Nursing is influenced by culture and society. You will learn the meaning of the care concepts, identify the major influential factors, and how Nursing responds to a few factors. You are expected to actively participate through your responses to exercises utilising your experiences in human society.

3.7.1 *Culture*

You must have come across the term 'culture' during your social studies at High School. Do you still remember how the social studies teacher defined it?

If you don't remember the school definition, you then need to check your dictionary. Culture refers to people in a group who share certain common values, artifact languages and understandings. Culture is everything that an individual learns from groups of which he is a part and that he transmits to succeeding generations. It is what all have in common. It includes under- standings, values and mutual expectations. It is made up of certain ways of acting, thinking, feeling and communicating. We are born into a culture that teaches us over a period what to eat, what to wear, how to get along and communicate with others, how to rear our children, how to care for our health among others. Culture is a fundamental concept to the anthropologist.

1.7.2 Society

What is it? Do you belong to a society? You must have come across this word in your social studies. However, a common definition is that society is an organised group working together or periodically meeting because of common interests, beliefs or professions. Or a voluntary association of individuals for common ends.

EXERCISE 1

List two activities you do that have been passed to you through culture. Can they be related to the discussion on culture? Read the paragraph again.

3.7.3 Culture and Nursing

From the two definitions one can conclude that society is the context in which culture takes place. We all belong to different societies in which different cultures are practiced. Nurses may come from different cultures from their clients; and this may have serious implications for the nurse-client interactions. Nursing and nurses are to render service to the clients according to the identified needs. Sometimes problems arise when the cultural backgrounds differ. For example, a mother with a malnourished toddler refuses to give the child eggs because of her cultural belief that the child will grow up to become a thief. The nurse on the other hand sees the egg as an effective intervention for the malnutrition. The nurse gets annoyed with the mother and totally ignores mother and child. Would you consider the nurse to be culturally sensitive or ethnocentric? The answer is that she is ethnocentric she feels her culture is superior to that of the other woman. With this attitude, she has disrupted her focus of nursing. Therefore, it is necessary for the nurse to acquire an appreciation for cultural differences. By so doing, the nurse will be in a better position to

understand his/her clients/patients. The nurse does this by making concerted and conscientious efforts to study different cultures and subcultures. Where will the nurse get the knowledge from? These days the curricula of schools of nursing have 'culture' as part of social science studies. Libraries have lots of literature on culture.

SELF-ASSESSMENT EXERCISE

1. Check the meaning of the word "ethnocentric"
2. Visit a Library and write 3 titles of books on Culture. Read one and discuss the summary with your tutor.
3. State 2 ways by which the reading has improved your understanding of culture.

A study of culture requires an accepting, non-judgmental and objective attitude. Cultural differences require that the nurse conscientiously observe and listen. The study of man places reliance on the holistic approach. This means looking at man as a whole from all views and in the context of his total environment and considering every part as related to every other part. This approach is best accomplished using an inter-disciplinary team, which takes advantage of the knowledge and skills of various specialists. Holistic approach utilised in nursing is the concept of meeting the-clients physiological needs, promoting psychological development, fostering socio- cultural relationships and supporting the fulfillment of spiritual aspirations.

3.2. 1 Comprehensive Nursing Care

Total nursing care, team nursing and comprehensive nursing are all concepts of care that were derived from the study of culture. These concepts will be discussed in the next course, *Foundations of Nursing*. The study of culture provides information that would assist nurses to render services that are relevant. Man is a very complex creature living in increasingly complex societies. Nursing must continue to render needs-relevant services through the study of cultures, as it is common knowledge that cultural factors exert strong influences on health and illness and attitudes towards them.

3.3 Society and Nursing

Historically, nursing developments are closely tied to changes in society. Nursing responds to societal needs and forces in its environment influence society. Some of the forces also originate from society. Contemporary nursing education, practice, and research are outgrowths

of economic, technological demographic, sociological and political issues.

Let us examine each issue briefly and the influence each has on nursing and how nursing is responding.

3.3.1 Demographic Changes

Demographic changes affect all segments of the population. Changes that have influenced health care include:

- Rural urban population shift.
- Decrease in life span of young adults.
- Higher incidence of chronic long-term diseases, (HIV/AIDS)
- Increased incidence of deaths from trauma (road accidents), violence, prostate cancer, and breast cancer.

Nursing responds to these changes by exploring new methods of providing care, developing new curricula with appropriate emphasis; education of those affected families and communities.

3.3.2 Consumerism

Consumers, being more conscious of their rights want value for the expenses incurred on their health. Consumers are becoming more knowledgeable, therefore demanding quality care. Health care consumers are more aware of their rights as clients, and the nurse supports these rights in the role of client advocates.

3.3.3 Health Promotion

There is now a greater emphasis on health promotion and prevention of illness. Targets are set for eradication of communicable diseases such as measles and poliomyelitis in children, guinea worm in adults and HIV/AIDS prevention programmes. Nurses are vanguards of many health promotion programs, Health promotion activities are normal activity of Nigerian nurses.

3.3.4 Human Rights Movement

Human rights movement is changing the way society views the rights of all it members. They are calling attention to those who had been sidetracked. Nurses are responding by respecting all clients as individuals with a right to good care and with basic human rights. Nurses advocate the rights of all clients and also of those with special needs.

3.3.5 Technological Advances

In recent years, scientific and technological advances have affected almost every aspect of life. Health care has changed in many ways, including the use of new equipment, new diagnostic treatment measures and new drugs.

Nursing has adapted and will continue to respond to these changes with continuing education, in-service programs and other educational approaches such as new curricular developments. Nursing is also concerned with the human side of technological advances. Society as a whole seems to accept technological advances in health care, but clients often experience problems related to them. As health care technology becomes more complex and sophisticated, nurses must help clients to adjust to the use of technology in care.

3.3.6 Partnership in Nursing Care Delivery

Clients are demanding participation in decisions that affect their health. Nursing is responding by utilising the holistic approach and objectives directed care. Clients and nurses derive the objectives from collaborative need identification.

SELF-ASSESSMENT EXERCISE

1) List the six – (6) societal changes identified already.
2) I want you to look back into the past 5 years and list the changes you have noted in the Nigeria society under the following headings: Economic; Political; Demographic; Technological; Sociological. Consult Potter and Perry for more information.

4.0 CONCLUSION

The scope and range of nursing responsibilities in meeting the needs of society mean assuming increasing responsibility for patient care, developing collaboration with other health practitioners, supporting and embracing new and promising methods for delivery health care service more effective.

Nursing has demonstrated interest in caring for society's unfortunates. The emphasis of the care is on compassion and understanding, sympathy and empathy in accepting the patient who is a member of the society as the nurse. Nursing is a member of the society as the nurse. Nursing as a profession holds the key to the holistic client care.

5.0 SUMMARY

In this unit, we have identified and examine concisely nursing and society with six (6) changes in the society that has positively influenced nursing practice. A dynamic society requires understanding and commitment on the part of service providers that will not be compromised.

6.0 TUTOR-MARKED ASSIGNMENT

1. Discuss in detail the societal changes that have come on Nursing and its influence on the practice.
2. State four definitions of *culture* and one of *society*.
3. Explain why it is important for the nurse to have an appreciation of *culture.*
4. List four societal factors that influence nursing.
5. Describe briefly how nursing responds to any two of the societal factors listed in 4.

7.0 REFERENCES/FURTHER READING

Akinsola H. A. (1993). "A to Z of Community Health and Social Medicine in Medical Nursing Practice" 3. A. M. Communications.

Furest, *et al.* (1974). "*Fundamental of Nursing; The Humanities and The Sciences in Nursing* (5th ed.). Toronto, Philadelphia: J. B. Lippincolt Co.

Potter & Perry (1993). *Fundamentals of Nursing: Concepts, Process and Practice,* (3rd ed.). St. Louis: J. B. Lippincolt Co.

Royle & Walsh (1980). *Watsons Medical-Surgical Nursing and Related Philosophy* (4th ed.). Toronto, Philadelphia: J. B. Lippincolt Co.

Smith, R. G. (1984). "*Nursing in the Community*. New York: Wiley Medical Publications.

School Craft V. (1984). *Nursing in the Community.* London: Wiley Medical Publication.

Lafargue, J.P. (Jan-Feb. 1972) "Role of Prejudice in Rejection of Health Care", *Nursing Res.* 21:53-58.

Potter, P.A & Perry A.G. (1998) *Fundamentals of Nursing: Concepts process and Practices,* St. Louis; Mosby Year Book Inc.

Spector, Re (1991). *Cultural Diversity in Health and Illness,* ed 3 Conn: Appleton and Lange. Weiss, M.O. (Jan, 1971) "Cultural Shock", *Nursing Outlook,* 19:40-43.

UNIT 4 NURSING AND HUMAN ENVIRONMENT

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
- 3.1 Definition
- 3.2 Types of Environment
- 3.3 Effects of Environment on Man's well-being
  - 3.3.1 Physical Environment
  - 3.3.2 Socio-cultural Environment
  - 3.3.3 Socio-economic Environment
  - 3.3.4 Spiritual/religious Environment
- 3.4 The Internal Environment
  - 3.4.1 Maintenance of Homeostasis
  - 3.4.2 Structures Supporting Homeostasis
  - 3.4.3 Conditions of Homeostasis
- 3.5 Nurses Responsibility Towards Promoting a Safe Environment

4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

In the last ten modules we have been examining the structure and management of healthcare delivery for meeting the health needs of man within his environment. This unit will discuss human environment in totality.

Human beings are constantly interacting with their environment. The environment influences human beings and vice versa. The relationship between human beings and the environment is a dynamic one, never static. The environment greatly influences the quality of life one enjoys. People need the environment that they can constantly manipulate so that they can develop their potentials. An environment that stifles may result in abnormal personality. The importance of the environment has been demonstrated in an account of creation. The Garden of Eden provided an environment that was physically pleasing with soil that supported all plants and animals in symbiotic relationship. Adam and Eve provided social supports to each other and were spiritual in harmony with God.

Everything was beautiful and peaceful. From this scenario, it could be deduced that the environment assumed the three dimensions of the physical, the psychosocial and the spiritual, the three being inter-related and inter-dependent. Any disruption in one area would affect the other areas. Adam and Eve's problems started with social disharmony, which affected the other two parameters. One could see the concepts of adjustment and adaptation at work.

What started millions of years ago in terms of equilibrium among the elements in the universe remain with us till today. This Unit will discuss the importance of a conducive environment in the promotion and maintenance of good health. The presentation will start with definitions and end with the discussion of nursing responsibility towards the provision of a healthy and safe environment.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- define 'environment'
- describe briefly the components of the environment
- describe at least two ways by which the environment could affect Man's health
- list at least three professional activities of the nurse that would support a safe environment for a client.

3.0 MAIN CONTENT

3.1 Definitions of the Environment

The environment may be defined as the aggregate of human beings, things, conditions or influences surrounding human beings. It is all of the many physical socio-cultural, socio-economic, and physical and psychosocial factors that influence or affect the lives and survival or people. The promotion and maintenance of a wholesome environment is a major concern of most world governments including Nigeria. A principle concerning human beings and their environment implies that any environmental condition that interferes with the wellbeing, is a threat to the human organism when he is no longer able to cope with it sufficiently well. Some people tolerate their environment better than others do. Also each individual may experience variations in ability to tolerate certain conditions depending on other factors in the situation. Concern for the physical as well as the sociological environment is global

in nature. Nigeria is part of the global movement to make the world a safer place to live in. There is an Agency in Nigeria, specifically responsible for monitoring the environment and implementing measures that would make it safe, the Federal Environmental Protection Agency (FEPA).

EXERCISE 1

i. Do you have your dictionary with you? Check the definition of 'environment' Note the key words in terms of the biological, social and physical.
ii. Name 2 major life-threatening environmental hazards in Nigerian cities. Are these problems present in the village?
iii. Name 2 intervention strategies of governments at the various administrative levels.

Here are some examples that violate a wholesome environment. The human organism enjoys optimum functioning when the air breathed is sufficiently free of physical and chemical pollutants so that irritation to the tissue is absent or at least negligible. But exhaust fumes from vehicles on our roads cause so much irritation to the eye and respiratory tissues. The noise emanating from music sheds and shops and every residence endanger our hearing mechanism. In recent years, Nigeria and the world population growths, and rural urban migration are leading to unprecedented congestion. Everywhere is being built up with temporary sheds, which often become permanent. Human welfare is being compromised due to lack of access to nature and beauty. All these should be of concern to nursing. An instability at the physical level can eventually affect the totality of well-being.

3.2 Types of Environment

The environment can be classified into two major types: External and Internal. The External Environment consists of:

- biological environment, which considers all living things such as plants, bacteria. etc.
- social environment, this is unique to human beings. It is concerned with the relationship between human beings and their environment.
- physical environment consists of non-living portions of the environment such as air, water and land.

3.3 Effects of Environment on Well-being

Now that the types of environment are identified, you will now proceed to learn how each type affects the well-being of individuals.

3.3.1 Physical Environment

The type of physical environment in which a person lives can lead to an increased incidence or certain health problems. For example, people living in urban areas with heavy industries are exposed to smoke and air pollution. People who live in rural areas are less likely to have this type of health concern, but they may experience other problems such as snake bites, contaminated water supply, and decreased access to healthcare.

The environment may restrict daily activity. The hustle and bustle in our cities has restricted the daily activities of many older adults. This has a negative consequence on the conditions of bones and joints. Women in their post- menopausal years are known to suffer from osteoporosis a result of long-term reduced physical activity.

Here is a new word -*osteoporosis*. Check the meaning from your English Dictionary as well as from the Medical/Nurses' Dictionary.

The environment in which one works and the type of physical activity engaged in, in terms of occupation, affect individual wellbeing. Those who work in coal mines, cement factories, flourmills, tobacco factories are subjected to environments that make them prone to lung disease. Those who work in rice paddies (wet land in which rice is grown) are known to be more prone to guinea worm infection. In short, what you should learn from the discussion is that the environment affects the lifestyle of the inhabitants.

SELF-ASSESSMENT EXERCISE

Look around you and identify at least two environmental lifestyles that may have negative effective on the individual. What solutions would suggest?"

(Discuss your idea with your tutor).

3.3.2 Socio-cultural, environmental

Each culture defines health and illness in a manner that reflects its previous experience. You will recall from the course that culture was defined as the sum of traditions, practices, beliefs and values developed by a group of people and passed on most often by the family from generation to generation. Cultural factors determine which health behaviors people perceive as 'normal or abnormal'. Cultural influence also determines whether or not a person seeks health care, and how a person seeks such care. Health practices are also based on cultural beliefs. Let us look at one or two examples.

You must have heard or read about female circumcision being practiced by some cultural groups in Nigeria. The reason proffered is that it would deter sexual promiscuity as the girls grow up. While there is virtue in discouraging promiscuity, the method being employed has left many women grossly incapacitated for life. What a price to pay for being born into such a cultural environment. Take another cultural practice that forbids meat and eggs to be fed to children because the children will grow up stealing. While the rationale appears to be morally acceptable but the child is being deprived the right to good health through good nutrition from being born into a particular r socio-cultural environment.

SELF-ASSESSMENT EXERCISE

Find out from your community 2 other cultural practices that might have implications for the well-being of the people.

3.3.3 Socio-economic Environment

In many countries of the world, economic status is a major determinant of the quality of the physical and psychosocial environment available to individuals. We see that persons in the low-income group tend to congregate in the crowded inner-city slums, where cleanliness and sanitation are poor, air is polluted by stench from public drains and refuse mountains. All these endanger well-being and often lead to high incidence of communicable and infectious diseases. The picture is more dismal when the people in these areas are outside the health care system because they could not afford the cost of healthcare.

On the other hand, people of high socio-economic status could afford to locate themselves in healthy environments; and could afford good medical care.

But, in spite of the problems of adjustment and adaptation, human beings continue to find solutions to problems created by his environment.

3.3.4 Spiritual/religious Environment

Spirituality refers to person's beliefs about a divine or a higher power or force, and related practices. Religion is an organised system of worship often directed towards the divine being, power or force. Spirituality and religion can affect a person's views of and actions towards health, illness and health care. For example, some religious groups regard illness as a form of punishment from God, and therefore refuse medical treatment or prevented care from being given. Some religious groups ban the use of drugs and alcohol for whatever reason. Being born and socialised into this type of environment means denying oneself or cause to be denied the rights to health care.

Conditions or circumstances in the external environment can be classified as life supporting or as hazardous. On the agents essential to survival are air, water, nutrients and shelter. Other agents favoring survival include people and a variety of other living organisms, from microorganisms to highly complicated multicellular organisms of both plant and animal origin. Even essential agents may be harmful when exposure is excessive or unbalanced. As an example, oxygen is required for survival. However, continued high concentrations of oxygen damage the respiratory membrane, and can cause blindness in newborn babies.

You have learnt about the external environment and some of the adverse effects it could have on health. The next emphasis is on the internal environment. By the end of this section you would have come to appreciate the inter-relatedness and interdependency of the external and internal environment; and that Man is not so easily dissected.

3.4 The Internal Environment

The environment listed in 3.3 above lies outside the body and is in contact with the skin, mucous, membrane, and the sense organs. The internal environment is made up of the fluid surrounding the cells and carrying material to and from them.

Similar to the dependence of health on stability within the external environment, health is also dependent on the maintenance of relative stability of the physical and chemical characteristic of the fluid comprising the internal environment. Survival of the cells and maintenance of their functions are dependent on conditions in the cell's

immediate fluid environment. It is from this environment that the cell obtains a continued supply of nutrients and into which it discharges its wastes. For all cells, this immediate environment is a pool of water in which a variety of substances such as sodium chloride and glucose are dissolved. For a unicellular organism such as the amoeba, the fluid environment is a pond or puddle of water.

Human beings and other multi-cellular organisms, the fluid environment consists of blood, lymph, and interstitial fluid form the immediate environment of the cells. These fluids are known as the internal environment. The fluids composing the internal environment not only serve individual cells as such, but are the medium by which all body cells are united and affected by the activities of all other cells within the entire organism.

The physiological process which maintains most of the steady states is termed homeostasis, which implies variations within limits as long as the individual is capable of making appropriate adaptations to change.

3.4.1 Maintenance of Homeostasis

The maintenance of homeostasis depends on a variety of elements. Substance required by cells must be available in adequate quantities. Material supplies include water, oxygen, and a variety of nutrients, including sources of calories, tissue-building materials, electrolytes and regulators not synthesised or present in the body. The intake, storage and elimination of excess supply are regulated so that the level of each substance is maintained within well-defined limits.

3.4.2 Structure Supporting Homeostasis I

The healthy organism is capable of responding to disturbances in such a manner that damage is prevented or repaired. The kinds of structures that fulfill this function include the following:

- Structure where required substances are absorbed from the external environment and when necessary, modified so that they can enter the internal environment. For example, Oxygen is absorbed into the blood unchanged., The air from which oxygen is taken however, requires conditioning. Nutrients usually require reduction to simpler forms before they can be absorbed and provision for the elimination of indigestible sub- stances is also necessary.

- Materials enter or leave the external environment through semipermeable membranes that separate the internal from the external environment. These semi-permeable membranes act to protect the internal environment from too rapid a change or from the entrance of potentially harmful or unusable particles.

- Structures to transport materials from point of entry to cells and from cells to points of elimination or exit such as the heart and blood vessels.

- Structures that store or eliminate excesses of intake and byproducts of metabolism. For example, glucose is stored as glycogen in the liver and muscles, much of the excess is stored as fat. Excess sodium is normally excreted in the urine.

- Structures that make movement in the external environment possible. They enable the individual to seek food and water, to alter the environment to suit his needs, to overcome or avoid danger and to find a partner.
- Structures that reproduce themselves to replace worm-out cells, to repair injury or to produce a new organism.

- Structures that protect the organism from injury.

- Finally, structures that regulate and integrate the activities of all individual cells and aggregates of cells so that the organism functions as a whole.

3.4.3 Conditions of Homeostasis

Conditions that must be maintained within limits include:

- Osmolality
- Blood pressure
- Level of glucose in the blood
- Cation-anion balance and concentration,
- Hydrogen ion concentration, and
- Body temperature

Conditions in the external environment must be within the limits to which human beings can adapt. For example, the capacity to adapt to extremes of temperature, high altitude, water and food supply, and physical trauma

is limited. However, human beings are able to live in some hostile environments by adapting them to their needs.

This section now completes the discussion on the environment, you now have a picture of what a conducive or an ideal environment consist of the substrates and the structure that would support healthy living. We now proceed to examine the role nursing plays with regard to the patient's environment.

SELF-ASSESSMENT EXERCISE

1) Review the sections on external and internal environment.
2) Study your physical environment.
3) Identify 3 elements that support a safe environment.
4) Identify 2 elements that would promote a health problem.

3.5 Nurses Responsibility Towards Promoting a Safe Environment

As earlier mentioned, a safe environment is one in which basic needs are achieved, physical hazards are reduced, transmission of pathogen and parasites is reduced, sanitation is maintained and pollution controlled.

Nursing care directed at health maintenance and illness prevention involves promoting the clients' safety in the community or within the health care environment, and is just as essential as meeting other physiological and psychosocial needs. Protection and safety are basic to survival, and these needs continue throughout life.

Safety in the home reduces the risk of accidents and illnesses, and the subsequent need for healthcare services. Safety is positively correlated to health promotion.

A safe environment is essential to maintaining and restoring health. Nurses are the first line of defense against environmental hazards.

Management of the environment is possibly the nurses most nearly independent function Florence Nightingale recognized the significance of the natural environment in the care of the sick when she wrote. "The thing which strikes the experienced observer most forcibly is this, that symptoms or suffering generally considered to be inevitable and incident to the disease are very often not symptoms of disease at all, but of something quite different-of the want of fresh air, or of light, or of warmth

or of quiet, or of cleanliness, or of punctuality and care to the administration of diet, of each or all of these". To this should be added the people. Nurses, physicians, paramedical personnel, family friends, and others who enter and leave the environment of the patient in the course of a day.

The nurse will concern herself with many additional environmental factors as she takes action to promote a healthy environment for her clients. First, the nurse must set exemplary examples by her personal behavior. The practice of washing hands thoroughly whenever indicated in order to control the spread of infection. The nurse knows that oxygen supports combustion, so she takes appropriate measures to decrease the likelihood of fire in the room of someone receiving oxygen therapy. Public education directed towards safe environment both in the healthcare institutions and homes watching electrical cords and connections, medications, house cleaning solutions and so on.

Water supply, good ventilation and clean air, balanced food, personal hygiene and environmental sanitation are all concerns of nursing. Florence Nightingale in her treatise on what nursing should do, wrote: "nursing ought to signify the proper use of fresh air, light, warmth, cleanliness, quite, and the proper selection and administration of diet-all at the least expense of vital power to the patient." All these are vital elements in the external environment that are necessary for homeostasis in the internal environment.
In subsequent Units you will be introduced to how nurses should identify and meet basic human needs both in theory and in practice.

4.0 CONCLUSION

Environment is all of the many physical and psychosocial factors that influence or affect the life and survival of the individual. Environment is subdivided into external and internal. External environment lies outside the body and is in contact with the skin, mucous membrane and the sense organs. The internal environment is made up of the fluid surrounding the cells and carrying to and from them. Similar to the dependence of health on the stability within the external environment, health is also dependent on the maintenance of relative stability of the physical and chemical characteristics of the fluid comprising the internal environment. For human beings and other multi-cellular organisms, blood, lymph and interstitial fluid form the immediate environment of the cells. Materials utilized in the internal environment come from the external environment through specialized structures.

Therefore, the quality and state of the external environment determine the state of the internal environment. For man to be in a health state, there should be equilibrium between the external and internal environment. Hence a safe external environment determines the quality of the internal environment. Conditions in the external environment must be within the limits to which an individual can adapt to.

Management of the environment for positive clients' health is possibly the most nearly independent function of the nurse. Florence nightingale recognized the importance of the natural environment in the care of the sick and in the prevention of illness.

5.0 SUMMARY

You have just concluded the study unit on the human being and his environment. The unit started with an introduction, which gave you an overview of the concept Environment.

How human beings and their environment are constantly interacting and influencing each other, how the relationship is dynamic and how human beings manipulate their environment to meet their needs.

The major types of environment external and internal were analysed, showing the characteristics of each, and how each compliments the other to support health and general welfare.
The concept of homeostasis as a mechanism for internal environment regulation was discussed, finally the role of nursing in providing and protecting the environment was discussed.

6.0 TUTOR MARKED ASSIGNMENT

1. Define *environment.*
2. State how environment is classified.
3. Discuss briefly how a type of external environment in which a person lives can lead to an increased incidence of a certain health problem. Illustrate your answer with an example.

7.0 REFERENCES/FURTHER READING

Bircher, A.U. (1972 "Mankind in crisis: an application of clinical process to population environmental issues" *Nursing Forum* 11:10-33,1.

Jamann, J.S. (May 1971) "Health is a function of ecology: *Am. J. Nursing* 71:970-973.

Potter, P.A. and Perry A.G. (1993) *Fundamentals of Nursing: Concepts, Process and Practice,* St. Louis: M. Mosby Year Book.

Nightingale, Florence (1860) *Notes on Nursing: What It is and What It Is Not.* New edition, revised and enlarged, London; Harrison and Sons.p.56

MODULE 3 HEALTH AND HUMAN NEEDS

UNIT 1 CONCEPT OF HEALTH AND ILLNESS

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 What is Health?
    3.2 Concepatients of Wellness
    3.3 Illnesses and Disease
    3.4 Etiology of Illnesses and Diseases
    3.5 Classification of Illnesses and Diseases
    3.6 Theoretical perspectives of health and wellness
    3.7 The Health-Illness Continuum
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

To many people health and illness virtually means the same thing or as accompanying one another. In fact, most individuals and societies in the past have viewed good health or wellness as synonymous to absence of illness. This limited view overlooks the complex interrelationships between the physiological, emotional, intellectual, socio-cultural, developmental and spiritual dimensions of health and illness (Cox, 1995) However like Kozier, Erb, Berman and Burke (2000) rightly noted, health may not always accompany well-being as a person with terminal illness may have a sense of well-being while somebody else may lack a sense of well-being yet be in good health. As nurses we therefore need a comprehensive and robust understanding of health and illness as this go a long way to affect scope and nature of nursing practice. To this end, this unit employs a comprehensive and integrated approach of health, wellness and illness. It particularly examined illness behaviour, models of health and wellness, as well as the health-illness continuum.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- differentiate health, wellness and illness
- describe five dimensions of wellness
- differentiate between acute, chronic and terminal illnesses; primary and secondary illnesses; and hereditary, congenital, and idiopathic illnesses.
- distinguish between the terms illness and disease
- outline the etiology of illnesses and diseases
- describe the health-illness continuum.

3.0 MAIN CONTENT

3.1 What is Health?

The term 'health' is so common a vocabulary in every culture; race or creed that one is often tempted to assume that it would have a homogeneous meaning. This is however not so. How each person perceives and defines health varies, and it is important to respect these individual differences rather than impose standards that may be personally unrealistic (Timby, 1996). In Watinson (2002) words 'Health' is a slippery concept to grasp in comparison with ill-health, which seems so solid and tangible.

Nonetheless, the World Health Organisation (WHO) asserts in the preamble of its constitutions that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being regardless of race, religion, political belief, economic, or social conditions. According to WHO, health 'is a state of complete physical, mental and social well-being and not merely the absence of disease on infirmity'. By this definition, health is much more than physical wellbeing. It means more than not having a physical disease but to be in harmony. The question that quickly comes to mind however is harmony with what and how? To answer this question, there is need to explore cosmological framework to show how physical and social component of the society helps to explain or determine the notion of health and illness. Conception of health is therefore ultimately based on the perception of the original and intended fashion of humanity. As a result, the body becomes an extension of moral perception.

Kozier, Erb, Berman and Burke (2000) in what looks like a critical review of the WHO definition submitted that the WHO definition

- Reflects concern for the individual as a total person functioning physically, psychologically, and socially. They noted that mental processes determine people's relationship with their physical and social surroundings, their attitudes about life, and their interaction with others.
- Places health in the context of environment. It takes cognisance of the fact that peo1ple's live, and therefore their health, are affected by everything they interact with – not only environmental influences such as climate and the availability of nutritious food, comfortable shelter, clean air to breathe and pure water to drink – but also other people, including family, lovers, employers, coworkers, friends, and associates of various kinds.
- Equates health with productive and creative living. According to them it focuses on the living state rather than on categories of disease that may cause illness or death.
- Health therefore in its global/broadest sense encompasses:
- Physical health – physical fitness, the body fixing at its best.
- Emotional health – feelings and attitudes that make one comfortable with oneself.
- Mental health – a mind that grows and adjusts; in control, free of serious stress.
- Social health – a sense of responsibility and caring for health and welfare of others.
- Spiritual health – inner peace and security, comfort with one's higher power, as one perceives it.

One cannot but agree with Delaune & Ladner, (1998) and Kozier, Erb, Berman & Burke, (2000) that the concept of health encompasses such things as emotional and mental stability, spiritual well-being and social usefulness. And while it is very true that health is the fundamental right of every individual, it is also a limited resource as well as a personal responsibility. It is considered a resource and personal responsibility because it is valuable; has no substitute; and requires continuous personal effort. Health however is not an absolute entity; rather there may be fluctuations along a continuum from time to time. Health is not a condition, it is an adjustment; it is not a state, it is a process (President's commission, 1953). Delaune and Ladner (1998) definition of health as a process through which the person seeks to maintain equilibrium that promotes stability and comfort aptly corroborate this fact. In other words, health is a dynamic process that varies according to the individual's perception of well-being.

Dubo (1978) views health as a creative process. In his words, individuals are actively and continually adapting to their environments. He stressed that individuals must however have sufficient knowledge to make informed choices about his or her health and also income and resources to act on choices. Pike and Forster (1995) compliments Dubo's statement by arguing that it is important to take into account people's own perceptions and views on health and that different people will see and express these in different ways. Individuals as they continuously adapt to their environment therefore are at different stages/level of wellness.

It is also noteworthy that man responds to the environment in which he finds himself as an integrated whole. This brings us to the concept of holism. Holism is a philosophy that views the "whole person". The person is seen as a complete unit that cannot be reduced to the sum of its parts. Health in holistic sense therefore is total wellness – wellness of mind, spirit as well as body (Timby, 1996). But in view of the fact that it is virtually impossible for someone to be well and stay well, or get well and remain well forever, nurses are expected to assists people in the prevention of illness and restoration of health through holistic health care i.e. comprehensive and total care of a person.

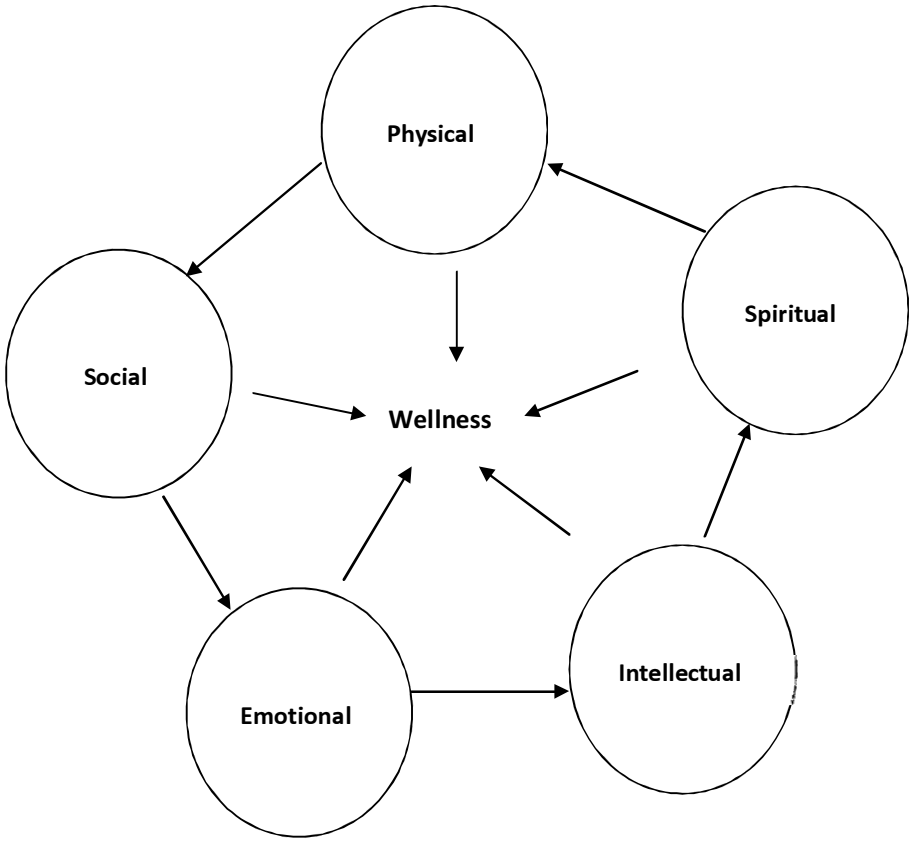
3.2 Concepts of Wellness

Simply put, wellness is a state of well-being. Kozier, Erb, Berman & Burke, (2000) drawing on the work of Leddy and Pepper (1998) contend that people do confuse the process of health with the status of wellbeing. Well-being they declared is a subjective perception of vitality and feeling well. It is a state that can be described objectively and can be plotted on a continuum. A more lucid definition however is the one given by Carroll and Miller (1991) which states that term wellness connotes good physical self-care, using one's mind constructively, expressing one's emotion effectively, interacting creatively with others and being concerned about one's physical and psychological environment. Akin to this, is the definition by Travis and Ryan (1988) which states that wellness is a choice; a process; efficient handling of energy; integration of body, mind, and spirit; and loving acceptance of self. In synopsis, wellness can be interpreted as full and balanced integration of physical, emotional, social and spiritual health i.e. the condition in which an individual function at optimal level.

According to Kozier, Erb, Berman & Burke (2000), the basic concepatients of wellness include self-responsibility; an ultimate goal; a dynamic, growing process; daily decision making in areas of nutrition, stress management, physical fitness, preventive health care, emotional

health, and other aspects of health; and most importantly, the whole being of the individual. Using the works of Anspaugh, Hamrick, & Rosata (1991) as the basis, they declared further that there are five dimensions to wellness and for people to realise optimal health and wellness, individuals must take cognisance of the factors within each dimension. See figure 2 – 1.

Fig 2 – 1 The Dimensions of Wellness



Source: Adapted from Kozier, Erb, Berman and Burke 2000 Fundamentals of Nursing: Concepatients, Process and Practice

Let us examine these factors one by one:

- **Physical** – The ability to carry out daily tasks, achieve fitness, maintain adequate nutrition and proper body fat, avoid abusing drugs and alcohol or using tobacco products, and generally to practice positive lifestyle habits.

- **Social –** The ability to interact successfully with people and within the environment of which each person is a part, to develop and maintain intimacy with significant others, and to develop respect and tolerance for those with opinions and beliefs.
- **Emotional –** The ability to manage stress and to express emotions appropriately. It encompasses the ability to recognise, accept, and express feelings and to accept one's limitations.
- **Intellectual –** The ability to learn and use information effectively for personal, family, and career development. It includes striving for continued growth and learning to deal with new challenges effectively.
- **Spiritual –** The belief in some force (nature, science, religion, or a higher power) that serves to unite human beings and provide meaning and purpose to life. It includes a person's own morals, values, and ethics.

In conclusion, they noted that the five components overlap to some extent, and factors in one component often directly affect another but nonetheless wellness involves working on all aspects of the model.

SELF-ASSESSMENT EXERCISE

List the five factors that contribute to wellness.

3.3 Illness and Disease

The term illness and disease to the layman means the same thing and no wonder they are used interchangeably in everyday language. However, the two terms are not synonymous even though they may or may not be related. Hence the need to differentiate between the two terms. Any deviation from the accepted standard of well-being is regarded as illness. To Kozier, Erb, Berman & Burke (2000) illness is highly personal state in which the person's physical, emotional, intellectual, social, developmental, or spiritual functioning is thought to be diminished. For instance, an individual may have a disease, say hypertension and not feel ill. By the same token a person can feel ill, that is feeling uncomfortable, yet have no discernible disease. By extension, illness may or may not be orchestrated by pathological abnormality. Therefore, illness can be described as a situation in which somebody fails to perform his/her normal roles in the society.

Disease on the other hand is a biological parameter of non-health a pathological abnormality that is indicated by a set of signs and symptoms. It could also be defined as a state of discomfort that results when a

person's health becomes impaired through disease, stress or an accident or injury. Implicit in the above statement is that this state of discomfort or abnormality may be the aftermath of one organism invading another with predictable negatively valued outcomes or consequences on the host. It could also be a result of breakdown of anatomic structures of an organism or a result of stress that the body cannot cope with. It may even not be organic phenomenon interfering with body function but the fabric of antisocial behaviour. For instance, among the Yoruba ethnic group of western Nigeria, distasteful behaviour are labelled as sickness as this has something to do with the state of mind. In other words, such behaviour tends to exhibit the relationship between the mind and the body thus reflecting the state of disharmony between the mind and the body. Perhaps it is good to mention at this juncture that disease may not necessarily be symptom manifesting as many forms of diseases are hidden and allow the carrier or victim to go about their normal business.

3.4 Etiology of Illnesses and Diseases

In the dark ages before the advent of science, diseases were thought to be consequences of running foul to the laws of the gods/deity i.e. a punishment inflicted on man by demons or evil spirits secondary to offending the deity. This explains why the first line of action when somebody falls sick then is to appease the gods. This was later replaced by the single causation theory. Today we however know that multiple factors are considered to be instrumental to causing disease. Outlined below therefore are some of the etiological agents of the various diseases confronting man:

- Inherited genetic defects
- Developmental defects/Congenital malformations. Example – Atria Septal Defect
- Biological agents or toxins
- Physical agents such as temperature extremes, chemicals, or radiations
- Generalised response of tissues to injury or irritation • Physiological and psychological reactions to various stressors
- Biochemical imbalances within the body.

It should however be mentioned as noted by Stephen (1992) that though many of these factors are interrelated, the causes of many diseases are still unknown.

3.5 Classification of Illnesses and Diseases

Illness may be classified as acute, chronic or terminal. Could also be classified as Primary (1°) or Secondary (2°). Let's quickly see what these means.

An **acute illness** is one that comes on suddenly and last a relatively short time. Example: Bacterial conjunctivitis, Gastroenteritis to mention a few. Acute illnesses are usually severe but curable; some however lead to long-term problems because of their sequelae. Sequelae are ill effects that result from permanent or progressive organ damaged cause by a disease or its treatment. A **chronic illness** on the other hand, is one that is gradual in onset and last a relatively long time. Stephen (1992) paraphrasing the work of Zindler-Wernet and Weiss on Health Locus of Control and Preventive Health Behaviour submitted that chronic illnesses are illnesses that lead to at least some of the following characteristics: (1) permanent impairment or deviation from normal, (2) irreversible pathological changes, (3) a residual disability, (4) special rehabilitation, and (5) long term medical and/or nursing management. Examples include Arthritis, Chronic renal failure [CRF], Hypertension, and Diabetes Mellitus. A **terminal illness** is one in which there is no known cure. The terminal stage of an illness is one in which death has become inevitable.

A **1°** illness is one that has developed independently of any other disease. Any subsequent disorder that develops from a pre-existing condition is referred to as **2°** illness Example - Hypertension leading to Congestive Cardiac Failure (CCF). Furthermore, illness could be classified according to their etiological factors as follows: Hereditary, Congenital and Idiopathic.

Hereditary – A hereditary condition is one that is transmittable down the family tree i.e. from parent to their offspring through their genetic code. A common example in our environment is sickle cell anaemia. Hereditary illnesses may be manifested immediately after birth or develop at some time later.

Congenital – Congenital disorders are those that are present at birth and are products of faulty embryonic development especially during the first three month of intrauterine life otherwise referred to as period of organogenesis. Example includes Tetralogy of Fallot.

Idiopathic – An idiopathic illness is one that for which there is no known cause. Treatment is usually palliative (directed at relieving symptoms alone). A typical example is cancer.

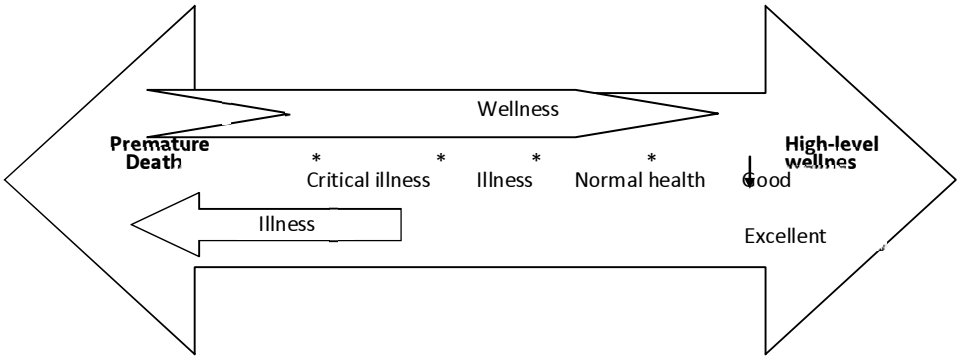
SELF-ASSESSMENT EXERCISE

List the two main classification of illness?

3.6 The Health – Illness Continuum

A continuum is defined as a continuous whole. Our health is in a dynamic state of continuity and change constantly being challenged, stressed, abused and even enhanced by our genetic make-up and lifestyle, and by our wider ecological environment (Watkinson, 2002). Consequently, fluctuations of health and illness can be illustrated on a health-illness continuum. See figure 2 – 2 below.

Fig 4 – 2 Illness–Wellness Continuum



Source: Adapted from Rosdal, 1995: Textbook of Basic Nursing & Kozier, Erb, Berman and Burke 2000: Fundamentals of Nursing: Concepatients, Process and Practice.

People do not tend to be totally healthy or totally ill at any given time. Individual's state of health however falls somewhere on a continuum from high-level wellness to death. There is no exact point at which health ends and illness begins. Both are relative in nature, and for each individual there is range and latitude in which he may be considered ill or well (Fuerst, Wolff & Weitzel, 1974). When needs are blocked or threatened, one moves towards the "illness" end of the continuum and vice versa. The body adapts to change in an attempt to maintain homeostasis but high-level wellness is optimum. Nursing actions involving health promotion and illness prevention assist the patient/client not only in maintaining and increasing the existing level of health but also in achieving an optimal health (Heath, 1995). However, to assist the

patient/client in health maintenance and promotion, illness prevention, and adaptation to the changes that illness produces in every dimension of functioning, the nurse must understand all the aforementioned dimensions.

4.0 CONCLUSION

This unit has shown you that health is a dynamic state and its conception/perception is highly varied. There however seems to be a consensus that it involves the whole person – mind, body and spirit – functioning at optimal level. And contrary to the traditional view of illness, it has been shown to be a highly personal state in which a person feels unhealthy or ill. Though usually associated with disease may occur independently of disease. To provide effective nursing care and assist clients/patients in regaining and maintaining high-level wellness, nurses must therefore understand patients'/clients conception of health as this influences their health belief and health practices.

5.0 SUMMARY

In this unit, you examined the concept of health and illness. The unit employed a comprehensive and integrated approach to health, wellness and illness. It also examined the health-illness continuum. Nursing as a holistic and humanistic discipline is therefore concerned with promotion, maintenance and recovery of health. The subsequent chapter expatiates on how this is achieved.

6.0 TUTOR-MARKED ASSIGNMENT

Is health static or changing? Explain with particular reference to the health-illness continuum.

7.0 REFERENCES/FURTHER READING

Anspaugh, D. J., Hamrick, M. H. & Rosata, F. D. (1991). *Wellness: Concepatients and Applications.* St. Louis: Mosby-Year Book.

Carroll, C. & Miller, D. (1991). The Science of Human Adaptation.

Cox, C.L. (1995). Health and Illness. In H. B. M. Heath (Ed.). *Potters and Perry's Foundations in Nursing Theory and Practice*. Italy: Mosby, An Imprint of Times Mirror International.

Delaune, S. C. & Ladner, P.K. (Eds.). (1998). The Individual, Health and Holism. *Fundamentals of Nursing, Standards and Practice.* Albany: Delmar Publishers.

Dubos, R. (1978). Health and Creative Adaptation. *Human Nature,* 74(1), Entire Issue.

Fuerst, E.V.; Wolff, L.U. & Weitzel, M. H. (Eds.) (1974). Fundamentals of Nursing (5th ed.). Toronto: J. B Lippincott Company.

Kozier, B.; Erb, G.; Berman, A.U. & Burke, K. (Eds.) (2000). Health, Wellness and Illness. *Fundamental of Nursing: Concepts Process and Practice* (6th ed.). New Jersey: Prentice Hall, Inc.

Leddy, S. & Pepper, J. M. (1998). *Conceptual Bases of Professional Nursing* (4th ed.). Philadelphia: Lippincott.

Pike, S. & Forster, D. (Eds). (1995). Health Promotion for All. London: Churchill Livingstone.

President's Commission on Health Needs of the Nation (1953). Building Americans' Health. Vol. 2. Washington, DC: U.S Government Printing Press.

Rosdahl, C. B. (Ed). (1995). Optimum Health for All People; *Textbook of Basic Nursing*. Philadelphia: J.B. Lippincott Company.

Stephen, P. P. (1992). *Experience of Health and Illness*. In S. M. Lewis and I. C. Collier (Eds). Medical-Surgical Nursing; Assessment and Management of Clinical Problems (3rd ed.). St Louis: Mosby Year Book, Inc.

Timby, B.K. (Ed). (1996). Health and Illness. Fundamental Skills and Concepatients in Patient Care (6th ed.). Philadelphia: Lippincott.

Travis, J. W. & Ryan, R. S. (1988). *Wellness Workbook* (2nd ed.) Berkeley, CA: Ten Speed Press.

Watinson, G. (2002). Promoting Health. In R. Hogston & P. M. Simpson (Eds). Foundations of Nursing Practice; Making the Difference (2nd ed.). New York: Palgrave Macmillan.

UNIT 2 HEALTH AND HUMAN NEEDS

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Overview of Individual Needs
    3.2 The Basic Human Needs
    3.3 Physiologic Needs
    3.4 Security and Safety Needs
    3.6 Affiliation and Social Needs (Love)
4.0 Conclusion
5.0 Summary
60 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Health and human needs are inextricably interrelated. Humans need a number of essentials to survive. The assertion that all individuals irrespective or age, sex, race or creed have needs that they strive to satisfy is therefore is no exaggeration. The Cambridge International Dictionary of English defined 'Needs' as things one must have or things required to live a satisfactory life i.e. things essential to life and quality living. As a corollary, illness or risk of illness occurs when individuals are not able to satisfy one or more of their basic needs.

Since the soul of nursing is caring, much of our career is weaved around helping people to satisfy these needs. This is consistent with the position of that renowned nurse theorist, Virginia Anderson, who submitted that Nursing is primarily assisting the individual (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) which he would have performed unaided if he had the necessary strength, will, or knowledge, as well as helping the individual to be independent of such assistance as soon as possible. Achieving this is however no mean work. This is because human beings are not merely physiological creatures and their needs are multifaceted and multidimensional. Besides, every individual is a unique being and as such requires some unique needs in addition to the basic human needs. This unit therefore takes a detailed look at human needs with a view to enhancing nurses' ability to help their clients meet these varied needs.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- state the basic human needs
- list at least five physiologic needs of all people
- describe relationships among the different levels of needs
- relate the achievement of basic human needs to health status
- discuss the nurses' role in assessing and meeting patient/client's need.

3.0 MAIN CONTENT

3.1 Overview of Individual Needs

Human needs are many. They encompass both physical and nonphysical elements needed for human growth and development, as well as all those things humans are innately driven to attain. Human needs therefore can be broadly classified into two major groups viz: Primary needs and Secondary needs (Rosdahl, 1995).

Primary needs otherwise known as Basic needs, are survival needs. They must be met to sustain life. Put differently, their absence or nonsatisfaction portends great threat to human existence. As such they take precedence over other needs called secondary needs. The beyond intractability project (2003) in their write-up on Leadership and Human Behaviour states that basic needs are physiological, such as food, water, and sleep; as well as psychological, such as affection, security, and selfesteem. According to this organisation, these basic needs are also called deficiency needs because if an individual does not meet them, then that person will strive to make up the deficiency and they are usually listed in hierarchical order.

Secondary needs or Meta needs (growth needs) as they are sometimes referred to, are additional higher needs that must be met to maintain the quality of life. They include justice, goodness, beauty, order, unity, etc. Basic needs normally take priority over growth needs. For example, a person who lacks food or water will not normally attend to justice or beauty needs. Unlike the basic needs, the Meta needs can be pursued in any order, depending upon a person's wants or circumstances, as long as the basic needs have all been met.

3.2 The Basic Human Needs

There are at least five sets or categories of needs, which we can classify as Basic Human Needs. They are physiological, safety, love, esteem and self-actualisation needs. These needs are related to each other, being arranged in a hierarchy of prepotency. This means that the most prepotent goal will monopolise consciousness and will tend of itself to organise the recruitment of the various capacities of the organism. The less prepotent needs are minimised, even forgotten or denied. But when a need is fairly well satisfied, the next prepotent ('higher') need emerges, in turn to dominate the conscious life and to serve as the center of organisation of behaviour, since gratified needs are not active motivators. Thus man is a perpetually wanting animal. Ordinarily the satisfaction of these wants is not altogether mutually exclusive, but only tends to be. The average member of our society is most often partially satisfied and partially unsatisfied in all of his wants (Maslow, 1943).

3.3 Physiologic Needs

Undoubtedly the physiological needs are the most pre-potent of all needs. Why? They are basic biological needs for life sustenance. This means that in the human being who is missing everything in life in an extreme fashion, it is most likely that the major motivation would be the physiological needs rather than any others. A person who is lacking food, safety, love, and esteem would most probably hunger for food more strongly than for anything else. Stated differently, if the physiological needs are unsatisfied, all other needs may become simply non-existent or be pushed into the background. All capacities are put into the service of hunger-satisfaction, and the organisation of these capacities is almost entirely determined by the one purpose of satisfying hunger. The receptors and effectors, the intelligence, memory, habits, all may now be defined simply as hunger-gratifying tools. Capacities that are not useful for this purpose lie dormant, or are pushed into the background. For instance, the urge to write poetry, the desire to acquire an automobile, the desire for a new pair of shoes are, in the extreme case, forgotten or become of secondary importance. For the man who is extremely and dangerously hungry, no other interests exist but food. He dreams food, he remembers food, and he thinks about food, he emotes only about food, he perceives only food and he wants only food (Maslow, 1943).

Perhaps it should be mentioned that any of the physiological needs and the consummatory behaviour involved with them serves as channels for all sorts of other needs as well. That is to say, the person who thinks he is hungry may actually be seeking more for comfort, or dependence, than

for vitamins or proteins. Conversely, it is possible to satisfy the hunger need in part by other activities such as drinking water or smoking cigarettes. In other words, relatively isolable as these physiological needs are, they are not completely so (Maslow, 1943). In synopsis, the first need of the body is to achieve homeostasis and this is achieved through the consumption of food, water and air; elimination of exogenous and endogenous wastes; sleep and rest; activity and exercise; and sexual gratification. Let us then take a look at each of these physiological needs.

Air/Oxygen – This is the most essential of all basic needs. Air is a name for the mixture of gases present in the earth atmosphere. By volume, dry air contains approximately 78.1% Nitrogen, 20.9% Oxygen, 0.9% Argon, and 0.03% Carbon Dioxide. Oxygenation (the delivery of oxygen to the body cells and tissues) is necessary to maintain life and health (Christensen, 1998). The brain for instance cannot function without oxygen for longer than 4 – 5 minutes (Cox, 1995). Oxygen is needed for internal respiration alongside the metabolic processes occurring in the body. The body meets its oxygen need via external respiration or what is called gaseous exchange. Variables affecting oxygenation include age, environmental and lifestyle factors and certain disease process. Consequently, anything that interferes with the airway, atmospheric oxygen content, human respiration and circulation can threaten the body's oxygen supply. Examples of such abound but briefly they include: some respiratory diseases like emphysema, asthma, pneumonia; air pollution; blockage of respiratory tract by secretion to mention a few (Rosdahl, 1995).

Clients with compromised oxygenation status need careful assessment and thoughtful nursing care to achieve adequate and comfortable level of oxygenation status (Christensen, 1998). Nursing measures to meet oxygen needs range from teaching client to rest in position that increases respiratory volume and thus the level of oxygen, to emergency cardiopulmonary resuscitation for cardiac arrest and supportive measures such as administration of oxygen to patients/clients with pulmonary disease (Cox, 1995).

Water and Fluids – It is no exaggeration that though a man can survive several days without food could last only a few hours without water. Water takes many different shapes on earth: water vapour and clouds in the sky, waves and icebergs in the sea, glaciers in the mountain, aquifers in the ground, to name but a few. From a biological standpoint, water has many distinct properties that are critical for the proliferation of life that set it apart from other substances. Water carries out this role by allowing organic compounds to react in ways that ultimately allows replication. It

is a good solvent and has a high, surface tension and thus allows organic compounds and living things to be transported in it. 60 – 70% of the body cells are made up of fluids.

The body constantly loses fluid to the environment via the various regulatory systems in the body. Howbeit, body fluid is replenished by ingestion of liquids and food products such as meats and vegetables, which contain 65% to 97% water and through the chemical oxidation of food substances. The healthy existence or otherwise of the cellular system, indeed the entire body therefore depends on the maintenance of proper volume, chemical composition, and placement of these fluids. This balanced internal environment is what is called homeostasis. Virtually all illness states (unconsciousness, kidney dysfunctions, gastroenteritis, diabetes mellitus etc.) threaten this balance. It is even threatened in a healthy state, especially when one engages in prolonged outdoor exercises without adequate fluid intake. Prolonged administration of certain therapeutic regimen could also alter this balance, for instance the use of diuretics and corticosteroids.

Dehydration and oedema indicate unmet fluid needs. Dehydration is the excessive loss of fluid from body tissues; it is accompanied by a disturbance of body electrolytes. Could follow prolonged fever, vomiting, diarrhoea, trauma or any other condition that causes a rapid fluid loss. Oedema is the abnormal accumulation of fluid in the interstitial spaces of tissues, pericardial sac, intrapleural space, peritoneal cavity, or joint capsules. Oedema may be caused by decreased serum protein level, altered functioning of the cardiovascular, renal, or hepatic system, or drugs. The nurse examines patients/clients for actual and potential fluid and electrolyte imbalance. Poor skin turgor (normal skin elasticity becoming lax), flushed dry skin, decreased tears or salivation, a coated tongue, decreased urine output (oliguria), confusion and irritability indicate dehydration (Cox, 1995). Pitting bipedal oedema, facial puffiness, ascites (accumulation of fluids in the peritoneal cavity), positive shifting dullness are all manifestations of excessive body fluids. The nurse can assist in conditions of altered fluid balance through accurate assessment, measuring of intake and output, weighing of patients and monitoring of intravenous infusions and so on and so forth.

Food and Nutrients – Food is any substance that can be consumed, be it of plant or animal origin including liquid drinks, and it is the main source of energy and of nutrition for man and other animals. The phrase ‘we are what we eat’ is frequently used to signify that the composition of our bodies is dependent in large measures on what we have consumed (Latham, 1997). Today there is a greater awareness of the relationship between health and nutrition, nutrition and the onset of illness, nutrition and wound healing, and nutrition and effective immunity.

Optimal nutrition (intake matches energy expenditure; proper amount of each essential nutrient) is essential for: Normal growth and development; maintenance of bodily functions; optimal activities status; resistance to infection; and repair of injuries to cells and tissues. Lack of adequate nutrition produces specific identifiable diseases such as kwashiorkor, marasmus, rickets, etc. Poor nutritional habits, inability to chew and swallow, nausea and vomiting equally pose a threat to nutritional status. Over-eating on the other hand also adversely affect health (results in obesity, hypercholestraemia` and other related problems). Perhaps the point that could be safely made is that while good nutrition is not synonymous to good health, good health is not achievable without adequate nutrition.

To determine whether patients/clients are meeting nutritional needs, the nurse considers body weight and other markers of nutritional deficiency. These include the physique, body mass index, hair texture and colour, some laboratory data (e.g. PCV), and food intake patterns. Signs and symptoms indicating that individuals are not meeting nutritional needs include failure to thrive, unplanned weight loss, fatigue, pallor and recurring mouth and gum sores (Cox, 1995). To help individuals meet their nutritional needs, the nurse must have a good understanding of the various locally available foodstuffs and their nutritive values as well as the digestive and metabolic processes of the body. Nursing action targeted at resolving nutritional problems range from health education to assuming total responsibility for the planning and feeding of patients.

SELF-ASSESSMENT EXERCISE

List the basic human needs.

Elimination of Waste Products – This is essential to maintain life and comfort. The integumentary (the skin and its appendages), respiratory, urinary, hepatic, and digestive systems are the organs primarily concerned with elimination of wastes from the body. The skin eliminates water and salt in form of sweat; the kidney, excess fluids and electrolytes; the lungs, carbon dioxide and water; the intestine, solid wastes and fluids; and the liver, detoxified drugs and toxins. Many conditions (kidney or renal problems, bowel obstruction, diseases of the respiratory tract etc.) impair this process of waste elimination in the body with grave consequences.

A patient/client whose urinary elimination needs are unmet may become incontinent or develop urinary tract infection. Unmet urinary elimination

needs also results in fluid and electrolyte imbalances. A patient unmet need for bowel elimination may lead to changes in pattern of elimination or diet intake (Cox, 1995). Nursing measures at helping clients/patients meet their elimination needs may be as simple as providing privacy or changing diet or giving enema or as complex as inserting a urethral catheter, conducting peritoneal dialysis or haemodialysis, or assisting with surgery to relieve bowel obstruction or administering medication to relieve constipation.

Sleep and Rest – Sleep is a recurrent, altered state of unconsciousness that occurs for sustained periods, during which the body experiences minimal physical activity and a general slowing down of physiological processes with resultant restoration of energy and well-being. It provides time for the repair and recovery of body systems for the next period of wakefulness. Rest refers to a state of relaxation and calmness (Coy, 1998). Like sleep it reduces physical and psychological demands on the body. Activities during rest periods range from lying down to taking a quiet walk. While it is very true that the much of sleep required by individuals depends to a large extent on such factors as age, pregnancy, state of health; sleep deprivation has been implicated in the worsening of certain mental disorders. Although the length of time that can be considered as adequate sleep is still controversial, there is a general belief that about 6 to 8hours of sound sleep is sufficed for healthy living. Rest and sleep habits of persons entering the hospital or other health care facility can easily be changed by illness, the strange hospital environment culminating in fear and anxiety, and hospital routines. The nurse must be aware of patient/client's need for rest and sleep as lack of it aggravates the existing deteriorating state of health of the clients. As nurses, we can assist our clients to get enough rest and sleep by providing safe, comfortable, and quiet environment, maintenance of proper anatomical alignment or positioning, provision of adequate ventilation, giving of warm tub bath, soothing back rub, and prescribed sleep enhancing medications (Rosdahl, 1995). Any bedtime habits, such as reading, walking, bathing or drinking milk should be incorporated into the care plan. When possible the nurse should plan care to fit the patient's/client's usual sleep-wake-cycle (Cox, 1995).

Activity and Exercise – Mobility or movement is an activity most people have taken for granted but the ability to move and be active brings about positive benefits to one's health status (Brillhart 1998). Mobility though not absolutely essential for survival is needed to maintain optimum health. According to respiration Rosedale (1995) activity stimulates the mind and body while exercise helps in maintaining body's structural integrity and health by enhancing circulation and respiration. Mobility

enhances muscle tone, increases energy levels, and is often associated with psychological benefits such as independence and freedom. Functional mobility is governed by body mechanics, the purposeful and coordinated use of body parts and positions during activity. Use of proper body mechanics maximises the effectiveness of the efforts of the Musculoskeletal and neurological systems and reduces the body's exposure to strain or injury during movement (Brillhart 1998).

The nurse can assist her client to obtain needed exercises in the following ways: (a) Through the teaching of pre-operative breathing exercises; (b) Encouraging early ambulation post-surgery; (c) Conduction of passive range of motion exercises; (d) Turning of immobilised patients (non-ambulant patients) to mention but a few.

Sexual Gratification – Everyone is a sexual being regardless of health status (Hodge, 1995), and sexual integrity is an integral part of a person's well-being. Even though there are no universal values about sexuality, individuals do experience sexual needs but unlike other physiologic needs, sexual gratification may be sublimated (Rosdahl 1995). This is to an extent underscores the fact that the sex need is not vital to survival of individuals but it is vital to the survival of the species.

Nurses often encounter clients whose sexuality is threatened. Some illnesses such as diabetes mellitus, chronic pain, some disabilities, certain surgeries and some medications like certain antihypertensives, and even hospitalisation may impair a person's sexual integrity (Delaune & Ladner, 1998). The nurse can be of great help in managing client's sexual problems by demonstrating understanding, creating an atmosphere that communicates consideration, and making the patient feel comfortable. In addition, clients and sexual partner need to be informed about the cause of the problem. Medications reducing sexual libido could be substituted while clients with chronic pain could be taught methods of increasing their comfort level (e.g. relaxation techniques). However, as Rosdahl (1995) rightly suggested, when a client present with major sexual problems such should be referred for professional counseling.

3.4 Security and Safety Needs

Once the physiological needs are relatively well gratified, there then emerges a new set of needs, which we may categorise roughly as the safety needs. All that has been said of the physiological needs is equally true, although in lesser degree, of these desires. They may equally well wholly dominate the organism. They may serve as the almost exclusive organisers of behaviour, recruiting all the capacities of the organism in

their service, and we may then fairly describe the whole organism as a safety-seeking mechanism. Again we may say of the receptors, the effectors, of the intellect and the other capacities that they are primarily safety-seeking tools. Again, as in the hungry man, we find that the dominating goal is a strong determinant not only of his current world outlook and philosophy but also of his philosophy of the future. Practically everything looks less important than safety, (even sometimes the physiological needs which being satisfied, are now underestimated). A man, in this state, if it is extreme enough and chronic enough, may be characterised as living almost for safety alone (Maslow, 1943).

Whereas the physiological drive has certain limit to their satisfaction, security needs seems to be infinite in nature. For example, excessive indulgence in eating could be harmful to people. Characteristics of safety include: predictability, stability, familiarity, as well as feeling safe and comfortable and trusting other people (Rosdahl 1995). Inherent in the above statement is that safety needs contains both physical and psychological components. Freedom from harm, danger and fear, financial security, need for shelter and warmth all are therefore subsumed under safety and security needs.

Physical Safety – Maintaining physical safety involves reducing or eliminating threats to body or life. The threat may be illness, accident, danger, or environmental exposure, lack of shelter and warmth. The threat could even be orchestrated by medical or surgical complications following a protracted illness or surgical intervention. Although lack of shelter may not create an immediate threat to life, its cumulative effect may eventually squeeze out life out of people. Furthermore, it will thwart the ability of an individual to progress towards a higher level needs. The need for warmth is however predicated on the fact that the human body functions in a relatively narrow range of temperature and any deviation from this narrow range will spell doom for the whole body (Cox, 1995; Rosdahl 1995). The nurse may assist in removing threats from patient's environment through keen observation and continual assessment, ensuring adequate bed spacing, keeping wards well illuminated and aerated, scrupulous hand-washing, aseptic wound dressing, locking up of poisons at home to safeguard children, to mention but a few.

Psychological Safety – According to Cox, 1995 'To be safe and secure psychologically, a person must understand what to expect from others, including family members and healthcare professionals, and what to expect from procedures, new experiences, and encounters within the environment'. Cox asserted that everyone feels some threat to psychological safety with new and unfamiliar experiences. By extension,

a newly hospitalised patient may feel threatened by the strange hospital environment and a patient/client about to undergo a diagnostic test may equally feel threatened by the technology involved.
The fact that people rarely open up that their psychological safety is threatened makes assessment of psychological safety often difficulty. To this end, the nurse will have to interpret the patient/client language and behaviour. The nurse may assist in alleviating psychological threat through explanation of procedures to patients before actual intervention, health education etc.

3.5 Affiliation and Social Needs (Love)

These encompass the need for friendship, love, belongingness, and acceptance. When both the physiological and the safety needs are fairly well gratified, then the affiliation needs will emerge and dominate the behaviour of human being. Now the person will feel keenly, as never before, the absence of friends, or a sweetheart, or a wife, or children. He will hunger for affectionate relations with people in general, namely, for a place in his group, and he will strive with great intensity to achieve this goal. He will want to attain such a place more than anything else in the world and may even forget that once, when he was hungry, he sneered at love (Maslow, 1943).

The drive to belong and be accepted by other people stems from the gregarious nature of human. Everyone needs to feel that they are wanted and belong to a group. Non-fulfillment of these needs may affect the mental health of the individual and indeed has implicated in the etiology of maladjustment and more severe psychopathology. For instance, a usually mild-tempered person may become easily irritated; an outgoing person may suddenly become withdrawn from friends and coworkers; could even affect a person's work habits leading to increased absenteeism or over commitment to the job.

For this reason, the nursing care plan for an ill hospitalised patient should include means by which love and belonging needs can be met. Some of the ways by which this need could be met include: getting patient/client actively involved in the development of their care plan; giving nursing care in friendly and empathetic manner; encouraging presentation of greeting cards to patient and visits by friends and relatives; and short social visits by members of the health care team.

SELF-ASSESSMENT EXERCISE

Itemise your physiological and psychological needs.

4.0 CONCLUSION

You have learnt that since the attainment of highest level of health by any individual is predicated upon a complex maze of needs achievement, no effort should be spared at ensuring that individuals meet their basic human needs. Nurses, the set of health workers that spend the longest hours with the patients, therefore need to be equipped with knowledge and skill of assessing and meeting the multifaceted needs of their clients.

5.0 SUMMARY

This unit has taken a broad look at the relationship between health and human needs. You must have noted that all human need a number of essentials to survive and that all human beings are driven by physiologic and psychological needs. It classified human needs into two broad groups – Primary needs and Secondary needs noting that the first level needs (physiologic needs) must be met before a person can address higher level needs. Employing simple illustrations, the unit shows that physiological needs can control thoughts and behaviours, and can cause people to feel sickness, pain, and discomfort. In addition, the unit buttressed the view that 'as illness or injury can interfere with a person's ability to meet needs, the duo could also cause an individual to regress to a lower level of functioning'. Lastly, the unit emphasised that nurses can do a lot in identifying and assisting patients/clients to meet their basic human needs.

6.0 TUTOR-MARKED ASSIGNMENT

Classify the basic human and physiological needs. Describe the relationship among the different levels of needs.

7.0 REFERENCES/FURTHER READING

Brillhart, B. (1998). Mobility. In S. C. Delaune & P.K. Ladner, (Eds). *Fundamentals of Nursing, Standard and Practice.* Albany: Delmar Publishers.

Christensen, B. (1998). Oxygenation. In S. C. Delaune & P.K. Ladner, (eds.). *Fundamentals of Nursing, Standard and Practice.* Albany: Delmar Publishers.

Cox, C.L. (1995). Health and Human Needs. In H. B. M. Heath (Ed). *Potters and Perry's Foundations in Nursing Theory and Practice*. Italy: Mosby, An Imprint of Times Mirror International.

Coy, J. (1998). Comfort and Sleep. In S. C. Delaune & P.K. Ladner, (Eds). *Fundamentals of Nursing, Standard and Practice.* Albany: Delmar Publishers.

Hodge, A. L. (1995). Addressing Issues of Sexuality with Spinal Cord Injured Persons. *Orthopaedic Nursing*, 14 (3): 21 – 24.

Latham, M.C. (1997). *Human Nutrition in the Developing World*. Rome: Food and Agriculture Organisation of the United Nations.

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review,* 50, 370-396. Retrieved August 2000, from http://psychclassics.yorku.ca/Maslow/motivation.htm

Rosdahl, C. B. (Ed). 1995. Optimum Health for All People; *Textbook of Basic Nursing*. Philadelphia: J.B. Lippincott Company.

UNIT 3 HEALTH AND HUMAN NEEDS II

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Esteem and Self-Esteem Needs
    3.2 Self Actualisation Needs
    3.3 Theories of Human Needs
    3.4 Criticisms of Maslow's Theory of Needs
    3.5 Application of Basic Needs Theory
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

The preceding unit opens the discussion on the universality of needs and the relationship between health and human needs but fail to address all aspects of this all-important issue. The present unit is therefore a continuation of that discourse. The unit particularly examines esteem needs, self-actualisation needs, Maslow hierarchy of human needs and other theories of human needs.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- differentiate between the esteem needs and self-actualisation needs
- discuss the Maslow hierarchy of needs
- describe what is meant by hierarchy of needs
- discuss Maslow Hierarchy of Needs and other Needs Theories
- examine the flaws of Maslow Hierarchy of Needs
- discuss the clinical and other applicability of Basic Needs Theory.

3.0 MAIN CONTENT

3.1 Esteem and Self-Esteem Needs

The term self-esteem (self-image, self-respect, self-worth) is related to the person's perception of self / personal feeling of self-worth and recognition or respect from others. All people in every society (with a few pathological exceptions) have a need or desire for a stable, firmly based (i.e. soundly based upon real capacity), usually high evaluation of themselves, for self-respect, or self-esteem, and for the esteem of others. This is because self-respect and dignity are essential to the psychological well-being of individuals who have reached some degree of satisfaction in the first three levels of human needs. Cox (1995) declared that a change in roles whether anticipated (for instance retirement), or sudden such as injury, may threaten self-esteem. Similarly, changes in body image whether obvious like amputation or hidden (e.g. hysterectomy) may also influence self-esteem. Cox (1995) stressed further that it is not the magnitude of the change or role that affects self-esteem, but rather how the person perceives the self after the change.

Esteem and Self-Esteem needs are met when the person thinks well of himself or herself (achievement, adequacy, competence, confidence) and is well thought of by others (recognition, status awards, prestige) (Rosdahl 1995). When both of these needs are met, a person feels self-confident and useful but thwarting of these needs produces feelings of inferiority, of weakness and of helplessness. These feelings in turn give rise to either basic discouragement or else compensatory or neurotic trends (Maslow, 1970). Consequently, indications of unmet needs for self-esteem include a feeling of helplessness/hopelessness/inferiority complex and becoming self-critical or unusually lethargic or apathetic about anything involving self, including appearance. In Cox (1995) words, a person feeling the lack of esteem of other people may test others by making such statements that call for their approval or praise, or may act in a way that prevents such approval if little self-esteem is present and the person is certain of failure.

Nursing intervention in cases of low self-esteem begins right from admission or first contact with the client/patient. The nurse can assist client/patient to regain positive self-esteem by conveying a feeling of acceptance and respect, employing a non-judgmental approach in handling the values and beliefs of the client/patient, encouraging independence, rewarding progress, allowing the client/patient to do as much self-care as possible, and tailoring specific nursing actions towards the root cause of the altered self-concept. But if patients' self-esteem is

so low that they fail to care for themselves, the nurse assumes total responsibility for meeting those other needs while taking steps to increase self-esteem (Rosdahl 1995; Cox, 1995).

3.2 Need for Self-Actualisation

This term, first coined by Kurt Goldstein refers to the desire for self-fulfillment, namely, to the tendency for him to become actualised in what he is potentially. This tendency might be phrased as the desire to become more and more what one is, to become everything that one is capable of becoming. They are more ego oriented in nature and frequently express themselves in highly independent behaviours. However, the clear emergence of these needs rests upon prior satisfaction of the physiological, safety, love and esteem needs. That is, even if all aforementioned needs are satisfied, we may still often (if not always) expect that a new discontent and restlessness will soon develop, unless the individual is doing what he is fitted for. A musician must make music; an artist must paint, a poet must write, if he is to be ultimately happy. What a man *can* be, he *must* be (Maslow, 1943). It must however be stressed that the specific form that these needs will take, will of course vary greatly from person to person. In one individual it may take the form of the desire to be an ideal mother, in another it may be expressed athletically, and in still another it may be expressed in painting pictures or in inventions. It is not necessarily a creative urge although in people who have any capacities for creation it will take this form.

Present needs, environment, and stressors influence how well people meet their need for self-actualisation. As a matter of fact, many psychologists believe that people continue striving to reach this level in life and very few people believe that they are self-actualised. Self-actualised individuals have mature multidimensional personality, frequently they are able to assume and complete multiple tasks, and the achieve fulfillment from the pleasure of a job well done. They do not totally depend on opinions of others about appearance, quality of work, or problem-solving methods. While it is true that they may have failings and doubts, they generally deal with them realistically (Cox, 1995). However, self-actualisers may focus on the fulfillment of this highest need to such an extent that they consciously or unconsciously make sacrifices in the fulfillment of the lower level needs.

Illness, injury, loss of loved one, change in role, change in status can threaten or disturb self-actualisation sometimes manifesting in behavioral changes. The gal of nursing care is to assist individuals to reach their fullest potential. As such nursing care is planned to encourage individual

to make decisions when possible, particularly those that concern his health. Because the self-actualised person tends to be creative, nursing care should give room for expression of creativity as well as encouraging the individual to continue with specific projects. And since the healthy self-actualised person generally has a strong need for privacy, the patient's need for privacy must be respected (Cox, 1995).

SELF-ASSESSMENT EXERCISE

What is the positive link of esteem and self-esteem needs?

Theories of Human Needs

Quite a number of theories have been propounded on human needs but prominent among them are the Maslow Hierarchy of Needs and the Alderfer's Existence/Relatedness/Growth (ERG) Theory of Needs.

(a) Maslow Hierarchy of Needs

Abraham Harold Maslow was a renowned psychologist and philosopher who lived between April 1, 1908 and June 8, 1970. He was a scholar and was referred to as the father of humanistic psychology. In 1943, Abraham H. Maslow observed and concluded that:

- Needs are hierarchical in nature. That is, each need has a specific ranking or order of obtainment.
- The need network for most people is very complex, with a number of needs affecting the behaviours of each person at any point in time.
- People respond to these needs in a progressive manner from simple physiological needs (survival needs) to more complex (aesthetic) needs; and that they do so as whole and integrated beings.
- When one set of needs is satisfied, it seizes to be a motivator.
- Lower level need must be satisfied in general, before higher level needs are activated sufficiently to drive behaviour.
- There are more ways to satisfy higher level needs than there are for lower level needs

Consequently, he identified various needs that motivate behaviour and place them in sequential hierarchy or graded order according to their significance to human survival i.e. in ascending order from lowest to the highest needs. He posited that that the basic needs of all people regardless

of age, sex, creed, social class, or state of health (sick or well) could be categorised into five levels:

Physiological: hunger, thirst, bodily comforts, etc.;

- **Safety/Security:** the need for structure, predictability, out of danger, free from harm, feel safe and secure;
- **Belongings and Love:** the need to be accepted by others and to have strong personal ties with one's family, friends, and identity groups;
- **Esteem:** the need to achieve, be competent, gain approval and recognition; and
- **Self-Actualisation:** the need to find self-fulfillment and reach one's potential in all areas of life;

Maslow's needs pyramid starts with the basic items of food, water, and shelter. These are followed by the need for safety and security, then belonging or love, self-esteem, and finally, personal fulfillment (Self-Actualisation). According to him, the first level needs, which are physiologic, occupying the bottom of the pyramid/ladder, are the most important as they are activities needed to sustain life such as breathing and eating.

Fig 3 – 1 Schematic Representation of Maslow Hierarchy of Needs



Source: Adapted from Dr. C. George Boeree (2004) Abraham Maslow. Available on

http://www.ship.edu/~cgboeree/maslow.htm

Each higher level represents one of lesser importance to human existence than the one previous to it. Maslow believed that it is when a particular physiological need is met with relative degree of satisfaction that other

needs of lesser importance to human existence take precedence. However, by progressively satisfying needs at each subsequent level, people can realise their maximum potential for health and well-being (Timby, 1996).

(b) Alderfer's Existence/Relatedness/Growth (ERG) Theory of Needs

The ERG Theory of Clayton P. Alderfer is a model that appeared in 1969 in a Psychological Review article entitled "An Empirical Test of a New Theory of Human Need". In a reaction to Maslow's famous Hierarchy of Needs, Alderfer, an American Psychologist, postulated that there are three groups of human needs that influence workers' behavior; existence, relatedness, and growth. These three needs categories are:

- **Existence -** This group of needs is concerned with providing the basic requirements for material existence, such as physiological and safety needs. (Maslow's first two levels). This need is satisfied by money earned in a job so that one may buy food, shelter, clothing, etc.

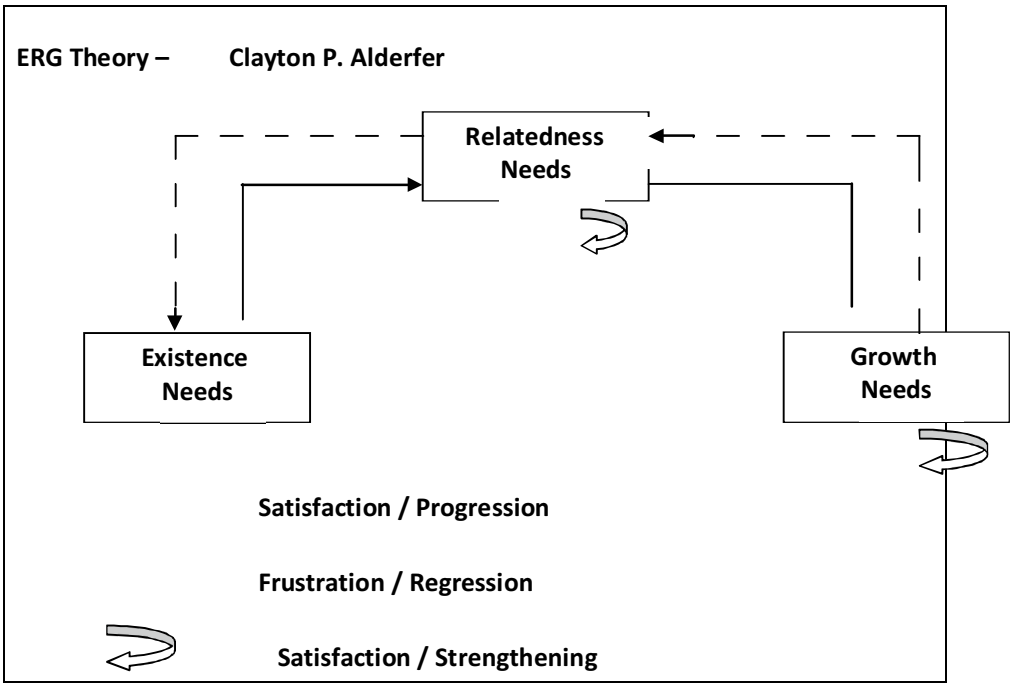
- **Relationships** - This group of needs center upon the desire to establish and maintain interpersonal relationships i.e. social and external esteem (involvement with family, friends, co-workers and employers) (Maslow's third and fourth levels.

- **Growth** – This encompasses internal esteem and self-actualisation (desires to be creative, productive and to complete meaningful tasks) (Maslow's fourth and fifth levels). These needs are met by personal development. A person's job, career, or profession provides significant satisfaction of growth needs.

Contrarily to Maslow's idea that access to the higher levels of his pyramid required satisfaction in the lower level needs, Alderfer declared that the three ERG areas are not stepped in any way. ERG Theory recognises that the order of importance of the three Categories may vary for each individual. Managers must recognise that an employee has multiple needs to satisfy simultaneously. According to the ERG theory, focusing exclusively on one need at a time will not effectively motivate. In addition, the ERG theory acknowledges that if a higher-level need remains unfulfilled, the person may regress to lower level needs that appear easier to satisfy. That is, if the gratification of a higher-level need is frustrated, the desire to satisfy a lower level need will increase. Alderfer identifies this phenomenon as the "frustration & shy aggression

dimension." This frustration-regression dimension affects workplace motivation. For example, if growth opportunities are not provided to employees, they may regress to relatedness needs, and socialise more with co-workers. The relevance of this on the job is that even when the upper-level needs are frustrated, the job still provides for the basic physiological needs upon which one would then be focused. If, at that point, something happens to threaten the job, the person's basic needs are significantly threatened. If there are not factors present to relieve the pressure, the person may become desperate and panicky (Alderfer, 1969).

Fig 3 – 2 Schematic Presentation of Alderfer's ERG Theory of Needs



Source: Adapted from http://www.valuebasedmangement.net/methods_alderfer_erg_theory.html

(c) Other Theories of Needs: A Summary

Huitt (2004) in what looks like a review of literature captures other scholars' contribution to 'Need Theory' as follows:

"Contrary to Maslow's categorisation of needs, James (1892/1962) hypothesised that there are three levels of needs namely: material (physiological, safety), social (belongingness, esteem), and spiritual. Mathes (1981) while agreeing with the three-tier categorisation of needs

proposed that the three levels were physiological, belongingness, and self-actualisation; he considered security and self-esteem as unwarranted. Ryan & Deci (2000) also suggest three needs, although they are not necessarily arranged hierarchically: the need for autonomy, the need for competence, and the need for relatedness. Thompson, Grace and Cohen (2001) submitted that the most important needs for children are connection, recognition, and power. Nohria, Lawrence, and Wilson (2001) provide evidence from a sociobiology theory of motivation that humans have four basic needs: (1) acquire objects and experiences; (2) bond with others in long-term relationships of mutual care and commitment; (3) learn and make sense of the world and of ourselves; and (4) to defend ourselves, our loved ones, beliefs and resources from harm. The Institute for Management Excellence (2001) suggests there are nine basic human needs: (1) security, (2) adventure, (3) freedom, (4) exchange, (5) power, (6) expansion, (7) acceptance, (8) community, and (9) expression".

As rightly noted by Huitt (2004), a common trait or regular feature of all these theories however is bonding and relatedness. Notice that there do not seem to be any other that are mentioned by all theorists. Franken (2001) suggests this lack of accord may be a result of different philosophies of researchers rather than differences among human beings. In addition, he reviews research that shows a person's explanatory or attributional style will modify the list of basic needs. This possibly explains why Huitt (2004) concluded that it will seem appropriate to ask people what they want and how their needs could be met rather than relying on an unsupported theory.

3.3 Criticisms of Maslow's Theory of Needs

Maslow concept of needs had been subjected to considerable research. For example, in their extensive review of research that is dependent on Maslow's theory, Wabha and Bridwell (1976) found little evidence for the ranking of needs that Maslow described or even for the existence of a definite hierarchy at all but rather are sought simultaneously in an intense and relentless manner. Other needs theorists have perceived human needs in a different way -- as an emergent collection of human development essentials (Marker, 2003). Some have contended that Maslow does not mention time period between various needs and that people do not necessarily satisfy higher order needs through their jobs or occupations. Besides, the concept of self-actualisation is considered vague and psychobabble by some behaviourist psychologists. They asserted that the concept is based on an aristotelian notion of human nature that assumes we have an optimum role or purpose. In their words, 'self actualisation is

a difficult construct for researchers to operationalise, and this in turn makes it difficult to test Maslow's theory. Even if self-actualisation is a useful concept, there is no proof that every individual has this capacity or even the goal to achieve it'. Other counter positions suggest that satisfaction which Maslow viewed as a major motivator has been found not to be directly related to production which is main goal of the manager.

3.4 Application of Basic Needs Theory

Huitt (2004) citing the works of Norwood (1999) submitted that Maslow Hierarchy of needs could be used to describe the kinds of information that individuals seek at different levels. For example, individuals at the lowest level seek coping information in order to meet their basic needs. Information that is not directly connected to helping a person meet his or her needs in a very short time span is simply left unattended. Individuals at the safety level need helping information. They seek to be assisted in seeing how they can be safe and secure. Enlightening information is sought by individuals seeking to meet their belongingness needs. Quite often this can be found in books or other materials on relationship development. Empowering information is sought by people at the esteem level. They are looking for information on how their ego can be developed. Finally, people in the growth levels of cognitive, aesthetic, and self-actualisation seek edifying information.

Maslow's theory of human needs has also gain a universal application in nursing care of patients/clients of all ages. It wide applicability in nursing is predicated upon the fact that illness often disrupt patients the ability to meet needs on different levels, hence patients/clients come up with many needs. It should however be noted that Maslow's hierarchy is a generalisation about the need priorities of most but not all people. As such when the nurse applies this theory in practice, the focus should be on the needs of the individual rather than rigid adherence to Maslow's hierarchy. In all cases, an emergency physiological need takes precedence over a higher-level need. However, the need for self-esteem may be a higher priority than a long-term nutritional need for one patient/client, whereas for another person, the reverse may be the case. Furthermore, although the hierarchy of needs suggests that one should be met before the other, nursing care often addresses two or more at the same time. As Cox (1995) suggests the provision of most effective nursing care therefore entails an understanding on the part of the nurse, the relationship among different needs for the individual. Indeed, in some nursing situations, it is unrealistic to expect a patient's/clients basic needs to be fulfilled in the fixed hierarchical order. The example given by Cox (1995) of a person who possibly enters the health care system as a result of chronic

respiratory infection but presents with multiple related unmet needs for nutrition, sleep, etc. aptly buttress this assertion. Nursing care in this situation will not simply be directed at meeting the respiratory needs but will be directed at resolving the pressing/life threatening needs while simultaneously addressing the higher level needs.

SELF-ASSESSMENT EXERCISE

Sketch a diagrammatic representation of Abraham Maslow's Hierarchy of needs**.**

It should also be noted that for different individuals, needs on different levels may be related in different ways. Some people may give sexual need a higher priority than the need for love, whereas for others, sexual need is deferred until the need for love is met. Similarly, people with unmet needs for self-esteem may be unable to seek fulfillment of the need for love if their self- esteem is so low that they feel inferior and fear rejection. In these and many other ways, needs on different level may be closely related for individuals. When assessing needs and planning care, the nurse must not assume that lower–level need always takes priority. As with all other aspects of providing care, the nurse individualises the nursing care plan to provide for the unique needs and desires of the patient / client (Cox, 1995). Factors influencing need priorities include: (a) A person's personality and mood. For instance, a depressed person may react negatively to a suggestion for an activity that could increase self-esteem, although in another mood the person might respond with enthusiasm. Thus, when providing care to help meet several needs, the nurse can adjust the care plan to correspond most effectively to the patients/client's personality and mood. (b) The health status of the client/patient. A frail looking anaemic patient for example, should not be encouraged to resume physical activities related to need for self-esteem until need for physical safety and security have been met. (c) Socio-economic status and cultural background – this affects a person's perception of needs.

To make any meaningful impact in meeting the hydra-headed needs of clients/patients, the nurse must therefore take into consideration all the aforementioned factors. In addition, in view of the interrelatedness of needs (e.g. if nutritional needs are not met for a long time, the person not only begins to grow lean and malnourished but also become deficient in meeting safety, love and self-esteem needs.

4.0 CONCLUSION

In conclusion, the human needs theory, no doubt, is a set of concepatients important for the nurse understanding of health and illness and the patient's/client's position on the health-illness continuum. Nonetheless, the nurse must as a necessity consider the uniqueness of each individual, their need References/Further Reading/Further Reading and the significance of each need in prioritising nursing care.

5.0 SUMMARY

The unit is a follow up of the discussion on health and human needs. You must have observed that it discussed the esteem and self-actualisation needs with particular reference to how nurses could assist patients/clients to meet these needs. The unit also incorporates a comprehensive discourse of the Maslow hierarchy of needs with its flaws/ weaknesses and other need theories. You also noted that the unit acknowledges that Maslow hierarchy of needs is a theoretical representation of the need priorities of most people and not all people and therefore cautioned that when the nurse applies this theory in practice, the focus should be on the needs of the individual rather than rigid adherence to Maslow's hierarchy.

6.0 TUTOR-MARKED ASSIGNMENT

1. Write an essay on Maslow's Hierarchy of needs**.** Discuss the application of Maslow's Hierarchy of Needs in a clinical setting.
2. What is its criticism?

7.0 REFERENCES/FURTHER READING

Alderfer, C. P. (1969). *Existence, Relatedness, and Growth; Human Needs in Organisational Settings.* Retrieved from, http://www.valuebasedmangement.net/methods_alderfer_erg_theory.html

Boeree, C. George (2004). Abraham Maslow. Available on http://www.ship.edu/~cgboeree/maslow.htm

Cox, C.L. (1995). Health and Human Needs. In H. B. M. Heath (Ed). *Potters and Perry's Foundations in Nursing Theory and Practice*. Italy: Mosby, An Imprint of Times Mirror International.

Huitt, W. (2004). Maslow's Hierarchy of Needs. *Educational Psychology Interactive*. Valdosta, GA: Valdosta State University. Retrieved from, http://chiron.valdosta.edu/whuitt/col/regsys/maslow.html.

Marker, S. (2003). What Human Needs Are. In Beyond Intractability. Available on http://www.beyondintratability.org/m/human_needs.jsp

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review*, 50, 370-396. Retrieved August 2000, from http://psychclassics.yorku.ca/Maslow/motivation.htm

Maslow, A.H. (1970). *Motivation and Personality* (2nd ed.). New York: Harper & Row.

Norwood, G. (1999). Maslow's Hierarchy of Needs. *The Truth Vectors* (Part I). Retrieved May 2002, from http://www.deepermind.com/20maslow.htm.

Rosdahl, C. B. (Ed). (1995). Optimum Health for All People; *Textbook of Basic Nursing*. Philadelphia: J.B. Lippincott Company.

Timby, B.K. (Ed). (1996). Health and Illness. Fundamental Skills and Concepts in Patient Care (6th ed.). Philadelphia: Lippincott.

Wahba, M. A. & Bridwell, L.G. (1976). Maslow Reconsidered: A Review of Research on the Need Hierarchy Theory. *Organisational Behaviour and Performance*, 15: 21 – 240.

UNIT 4 PROMOTING HEALTH

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Factors/Variables Affecting Health
    3.2 Defining Health Promotion and Illness Prevention
    3.3 Health Promotion Goals
    3.4 Behaviours that Promote Health (Healthy Habits)
    3.5 Nurses Role in Health Promotion and Illness Prevention
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

The popular axiom – prevention is not only better than cure but also cheaper than cure – cannot be more relevant than in today's world. This is because the recent past had witnessed more natural disasters than ever recorded. Emerging infectious diseases had been on the rampage with the resurgence of those hitherto eradicated communicable diseases, that have not only become more virulent but resistant to the simple therapeutic agents. All these coupled with the global economic recession and depreciation of currencies in many African states had compounded the already precarious level of people in the African nation. Therefore, health promotion becomes a veritable weapon to stem the all-time high morbidity and mortality rate that has been trailing the African nation.

Interestingly health promotion is an important component of nursing practice. Health Promotion as Kozier, Erb, Berman, & Burke (2000) puts it 'as a way of thinking that revolves around a philosophy of wholeness, wellness, and well-being.' Implicit in the above statement is that there is a level of commitment that should be displayed by the individual, community, organisation, and the government if the goal of health promotion is ever to be achieved. The role of each of this player and how the nurse can assist in health promotion therefore forms the focus of this unit.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- identify variables affecting health and explain the relationship between such and health
- define health promotion and distinguish it from illness prevention
- enumerate health promotion goals and discuss the levels of preventive care
- describe the behaviours that promote health
- discuss theoretical models of health and illness together with their assumptions
- differentiate health preventive or protective care from health promotion
- discusses the nurses' role in health promotion and illness prevention.

3.0 MAIN CONTENT

3.1 What Affects Health?

Health status of individuals in any community depends to a large extent on their level of awareness of factors that enhance and/or militate against their health. White (1998) contends that a great many things affect health. She groped them into four broad categories namely:

1. ***Genetic/Human Biology*** – It is not uncommon to hear that certain diseases run in families or have familial tendency. This is because human traits are transmissible from parents to offspring via the genes. Hence an individual genetic make-up to a large extent affects his state of health.

2. ***Personal Lifestyle/Behaviour*** – This is the area that exerts the most influence on health and well-being, and it is controlled entirely by the individual. As such it is the individual's decision whether these factors will promote health or lead to ill health. Although an increasing number of people are becoming aware of the relationship between health, lifestyle and illness, and are already developing health-promoting habits, but a sizeable proportion of the population are still naïve of this relationship. Simply put health promoting habits encompasses such things as: Diet, Exercise, Personal Care, Safe sex and Control sex, Tobacco and Drug use, Alcohol Consumption, and safety.

3. ***Environmental Influences*** – The aggregate of people, things, conditions, or influences surrounding man is what is referred to as the environment. It could be physical, biological or social. Man and his environment are constantly interacting. The environment influences man and man influences his environment at all times i.e. the relationship is never static but always changing. Interestingly, health and the quality of life are greatly affected by this interaction.

Human beings enjoy optimum functioning when the air they breathe, the food they eat, the houses they live in, indeed the neighbourhood in which they stay is of good quality. If they are bad, they tend to promote disease, disability and discontent. For instance, in metropolitan cities where domestic and industrial pollution is high, tarry particles, which contain cancer-producing chemicals, may exist. As such irritation to the eye and respiratory tissue may be rampant. In addition, overcrowding secondary to rural-urban migration and problems of population control enhances the spread of communicable diseases such as droplet infections. Besides, bad housing, lack of adequate facilities for the storage, preparation, and cooking of food are also intricately related to the development of malnutrition, poor growth and low immunity among people. Poor sanitation as well as lack of provision of drinkable water will also promote the spread of water borne disease with adverse consequences on healthy living.

It is also worth mentioning that technological advancement and industrialisation with its attendant problems has placed new stresses on man such as transport difficulties, noise, and loneliness. All these factors are associated with greater incidence of hypertension, mental disorder and suicide. Noise can produce alteration in respiration and circulation, in the basal metabolic rate, and in muscular tension. Even the fetus is affected by certain factors in the mothers' environment. For instance, the baby's well-being to a large extent depends on her mother's capability and knowledge of standard of hygiene, good nutrition, and avoidance of harmful substances e.g. some drugs.

4. ***Health Care*** – This encompasses such things as immunisation, regular examinations and screening tests, prophylactic medications, to mention a few that man undertakes to prevent invasion of disease causing organisms and prevent the body from breaking down. Failure to undergo such treatment could spell doom for the body with serious adverse consequences on healthy living.

3.2 Defining Health Promotion

The concepts of health promotion, self-care and community participation emerged during 1970s, primarily out of concerns about the limitation of professional health. Since then there have been rapid growth in these areas in the developed world, and there is evidence of effectiveness of such interventions states system although these areas are still in infancy in the developing countries (Bhuyan, 2004). The Ottawa charter, an important milestone in Health Promotion practice worldwide, defines Health Promotion as the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being (WHO Ottawa charter for health promotion, 1986). Consequently, the Ottawa charter noted that five key strategies for Health Promotion action are building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services). This no doubt, settles any storm about the genesis of Health Promotion but has not addressed what Health Promotion is all about and how it is different from illness prevention.

Health promotion and illness prevention are closely related concepts, and in practice, overlap to some extent. Activities for **health promotion** help the patients/clients maintain or enhance their present levels of health while activities for **illness prevention** protect patients/clients from actual or potential threats to health. Both types of activities are future orientated. The difference between them involves motivations and goals. Health promotion activities motivate people to act positively to reach the goals of more stable levels of health. Illness prevention activities motivate people to avoid declines in health and functional states (Cox, 1995).

Health promotion activities can be passive or active. With passive strategies of health promotion, individuals gain from the activities of others without doing anything themselves. The fluoridation of municipal drinking water, the fortification of salt with iodine and milk with vitamin D are common examples of passive health promotion strategies. The active health promotion strategies on the other hand, involves active participation of individuals i.e. individuals are motivated to adopt specific health programs. For instance, the weight reduction and smoking

cessation programmes require the patient/client to be actively involved in measures to improve their present and future levels of wellness while decreasing the risk of disease. Some health promotion and illness prevention programs are operated by health care agencies. Others are independently operated. Whichever, the point to be made is that health promotion and illness prevention activities are important to both the consumer and the health care provider (Cox, 1995).

The avian influenza (bird flu) that recently broke out in certain parts of Nigeria presents an excellent picture of the how there could be an interplay of actions among the major actors in the health sector. The avian influenza epidemics, being a deadly disease that can be transmitted to man, arouse the society concern about the disease. Being a communicable disease and one that affect poultry farming, it also arouses the interest of commercial organisations and agriculture. Besides it also has a political element, with potential global repercussions. The jobs and livelihood of some farmers and those within the food industry particularly the fast food centers are at stake. There is of course, the possibility of widespread trans-species infection. We can then appreciate the concerted efforts of the individuals, the organisation, the environment, the society, and the government (political). One cannot but therefore agreed with Kelly et al. (1993) that health cannot be effectively be promoted unless the organisational, social, individual, and environmental aspects are combined in an integrated approach.

3.3 Health Promotion Goals

Delaune & Ladner (1998) submitted the following as health promotion goals:

- Respect and support clients right to make decisions.
- Identify and use clients' strengths and assets.
- Empower clients to promote own health or healing.

Levels of Preventive Care

The three levels of prevention are:

- **Primary Prevention** – This is true prevention; it precedes disease or dysfunction and is applied to patients/clients that are considered physically and emotionally healthy (Cox, 1995). The goal is to decrease person's vulnerability to disease. It includes such activities as health education, immunisation/vaccination, personal and environmental hygiene, good nutrition, good

housing/avoidance of overcrowding, quarantine of suspects, and chemoprophylaxis.

- **Secondary Prevention** – Focuses on individuals who are experiencing health problems or illness or who are at risk of developing complications or worsening conditions. Activities are directed at diagnosis and prompt treatment, thereby reducing the severity and enabling the patient/client to return to normal health at the earliest possible time (Edelman & Mandle, 1990; Cox, 1995). Secondary prevention includes screening techniques and treatment of early stages of disease to limit disability or delay the consequences of advanced disease (Cox, 1995; Delaune & Ladner, 1998).

- **Tertiary Prevention** – Instituted when a defect or disability is permanent and irreversible. It involves minimising the effect of a disease or disability through such activities as rehabilitative nursing care for clients with permanent defect like blindness, to avert further disability or reduced function. The focus is to help clients reach and maintain their optimum level of functioning (Delaune & Ladner, 1998).

3.4 Behaviours that Promote Health (Healthy Habits)

Have you heard such phrase like habit is stronger than information? When we say something has become habitual, we mean it has become one's second nature; a regular way of behaving; a reflex action or instinctive response to a stimulus. Good health habits help to prevent disorder and/or enhance total wellness. On the contrary poor health habits will almost always adversely affect health status and individual's capability and efficiency. What then can we consider as healthy habits? The answer to this is obvious as practicing healthy habits cut across practically all aspects of our life viz:

Exercise: It's important for everyone to exercise, and we should all find the preventive maintenance fitness programme best suited for us. There is no alternative, nor substitute that increases the potential for a happier, healthier and improved quality of life. "If exercise could be packed into a pill, it would be the single most widely prescribed, and beneficial medicine in the nation," says Robert N. Butler, MD, director of the National Institute on Aging (DiMartino, 1999). Exercise is necessary to maintain muscle tone, to stimulate circulation and respiration, and to help control body weight. All people need some sort of exercise daily. A person's age, occupation and general condition help to determine the

appropriate amount and kind of exercise (Rosdahl, 1995). A moderate amount of daily exercise is better than occasional sports of strenuous activity. A study conducted by the Journal of Medical Association (JAMA, 277(16), April 23-30, 1997) included 11,470 women to determine the numerous benefits that ensues when a sedentary level is increased to merely a normal level – daily routine movement. The study revealed that the life preserving aspect of this minor change is huge" (DiMartino, 1999).

Nutrition and Diet: A First Cousin to Exercise. One without the other is like eating fries without catsup – it just doesn't work as well. A regular exercise regime means eating a balanced menu of foods, watching fat intake and supplementing the diet with nutrients and vitamins. However, when people exercise regularly, their diet must compensate for the extra calories burned. Although, individuals' nutritional needs vary, according to body build, age and activity, everybody needs certain nutrients to keep the body functioning and in good repair Eating regular and balanced diet and maintaining one's weight within the normal range are factors that contribute to wellness. Intake of salt, sugar, fat and red meat should be limited while liberal intakes of fruits, vegetables, and grains should be encouraged. Avoid alcohol consumption.

Elimination: The integumentary, respiratory, urinary and digestive systems are the organs primarily concerned with elimination of wastes from the body. Moderate intake of fibres in form of roughages (fruits and vegetables) supplies the bulk that stimulates proper adequate elimination of solids as faecal matter. Water intakes do assist the kidney in getting rid of liquid wastes. Avoidance of cigarette smoking and polluted air helps in preserving your lungs and your cardiovascular system (Rosdahl, 1995).

Sleep and Rest: Rest is soothing to the body. Most people need 7 – 8 hours' sleep per night. Sometimes after a day's work, rest is needed rather than sleep. Try lying relaxed and letting your thought drift. Some people find that meditation or 'emptying the mind of all thoughts' is restful (Rosdahl, 1995).

Personal Hygiene: Maintenance of personal hygiene is necessary for comfort, safety and well-being. Activities of personal hygiene are basic to normal functioning. Hygiene refers to practices that promote health through personally cleanliness and it is fostered through activities like bathing, tooth brushing, cleaning and maintaining fingernails and toenails, and shampooing and grooming hair. Such activities help to protect the body from infections, make a good impression on others, and

help to promote a positive self-image. For instance, regular bathing or cleansing removes perspiration oil, and pathogens from the skin. It also increases circulation and helps maintain muscle tone. Besides, bathing is refreshing; it can help wake one up in the morning and to induce sleep at night. Many a people shed their worries along with the day's accumulation of dirt by taking baths or showers. Grooming is equally important to one's well-being. Nails should be trimmed to comfortable length. Bitten nails are unsightly and may lead to infection. Shoes should be well fitted and comfortable. Clothes should be clean, well-fitting and comfortable too. They should be appropriate for the type of activity being performed. Dental care is also essential. Teeth to be brushed regularly and regular dental check-up encouraged. Fluorination of water to lessen tooth decay and consumption of food rich in calcium, phosphorus, vitamins A, C, and D for healthy and normal teeth formation and growth is expedient. The cutting down on consumption of sugary foods that is often overlooked is vital to the prevention of dental caries. While the eating of soft food is good, continuous eating of such foods affects the gums and teeth because chewing itself is needed to maintain the tone and holding power of the gums and the strength of the teeth. Eye care is another important aspect of personal care that must not be neglected in order to achieve full health. To this end, eyes examination should be done at least once a year.

Posture and Body Mechanics: Posture is the position of your body, the way its part line up when you stand, sit, move or lie while body mechanics is the term that refers to the use of the body as a tool. The way you stand, sit, or move affects your efficiency and the impression you create. Good posture improves your health saves your energy and prevents unnecessary muscle strains and back disorder (Rosdahl, 1995).

Safer Sex: The late twentieth century recorded an astronomical increase in the emergence and spread of deadly infectious diseases emanating primarily from unhealthy sexual practices. This informs the gospel of safer sex and the doctrine of ABC in the prevention of AIDS (Acquired Immune Deficiency Syndrome) and other sexually transmitted diseases. Safer sex involves carefully choosing one's sexual partner, mutual fidelity, and the use of condom where in doubt.

Healthy Environment: As earlier stated, man and his environment are constantly interacting. The environment influences man and man influences his environment at all times i.e. the relationship is never static but always changing. Interestingly, health and the quality of life are greatly affected by this interaction. It is sufficing to say "it is difficult to have optimum health if the environment is not safe."

Note: As beginning health care providers, nursing students are encouraged to develop their own health-promoting behavior to be better role models for clients.

3.5 Nurses' Role in Health Promotion, Health Protection, and Disease Prevention

It is an open truth that investment in the health sector is rapidly becoming an amalgam of public and private partnerships. While it is becoming increasingly glaring that the responsibility for health promotion does not lie with health sector alone, Watinson (2002) argued that nurses nonetheless have an unequal contribution to make to alliances created in the pursuit of health. Speaking in the same vein, Delaune & Ladner (1998) asserted that nurses play a key role in promoting health and wellness. Therefore, there is no doubt about the nurses' role in health promotion and disease prevention however the challenge before us as nurses is to find ways to motivate clients and families to develop health-promoting behaviours. This is against the background that health promotion is not simply something that is done to the client or patient, as in changing a dressing, but something that pervades the entire nursing care ranging from needs assessment, planning health gain to evaluating interventions and strategies for effectiveness and efficiency (Watkinson, 2002).

Delaune & Ladner (1998) identified health education/health counselling and motivation as two key components of health promotion strategies employed by nurses. Watkinson (2002) citing the English National Board's Higher Award (ENB, 1991) document observed the health promotion stands out as the 6th key characteristic of that document. Inherent in the said document (highlighted below), are salient features considered as essential to the performance of health promotion activities by nurses.

- Promote understanding of health promotion, preventative care, health education and healthy living.
- Understand and apply the principles and practice of health promotion in the work setting and create, maintain and take responsibility for a healthy work environment.
- Facilitate responsibility and choice among clients for healthy living, and their ability to determine their own lifestyles.

- Develop and implement strategies for health care based on understanding of the impact of health trends on resources.
- Consequently, Watkinson (2002) illustrated the many sided roles of the nurse in health promotion with this schematic diagram (Fig 3 – 1).

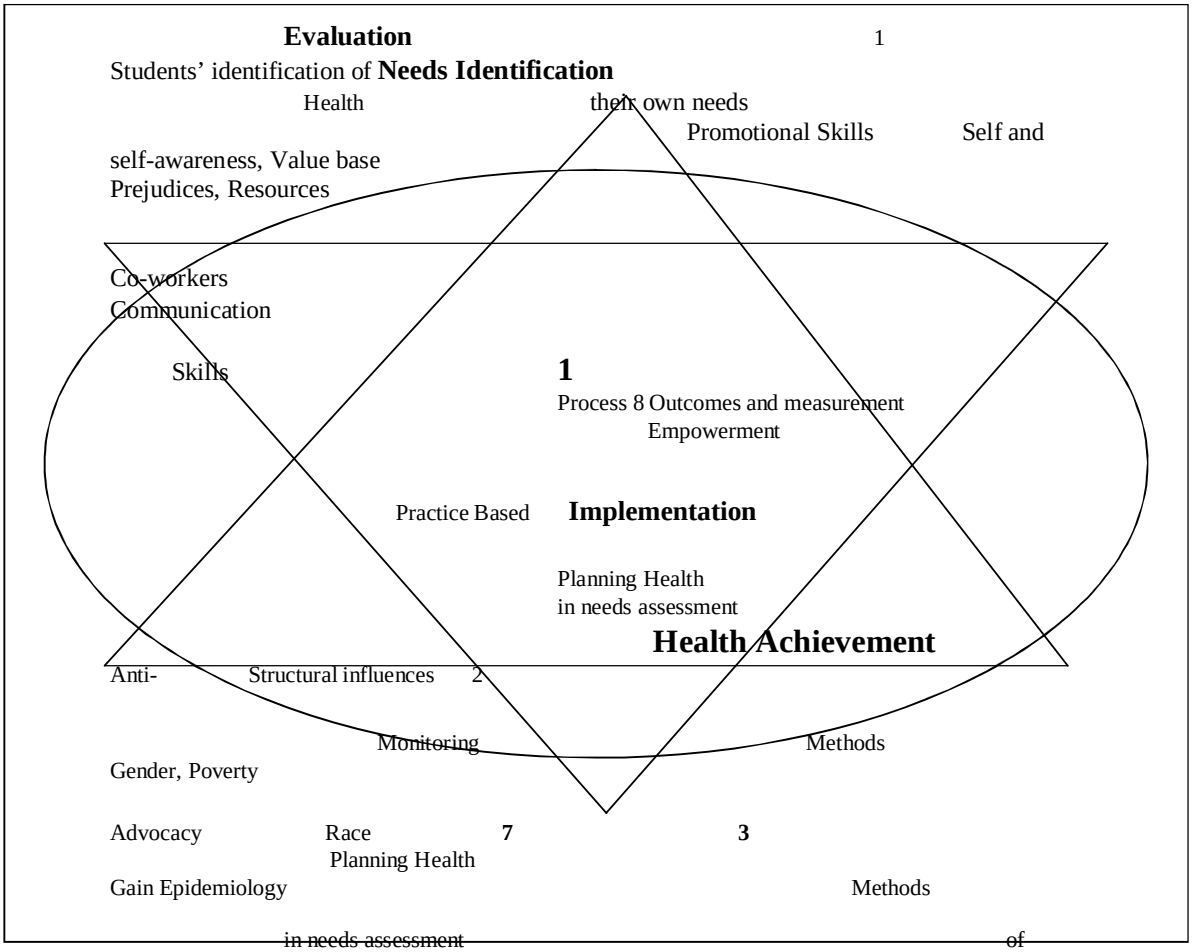


Fig 3.1 The Role of the Nurse in Health Promotion

Source: Watinson (2002). Promoting Health. In R. Hogston & P. M. Simpson (Eds). *Foundations of Nursing Practice; Making the Difference* (2nd ed.)

4.0 CONCLUSION

The issue of health promotion is an all-encompassing one. This unit has demonstrated on one hand the limitations of modern medicine and health care systems in single handedly improving the health status of the population. On the other hand, it emphasised the role of nurses as a key strategy for improving health through a holistic approach consisting of not only a medical dimension but also psychological, social and economic dimensions.

5.0 SUMMARY

The Ottawa charter, an important milestone in Health Promotion practice worldwide, defines Health Promotion as the process of enabling people to increase control over, and to improve, their health. You have noted that to reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Therefore, health status of individuals in any community depends to a large extent on their level of awareness of factors that enhance and/or militate against their health. However, good health habits help to prevent disorder and/or enhance total wellness. On the contrary poor health habits will almost always adversely affect health status and individual's capability and efficiency. As such nurses play a key role in helping clients to adopt healthy lifestyles and use approaches such as role modeling and formal teaching to motivate client change.

6.0 TUTOR-MARKED ASSIGNMENT

As a nurse in a remote village, you observed that majority of the pregnant women becomes anemic during pregnancy with frequent incidence of malaria in pregnancy, and besides, over 90% are already genitally mutilated. You initially focus on diet and reduction in malaria attack. How would you begin to design the program? What resources do you need?

7.0 REFERENCES/FURTHER READING

Bhuyan, K. K. (2004). Health Promotion through Self-Care and Community Participation: Elements of a Proposed Programme in the Developing Countries. BMC Public Health. 4: 11.

Cox, C.L. (1995). Health and Illness. In H. B. M. Heath (Ed). *Potters and Perry's Foundations in Nursing Theory and Practice*. Italy: Mosby, An Imprint of Times Mirror International.

Delaune, S. C. & Ladner, P.K. (Eds). (1998). The Individual, Health and Holism. *Fundamentals of Nursing, Standards and Practice*. Albany: Delmar Publishers.

DiMartino, C. (1999). Healthy Living: A Combination of Diet, Nutrition, and Exercise. *In Motion*, 9(6).

Edelman, C. L. & Mandle, C. L. (1990). Health Promotion throughout the Life Span (2nd ed.). St Louis: Mosby.

Kelly, M., Charlton, B & Hanlon, P. (1993). The FOUR LEVELS of Health Promotion: An Integrated Approach. *Public Health*, 107(5): 320.

Kozier, B.; Erb, G.; Berman, A.U. & Burke, K. (Eds). (2000). Health, Wellness and Illness. *Fundamental of Nursing: Concepts Process and Practice* (6th ed.). New Jersey: Prentice Hall, Inc.

Rosdahl, C. B. (Ed). (1995). Optimum Health for All People; *Textbook of Basic Nursing*. Philadelphia: J.B. Lippincott Company.

Watkinson, G. (2002). Promoting Health. In R. Hogston & P. M. Simpson (Eds). *Foundations of Nursing Practice; Making the Difference* (2nd ed.). New York: Palgrave Macmillan.

World Health Organisation (1986). Geneva: Ottawa Charter for Health Promotion.