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A Mixed Method Study to assess the Perception of Nursing Faculty on Uncivilized Behavior among Nursing Students

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Abstract

***Background*:** Uncivilized behavior is a concern in higher education especially in professional education and which is predominantly seen in Nursing and Medical education. However, most recently faculties have complained of a steady increase in more disturbing behavior such as yelling at faculty, and physical hostility. There is an area of significance, leading nurse educators to believe that the level and seriousness of incivility has increased and it is having impact on teaching and learning environment.

Objectives: (1) To assess the perception of nursing faculty on uncivilized behavior among nursing students. (2) To describe the lived experience of nursing faculty regarding uncivilized behavior among nursing students.

Methodology: Mixed method research approach with the embedded research design was used for study. Data was collected form 20 nursing faculties of Rajasthan. Non probability purposive sampling (criterion sampling) techniques was used for selecting the samples. Incivility in nursing education survey (INR-R) developed by Clark was used to assess the nursing faculty perception about the uncivilized behavior of nursing students.

Results: Findings related to assessment of level of disruption among students in classroom/clinical showed that majority of (56.56%) students had fall in to "Sometimes" level of disruption, (17.50%) belongs to "Usually" level of disruption.Findings related to assessment of faculty experience regarding threatening behavior of student's in classroom in past 12 months showed that the highest 80% of faculties were most frequently observed threatening behavior of students faced by the faculty were doing property damage by the students & general taunts or disrespects to others, lowest percentage (5%) and less frequently observed threatening behavior faced by the faculty were making inappropriate mails or message to the faculty and statements about having assess the weapons. Four themes emerged from the data were Factors contributing incivility among students, Types of student's incivility in classroom & clinical settings, Faculty incivility, Strategies for reduce incivility.

Conclusion: Nursing is a profession regarding humanity & caring aspects; inappropriate training or improper lifestyle or uncivilized behavior will affect the human life & professional life. Hence teachers are having a contributory role to assess and limit the incivility among their students.

Keywords: Mixed Research; Assess; Perception; Nursing faculty; Uncivilized behavior; Nursing student.

Introduction

Nursing education is the formal learning and training to promote team based interprofessional health care which includes roles and responsibilities in the physical, emotional, and spiritual care of patients, as well as a mix of disciplines that helps the patient

recover and maintain his or her health.[1]

When politeness is the only thing that connects us to others, incivility takes on a new meaning. Incivility exists in many aspects of society, obstructs effective communication, and has negative consequences for interpersonal relationships and the learning environment.[2]

Uncivilized behavior is a concern in higher education especially in professional education and which is predominantly seen in Nursing and Medical education. This serious concern of incivility is seen as different forms such as use of offensive language, impolite behavior, hostility behavior in campus, malpractices during examinations, inattention in classes, absenteeism etc.[3]

Uncivilized behavior is defined as rude or disruptive behavior which include lack of courtesy, rudeness of manners and impoliteness or behavior which may range from misuse of cell phones, sarcastic comments that disrupts the teaching-learning environment and often result in psychological and physiological distress of the people involved and if left unaddressed may progress to threatening situation.[4]

Natarajan J, Muliira JK, Van der Colff J(2017) conducted a quantitative cross sectional survey on incidence and perception of nursing students, academic incivility in Oman. The data was obtained from a sample of 155 nursing students and 40 nursing faculty using the incivility in nursing education survey. The finding showed that the most common uncivil behaviors were acting bored or apathetic in class, holding conversations that distract others in class, using cell phones during class, arriving late for class, and being unprepared for class. There were significant differences between Nursing faculty and Nursing students perceived incidence of uncivil behaviors such as sleeping in class ($p = 0.016$); not paying attention in class ($p = 0.004$); refusing to answer direct questions ($p = 0.013$); leaving class early ($p = 0.000$); cutting or not coming to class ($p = 0.024$); and creating tension by dominating class discussions ($p = 0.002$).[5]

With the professional and personal experiences, the investigators felt that incivility is an area of increased concern in nursing education. Many times nursing educators complain about uncivilized behavior in their students which can weaken professional relationship and it can hinder teaching learning process. Uncivilized behavior can be minimized if proper action has taken by nurse educators. Uncivilized behavior can cause physical and psychological illness. There is lack of empirical studies on uncivilized behavior among nursing students in Indian scenario. Hence the investigators felt that it is an emerging issue in nursing education to look at phenomenon of incivility among nursing students from nursing faculties' perspectives.

Methodology

Mixed method research approach with Embedded research design was used in present research. Quantitative data was embedded within a qualitative methodology in the design.Phase one of the study was formed by quantitative paradigm by using non experimental, descriptive, exploratory approach. Phase two of the study was formed by qualitative paradigm using phenomenological approach.The present study was conducted in Rajasthan. The sample for the present study was nursing faculty who are working in Rajasthan. Non-probability purposive sampling (Criterion sampling) technique was used for the present study. Since the study is predominantly focused on qualitative approach, hence the sample size was 20. Nursing faculties who were having minimum 1 year of teaching experience was included in the study.

The tool consisted of section A included baseline variables such as age, gender, qualification, teaching experience, designation, classes conducted, teaching program, number of students etc, Section B included incivility in Nursing Education Survey developed by Clark Revised 2010 (INE-R)[6] which consisted of nursing faculty perception about uncivilized behavior of nursing students and list of student behavior. Section C was consisted of open ended questions about their live experience with incivility in nursing education. Institutional ethical approval was obtained and data was collected from Institutional Ethical and Research Committee. Data was collected through semi structured questionnaire and direct interview as it included open ended questions as well. Data was collectedfrom 2nd January to 23rd January. In phase 1 ie quantitative analysis, data was analyzed by using descriptive statistics. In phase 2, ie qualitative analysis, data was analyzed by using Coloizzi's method. The data was organized and transcribed. Each statement were read and significant statements were extracted and spelt out the meaning of each significant statements (i.e formulate meanings). Finally the formulated meanings were organized into cluster of themes and subthemes.

Results

Description of baseline variables

Highest percentage (70%) were in the age group of 26-30 years, majority of (70%) faculties were male,

maximum of them had qualified M.Sc. Nursing (45%), highest percentage (55%) were having 1-3 years of teaching experience, maximum (50%) of them were tutors, maximum (85%) the faculty were teaching B.Sc. Nursing course, majority (85%) of them had worked previously in 1-2 institution, maximum(75%) faculties had 5-10 hours of classes per week.

Assessment of faculties experience regarding student's incivility in classroom.

a. Level of disruption among students in classroom/ clinical.

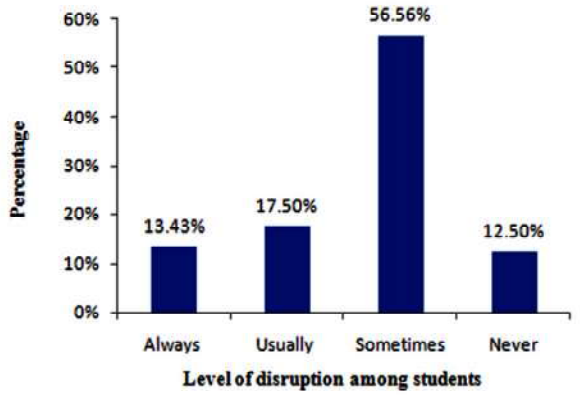

Fig. 1: Bar diagram showing percentage wise distribution of level of disruption among students in classroom/clinical.

Percentage wise distribution of level of disruption among students in classroom/clinical showing that highest percentage (56.56%) had fall in to **"Sometimes"** level of disruption, (17.50%) belongs to **"Usually"** level of disruption, (13.43%) had fall in **"Always"** level of disruption and only (12.50%) faculty said they **"Never"** felt level of disruption.

b. Uncivilized behavior of students experienced by faculty in past 12 months.

Table 1: Table showing percentage wise distribution of uncivilized behavior of students experience by faculty in past 12 months

N=20

Items	O	U	S	N
Acting bored or apathetic	0%	30%	70%	0%
Making disapproving groans	0%	40%	55%	5%
Making sarcastic remarks or gestures (staged yawning, eye rolling)	5%	25%	55%	15%
Sleeping in class	5%	35%	40%	20%
Not paying attention in class (doing work for other classes, reading a newspaper, not taking notes)	10%	30%	45%	15%
Holding conversation that distract you or other students	15%	25%	40%	20%
Refusing to answer direct questions	0%	25%	50%	25%
Using computer during class for purposes not related to the class	0%	0%	25%	75%
Using cell Phone during Class	10%	25%	25%	25%
Arriving late for class	10%	30%	50%	10%
Leaving early class	5%	15%	55%	25%
Cutting class	5%	20%	60%	15%
Being unprepared for class	15%	20%	60%	5%
Cheating on Exams or quizzes	10%	30%	50%	10%
Demanding make up exam, extensions grade changes or Other special favors	0%	15%	80%	5%

*O= Often, U= Usually, S= sometime, N= Never

Table No. 1 showed about the uncivilized behaviors exhibited by students in the last 12 month according to faculty experience showed that 15% of them often hold conversations that distracts, being unprepared for the class & creating tension by dominating class discussion, 40% were usually making disapproving groans and 35% were sleeping in the class.

c. Most frequent threatening behavior of student faced by faculty in classroom/clinical in past 12 months.

Table 2: Table showing percentage wise distribution of most frequent threatening behavior of student faced by faculty in classroom/clinical in past 12 months

N= 20

Threatening behaviors	Frequency	Percentage
General taunts or disrespect to other students	16	80%
General taunts or disrespect to faculty	15	75%
Challenges to faculty knowledge or credibility	9	45%
Harassing comments (racial, ethnic, gender) directed at students.	12	60%
Harassing comments (racial, ethnic, gender) directed at faculty	3	15%
Vulgarity directed at students	11	55%
Vulgarity directed at faculty	5	25%
Inappropriate emails / Messages to other Students	15	75%
Inappropriate emails/messages to faculty	1	5%
Threats of physical harm against other students	13	65%
Threats of physical harm against Faculty	6	30%
Property damage	16	80%
Statements about having access to weapons	1	5%

The **most frequently** (80%) observed threatening behavior of students faced by the faculty were doing property damage by the students & general taunts or disrespects to others and **less frequently** (5%) observed threatening behavior faced by the faculty were making inappropriate mails or message to the faculty and statements about having assess the weapons.

Qualitative analysis of description of lived perception & experience of nursing faculty regarding uncivilized behavior among nursing students.

Table 3: Table showing Thematic representation on uncivilized behavior among nursing students.

Emerging Themes	Subthemes
Factors contributing incivility among Students	Disruption in familial and social environment
	Negative impact of individuality
	Inappropriate relationship among peers
	Negative influence of faculty
	Poor managerial support and policy
Types of student's incivility in classroom & clinical setting	Unruly behavior in the classroom
	Misconduct behavior of student
	Malpractice in the exams
	Disregard to the faculty
	Negative attitude towards the institution
	Inappropriate behavior in clinical area
Faculty incivility	Undesirable behaviors towards the students in classroom & clinical
	Dysfunctional relationship with the staff
	Unreliable attitude towards the institution
	Unacceptable personality of faculty
Strategies to reduce incivility	Institutional plan of proposed action
	Faculties strategies
	Student's positive approach

Theme 1: Factors contributing incivility among students - Participants had experienced various factors that contribute incivility among students.

Subtheme 1.1 Disruption in familial and social environment : "*In my opinion the provoking factors of incivility among student is poor schooling of the students, inappropriate familial and cultural background, locality of the student can also add up to their uncivilized behavior as family is the basic area where the child are grown up.* (*Transcript no. 14, line no. 63-66, page no. 69*)"

Subtheme 1.2 Negative impact of individuality: Out of 20 faculties, 3 of them had said that frustration & inappropriate behavior of students were contributing uncivilized behavior.

Subtheme 1.3 Inappropriate relationship among peers: Out of 20 faculties, 14 had reported that bad company of peer group and peer pressure for wrong habits, attitude and behavior can lead to incivility. "*Another factor which can also contribute can be influence of wrong company of students & substance abuse among them.* (*Transcript no. 16, line no. 76-77, pageno.69)*".

Subtheme 1.4 Negative influence of faculty: "*According to my opinion the teacher must go in class with full preparation when the teacher is not ready & strict with the student, the students become uncivilized.* (*Transcript no.5, line no.21-23, page no.67*)"

Subtheme 1.5 Poor managerial support and policy:- "According to my opinion management supports for negative things & institutional poor disciplinary policy can provoke students to contribute incivility. (Transcript no. 4, line no. 19-20, page no.67)"

Theme 2: Types of student's incivility in classroom & clinical setting

Subtheme 2.1 Unruly behavior in the classroom: 16 faculties have revealed that student never show concentration in class, yawning and sleeping in class hours, checking mobile phone during class, act bored or apathetic, cheating in exam & property damage. "*In my opinion the other behaviors can be making disapproving groans, making sarcastic remarks or gestures and holding conversations that distract faculty or other students.* (*Transcript no. 3, line no. 120-121, page no.81*)"

Subtheme 2.2 Misconduct behavior of student: 10 of them have reported that the student were acting rude and being arrogant, aggressive & justify their mistake and not accepting their mistakes.

Subtheme 2.3 Malpractice in the exams: Majority of the faculty indicated that students did cheating in exams by various methods. "*In my opinion doing cheating in exams & using mobile phones in the washroom during the exams and in classroom are very commonly seen malpractice behavior.* (*Transcript no.2, line no. 109-111, page no.81*)"

Subtheme 2.4 Disregard to the faculty: "*In my point of view arguing with teacher, disrespect to female faculty and giving back answers commonly seen.* (*Transcript no. 2, line no. 108-109, page no.81*)" "*Even when the teacher asks something about the topic they don't reply to it and challenge the teacher's knowledge. (Transcript no.8, line no.155-156, page no.82*)"

Subtheme 2.5 Negative attitude towards the institution: "*In my point of view they do classroom & college property damage E.g. chair, table, switchboard, whiteboard and walls.* (*Transcript no. 2, line no. 115, page no.81*)"

Subtheme 2.6 Inappropriate behavior in clinical area: Majority of the faculty had said that student are using mobile phone in clinical and arriving late or bunk from the duty. "*In my opinion they are arguing with the staff nurse in clinical areas and being aggressive.* (*Transcript no. 2, line no. 113-114, page no. 81*)"

Theme 3: Faculty contributes to incivility within the academic environment.

Subtheme 3.1 Undesirable behaviors towards the students in classroom & clinical: Majority of the faculty also said that faculty handle the student with prior judgment, shares the management confidential decisions, misguide the students, connect with the students on social sites and enter in their personal life. Out of 20 faculties, 14 had said that faculty contribute to incivility by ignoring the students, not being very strict with the students, maintaining lack of discipline, using inappropriate words or language and doing partiality among the students in classroom & clinical. "*In my opinion they sometimes intentionally treat the student in bad ways and take revenge from them and also support the students in negative things and become too much friendly with the students.* (*Transcript no.2, line no. 251-253, page no. 104*)"

Subtheme 3.2 Dysfunctional relationship with the staff:- Faculties reported that they are disrespecting them, involve them in wrong activities, criticizing them, not helping the others and take advantage of others.

Subtheme 3.3 Unreliable attitude towards the institution: Majority of the faculty had reported that the faculty shows incivility towards management by showing negative attitudes towards the institution, misbehavior towards management and not following or obeying the orders and policy.

Subtheme 3.4 Unacceptable personality of faculty: "*In my opinion the other behavior among the faculty were they are not serious in upgrading themselves, having inappropriate dress sense and sometime using bad language in college premises.* (*Transcript no. 5, line no. 281-282, page no. 105*)"

Theme 4 : Faculty perception regarding strategies to reduce uncivilized behaviors

Subtheme 4.1 Institutional plan of proposed action:- Majority of the faculty have said that the managing strategies can be maintaining discipline & punctuality, feedback system for students & faculty, meditation, yoga, spiritual classes, recreational & educational visit, reward & the reinforcement to students for any good things and having a code of conduct. "*In my point of view disciplinary pattern should be followed to implement by college guidance and counseling can help the student to reduce incivility and regular parent-teacher meeting & faculty meeting should be organized. (Transcript no. 19, line no. 639-643, page no.136)" "In my opinion the managing strategies for reducing uncivilized behavior are providing guidance & counseling, providing behavioral & relaxation therapy, various co-curricular activities can be planned, recreational activities, role-play, discussion sessions and communication training. (Transcript no. 10, line no. 528-533, page no. 133)*"

Subtheme 4.2 Faculties strategies: "*In my opinion the managing strategies can be listen to students with a respectful manner, show empathetic behavior towards students and don't be preoccupied with thought.* (*Transcript no. 7, line no. 498-500, page no. 132-133)*".

Subtheme 4.3 Student's positive approach- Out of 20, 13 of the faculty had advised that the students should communicate with the teachers, follow the discipline, there should be no prior judgment of the faculty, code of conduct should be followed and students should believe on their teachers and should use civil language.

Discussion

The types of uncivilized behavior exhibited by the students according to faculty experience were 45% were usually doing cheating in exams, 95% were sometimes hold conversation that distract. The finding are also supported by another study conducted by Anil Sharma (2018) who found that 90.9% of nurse educators experienced frequent yawning by student in class 30% were cheating in exams & 80% of them experienced students talking to other students at inappropriate time or during session.[7]

Faculties experienced about 80% of students were doing property damage and general taunts or disrespect to other. The findings are also supported by another study conducted by Liang H, Flisher AJ, Lombard CJ(2007), the finding revealed that over a third 36.3% of students were involved in bullying behavior & property damage and 8.2% as bullies, 19.3% as victims and 8.7% as bully victims.[8]

Factors contributing incivility among studentswere Disruption in familial and social environment, Negative impact of individuality, Inappropriate relationship among peers, Negative influence of faculty & Poor managerial support and policy. The findings are supported by another study conducted by Vink H, Adejumo O(2015) on factors contributing to incivility amongst students at a South African nursing school indicated that the educators had varying but often similar perspectives on which factor contribute to incivility among nursing students. The three themes that emerged from the data were academic, psycho-pathological and social factors. Nurse educators probably often found it difficult to manage students' behaviours, as they would not be able to identify who the perpetrators were due to the high student numbers per class.[9]

Faculty incivility were another theme emerged in

the study in which the subthemes were Undesirable behaviors towards the students in classroom & clinical, Dysfunctional relationship with the staff, Unreliable attitude towards the institution & Unacceptable personality of faculty. The findings are also supported by another study conducted by Lasiter S, Marchiondo L, Marchiondo K (2011) on Student narratives of faculty incivility the narrative analysis about their "worst experience" of negative faculty behavior. Four categories were identified: "In front of someone," "Talked to others about me," "Made me feel stupid," and "I felt belittled."Incivility had a profound effect on students which causes academic pressure and interferes withtheir learning and safe clinical performance.[10]

Strategies for reduce incivilityin were Institutional plan of proposed action, Student's positive approach & Faculties strategies. The findings are also supported by other study conducted by Patrick J Morrissette (2000) on reducing incivility in the university/college, classroom who found that the strategies are effective communication skills. Spelling out academic & behavioral expectations in the syllabus, arranging for midterm teaching feedback, arranging for peer observation and review, establishing collaborative learning environment, setting a good example, reframing potential conflicts, establishing students grievance process and re-engaging students.[11]

Conclusion

These days incivility is growing faster and having greatest concern among students since from the childhood, if the child is having inappropriate upbringing by the parents, the parents having lack of awareness about the incivility and poor background of child affects the behavior of child. Recently more high tech approach is used by the student that affects their behavior and involved them in uncivilized behavior. Nursing is a profession regarding humanity & caring aspects; inappropriate training or improper lifestyle or uncivilized behavior will affect the human life & professional life. Hence teachers are having a contributory role to assess and limit the incivility among their students.

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Attitude of Nursing Teachers' Towards Virtual Classes During COVID 19

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Abstract

The world has immensely been affected due to outbreak of COVID-19. It forced shut down of all organisations and institutions, corporate, transportation everything, so as the educational institutions. In theabsence of traditional classroom teaching and one to one interaction, on-line teaching has emerged as a substitute. Educational institutions and students across the globe have accepted the online platform of learning. However, despite its multiple advantages there are certain limitations of e-learning.Some of the studies revealed that the students and teachers experienced much panic and anxiety, since e-learning has never been a formal mode of education before this ongoing pandemic.The current study was aimed to explore the attitude of nursing teachers towards virtual learning. The current study concluded that68% nursing teachers had positive attitude towards virtual classes thus the teachers not having a positive attitude is a matter of concern. There was significant association found between all three demographic profile of the nursing teachers such as gender, age and qualification and their attitude towards virtual class. Female teachers (75%) have more positive attitude towards virtual class than male teachers (43%). Age wise it was found that more the age, was more positive towards virtual classes. According to qualification more graduate teachers were having positive attitude towards virtual classes than post-graduate teachers.Majority of teachers disagree that conducting virtual classes from home is very comfortable and believe that virtual learning is not much effective in comparison to face to face learning method. Majority of the teachers also disagree about improvement of the quality of education through virtual sessions.

Keywords: Nursing; student; attitude; towards; virtual; classes; COVID.

Introduction

The COVID 19 pandemichas brought a dramatical change in the society. Education, environment and economy, everything got impacted. The outbreak of the pandemic, imposed partial or full time curfews around the world. Individuals are isolating themselves, working from home have been implemented in order to reduce the spreading of infection.

Within such measures, the education sector also has complied with the restrictions imposed. UNESCO has announced that 1.6 billion students, at all educational levels globally, are unable to continue their education (UNESCO, 2020).The education process completely transfers to digital media. The whole academic year in 2020 maintained digitally. Unlike traditional education, e-learning has many advantages that make e-learning environments. (Naved et al., 2017). However there are still deficiencies in the correct and responsible use of technology in the education sector during the COVID-19 pandemic.[1]

Sari and Nayir (2020) stated that parents and

teachers who were unprepared for distance education and e-teaching, during the COVID 19 they experienced difficulties in managing learning through such method. Teachers and students could not demonstrate the level of technology usage expected from them. Deshmukh (2020) stated in a similar study that the digital competence and skills needed in the pandemic process could not be obtained. Both educators, students and parents experience a panic in using online platforms.[1]

The current study conducted to assess the nursing teachers' attitude towards virtual classes conducted during the COVID pandemic.

Methodology

A cross sectional surveywas conducted among nursing teachers from selectednursing educational institutions across Jharkhand. Data collected during 1st of September to 30th of September 2021.

The dependent variable was attitude andindependent variable was virtual class. Nursing teachers werethe target population. A total of 93nursing teachers had participated in the study.

A validself-administered structured survey questionnaire was constructed in Google forms and made accessible through link.Convenient nonprobability sampling technique was used via instant messaging and social media and the connections were requested to share as much as they can within their connections.

The questionnaire has two parts socio-demographic profile and attitude towards virtual classes. Socio-demographic profile comprises of 3 items such as, gender, age and qualification.

To assess the attitude of nursing teachers towards virtual classes 17 items were developed. Each answer was scored on a Likert scale from 0 to 4in a way that, score 0 = strongly disagree, 1= disagree, 2=undecided, 3=agree and 4=strongly agree. The final score was obtained by summing the scores of all items. The higher score represents a positive attitude towards virtual classes. The total score between 0-17 represents a negative attitude, 18-34 not sure, and 35-68 represents positive attitude. The scale showed very good internal consistency and high positive correlation.

An informed consent briefly explaining the study objective was provided at the beginning of the questionnaire. Nursing teachers those who responded to the survey were assumed to have consented to participate in the study. No potential identifiers of the participants werecollected to maintain the confidentiality.

The collected data were analysed using the SPSS-26. Descriptive analysis such as frequencies, and percentages and chi-square tests used to determine the association between demographic profile and attitude. The statistical significance level was set at p = 0.05.

Result

Table 1: Attitude of nursing teachers towards virtual classes. n = 93

Attitude	Criteria Score	Frequency	Percentage
Positive	35 - 68	63	68
Neutral	18 - 34	30	32
Negative	0 - 17	0	0

Table showing 68% nursing teachers had positive attitude towards virtual classes.

Table 2: Association of attitude towards virtual classes and demographic profile n = 93

Demographic profile Variable	Total N(%) 93(100)	Attitude towards virtual classes Neutral n(%) 30(32)	Positive n(%) 63(68)	Chi square p Value
Gender				**0.006**
Female	72 (77)	18 (25)	54 (75)	
Male	21 (23)	12 (57)	9 (43)	
Age				**0.04**
30-39	69 (74.2)	27 (39)	42 (61)	
40-49	18 (19.4)	3 (17)	15 (83)	
50-59	6 (6.5)	0 (0)	6 (100)	
Qualification				**0.03**
Graduate	33 (35.5)	6 (18)	27 (82)	
Post-graduate	60 (64.5)	24 (40)	36 (60)	

There was significant association found between all three demographic profile such as gender, age and qualification of the nursing teachers and their attitude towards virtual class. In comparison to females (75%), less number of males (43%) have positive attitude towards virtual class.

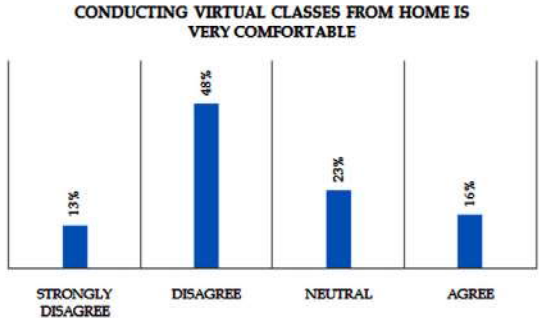

Fig. 1: Showing majority of teachers disagree that conducting virtual classes from home is very comfortable.

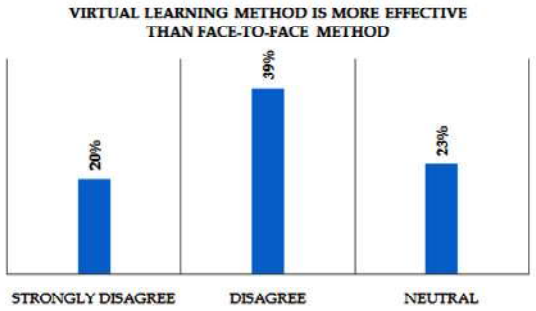

Fig. 2: Showing most of the teachers disagree about the effectiveness of virtual learning in comparison to face to face learning method.

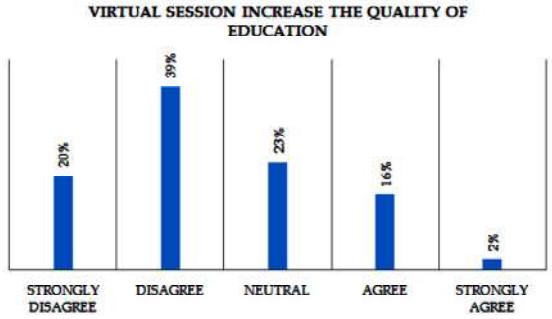

Fig. 3: Showing majority of teachers disagree with the statement that 'virtual sessions increase the quality of education'.

Discussion

Majority of nursing teachers 68% had positive attitude towards virtual classes. The finding has its support from the study conducted by Dalton H. Kisanga (2016), Sandra Kucina Softic (2015) and kumar Pawan (2017).[2-5] However the finding is in contrast to the finding of the study conducted by Kar Sankar (2020)6that indicates the attitude of the teachers towards online teaching is not satisfactory.

In the current study more female teachers (75%) had positive attitude towards virtual class than the male teachers (43%). The finding is contrast to the finding as observed by Gururaja Cs (2021)[7] and Sankar (2020)[6] whichshowed that male teachers develop a more favourable attitude toward online teaching than female teachers. The study conducted by Xhaferi, G., Farizi, A. and Bahiti, R. (2018)[8] reported that there was no significant correlation between teacher' attitudes towards various e-learning according to gender.

The study by Gururaja Cs (2021)[7] and Sankar (2020)6 also found that more experienced teachers show less interest in online teaching than less experienced teachers. This is in contrast to the finding of the current study, which shows more senior teachers have more positive attitude towards virtual classes.

There was significant association between all three demographic profile such as gender, age and qualification of the nursing teachers and their attitude towards virtual class. Similar findings reported by the study conducted byGururaja Cs (2021).[7]

However the finding is contrast to the finding of the study conducted by Chandwani, Sanjay; Singh, Nirmal; and Singh, Gurpreet (2021).[9] In the current study increased age found positive correlation with attitude towards virtual learning whereas the study conducted by Chandwani, Sanjay; Singh, Nirmal; and Singh, Gurpreet (2021)[9] reported negative correlation.

Implications

The findings draws attention towards the barriers that makes the online learning less effective and thus can help developing strategies to improve the experience of online teaching.

Recommendation

Further study can be replicated on a larger sample size for the deeper understanding of problems faced by teachers.Similar studies can be replicated in different settings and comparative studies can be done among teaching groups imparting teaching to various professional courses.

Limitations of the Study

Though the researchers tried best to get maximum response but the data collection became challenging. Thus, the results of the study have been confined to the 93 responses only.

Conclusions

E-platform was a great measure during the pandemic for solving and reducing the academic gap, which would have arisen otherwise.The nursing teachers started adapting themselves to the changed virtual academic scenario. Since the online teaching is in infancy stage in the India, primarily due to COVID-19, there will be a need to strengthen the digital culture and infrastructure.

Declarations

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Disaster: Role of Regulatory Agencies, NGOs, Citizens and Nurses

Seema Rani

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Abstract

A disaster is a phenomenon which disrupts the normal environmental conditions required for normal existence and causes enormous sufferings beyond the capacity of adjustment of the affected community. As per origin, disasters are classified into natural and man-made disasters and as per impact, minor or major. There are physical, social, economic and psychological impacts of disaster. There are differential impacts of disaster on vulnerable groups like children, elderly, women and physically and mentally challenged people. Disaster cycle has many phases namely; preparedness, impact and rescue, relief, response, recovery, rehabilitation and mitigation. The Disaster Management Act provides directions for effective management of disasters. Primary focus of this act is to prepare, prevent and plan well ahead of the disaster. This act aims to provide the effective management of all aspects pertaining to disaster. The local community usually responds first and calls for help in any disaster. Local community best knows its resources, traditional knowledge of coping with such events in the past and relevant counter measures regarding disaster management. There are various ways by which well informed citizens can reduce the fear, anxiety, and losses that are bound to occur after a disaster. Nurses play an important role in all phases of disaster-cycle. Nurse makes and leads the preparedness plan. Nurse participates in triage and first aid of the disaster victims. She plans for recovery and rehabilitation of the affected people. She also collaborates with other disciplines, governmental and non-governmental agencies.

Keywords: Disaster; Disaster cycle; Role of nurses; Classification of disasters; Impact of disasters.

Introduction

Disasters have been integral parts of the human existence since the beginning of time, causing untimely death, loss and damage of property and altered health status. In addition to the natural disasters, wars, acts of aggression, use of biological weapons and the terrorist attacks leave grave imprint on humanity.

The origin of the word disaster ("bad star" in Greek) comes from anastrological the mein which the ancient susedt or efer to the destruction or deconstruction of a star as a disaster. Disaster may affect one family at a time, a city, astate, one nation or the entire world.

A disaster is a phenomenon whichdisrupts the normal environmental conditions required for normal existence and causesenormous sufferingsbeyond the capacity of adjustment of the affected community.[1] World Health Organization has defined disaster as a sudden and abrupt environmental phenomenon of great magnituderequiring external assistance.[2] Indian Red Cross Society defined disaster as any event such as hurricane, tornado, storm, flood, high water, tidal wave, earthquake drought, famine, fire, explosion, building collapse, transportation wreck,

or other situation that cause suffering for human beingsand victims cannot cope withoutoutside help and cooperation.[3]

Classification of Disasters[4]

As per origin, disasters are classified into natural and man-made disasters and as per impact, minor or major.

Natural disasters

Natural disasters are major adverse events which are outcome of serious change in the natural processes on or beneath earth resulting in loss of human lives, destruction of property, economic losses, etc.

- *Hydrometer logical disasters*- Natural events of extreme climate changes. Examples are floods, droughts, landslides, mudslides, cyclones, typhoons, hurricanes, tornadoes, etc.
- *Geographical disaster* - Natural earth processes or phenomena that include processes of endogenous origin or tectonic or exogenous origin such as mass movements, Permafrost, snow avalanches. Examples are earthquake, tsunami, volcanic activity, mass movements, landslides, surface collapse, geographical fault activities etc.
- *Biological Disaster* – These result in mass scale deaths due to diseases or disabilities among living beings like animals, men and plants by biological vectors, such as exposure to pathogenic microbes, toxic substances. Examples are outbreaks of epidemic and pandemic diseases and extensive infestation etc.

Man-Made disasters

These are the serious abrupt events causing because of hazardous man induced activities. These may be accidental or incidental activities but magnitude is huge in terms of loss of lives and property.

- *Technological disaster* - Accidents associated with technological or industrial failure e.g. industrial pollution, radioactivity, nuclear toxic waste release, failure of dams, spills of oil, waste, in water body, fires due to explosives, etc.
- *Environmental Degradation* - Activities induced by human behaviors that damage or change the ecosystems. Effects are varied and may contribute to the increase in vulnerability, frequency and the intensity of natural hazards. Examples include ozone depletion, deforestation, desertification, and land, water and air pollution, sea level rise, etc.

Impacts of Disaster[5]

Physical

- Injuries
- Death
- Physical disa-bility
- Burn
- Epidemic
- Weakness/uneasiness
- Physical illness
- Sanitation
- Miscarriage
- Reproductive health
- Fatigue, loss of sleep
- Loss of appetite

Economic

- Loss of life
- Unemployment
- Loss of livelihoods
- Loss of property/land
- Loss of household articles
- Loss of crops
- Loss of public infrastructure

Social

- Disruption of social structure
- Isolation
- Change in marital status
- Sexual abuse and domestic violence
- Orphans/ single parent children
- Family and social organizations
- Migration
- Life style changes
- Breakdown of traditional social status

Psychological

- Distress
- Flash backs
- Intrusion/ avoidance
- Hatred/revenge
- Dependence/insecurity
- Grief/withdrawn/isolation
- Guilt feelings
- Hyper vigilance
- Lack of interest
- Helplessness
- Hopelessness

Impact on Vulnerable Groups

Vulnerable groups include:

- Women
- Children
- Old aged
- Physically and mentally challenged
- People with critical needs

Differential impact on women

- Deterioration of health due to lack of food and nutrition
- Restricted mobility prevents from taking early warning and evaluation
- Greater stress
- Perceived to be victims rather than responders

Impact on children health

- Undernourishment, malnutrition, inadequate hygiene and sanitation
- Fear, anxiety, childish or regressive behavior, difficulty in sleeping and concentrating (play therapy, story telling etc.)

Education

- Studies discontinued, schools being used as shelter girl children dropout.

Impact on mother and child

- Increased case of complication and premature delivery amongst women (children born are weak)
- Feeing of Infant (stress interferes with release of milk in mother and it weakens the immune system of child)
- Children born as consequence of gender based violence

Impact on aged

- Unable to hear and see the danger signals and alarm etc.
- Difficulty in evaluations
- Difficulty in getting relief and compensation
- Shock of losing all the belongings

Impact on Physically and mentally challenged

(Visually challenged, hearing impaired, physically disabled, mentally challenged and people with critical needs like balance disorders)

- Dependency upon health care facilities and health care professionals
- Dependent on life sustaining mediations such as with HIV/AIDS, on dialysis, epileptic, diabetes or are dependent on medication to control condition and maintain quality of life such as pain medication, seizures control medications
- In disaster, pre-existing medical condition inhibit ability to function and are aggravated.

Disaster Cycle

Disaster Preparedness

During this phase measures are taken to prepare for and reduce the effects of disasters. That is, to predict, prevent disasters, mitigate the impact on vulnerable populations, and respond effectively to cope with their consequences. These include effective infra structure, inter and intra-sect oral planning, avoiding duplication of efforts and increasing the overall efficiency and effectiveness of disaster management organizations, household and community members' disaster preparedness and response efforts. Well-coordinated disaster preparedness activities along with risk reduction measures can prevent disaster situations and also result in saving maximum human lives during any disaster situation, reducing the time to get back to normalcy in the affected population.

Disaster Impact and Rescue

The immediate impacts of any disaster include loss of life and damage to property and infrastructure, leaving many injured and shocked by the experience and unable to do much for their own escape from the scene. Sometimes affected population is left without shelter, food, water and other basic necessities to lead life. Prompt action is required to search the victims, prevent further damage and loss of life. Transport to health care facility and treatment for large number of casualties is needed after disaster. Most injuries are sustained during the impact, and thus, the greatest need for first aid and emergency care occurs in the first few hours.

Relief Phase

This phase marks the beginning with assistance from outside. The determinants of type and quantity of relief supplies are type of disaster and quantity of supplies available locally. Disaster may increase the transmission of communicable diseases through overcrowding and poor sanitation in temporary resettlements, disruption and the contamination of water supply. Disruption in sewerage and power system increase the disease causing vector density and displacement of domestic and wild animals;

which further pose a threat.

Disaster Response

The aim of disaster response is to rescue the disaster victims from immediate and potential danger. Stabilization of the physical and emotional condition of survivors and relatives living in other areas is a herculean task. These activities go simultaneously with the recovery of the dead and the restoration of essential services such as water, sewerage, communication and power.

Disaster Recovery

It refers to programs initiated towards helping those who have faced the disaster in full swing. In this phase victims require to rebuild their homes, gather lives and need support and services to strengthen their capacity to cope with future disasters. After a disaster, life-saving assistance is the most urgent need. Getting food, water, shelter and health care is vital to prevent further loss of life and alleviate suffering.

Rehabilitation Phase

In this phase water supply, food safety, basic sanitation and personnel hygiene and vector control receive the priority. Vocational and psychological rehabilitation are also addressed during this phase.

Disaster Mitigation

Disaster mitigation measures eliminate or reduce the impacts and risks of hazards through timely and proactive measures taken before disaster occurs. Disaster mitigation measures may be structural or non-structural. Mitigation measures include hazard mapping, adoption and enforcement of land use and zoning practices and adequate engineering practices, flood plain mapping, public awareness and insurance programs.

Disaster Management Act

In India Disaster Management Act was passed in 2005 which extends to the whole of India. The Act provides directions for effective management of disasters. Primary focus of this act is to prepare, prevent and plan well ahead of the disaster. This act aims to provide the effective management of all aspects pertaining to disaster.[6]

National Disaster Management Authority

National Disaster Management Authority, abbreviated as NDMA, is an apex body of Government of India, lays down policies for disaster management. NDMA is responsible for framing policies, laying down guidelines, approving the plans prepared by different ministries and departments of GoI and laying down the guidelines to be followed by the State Disaster Management Authorities. NDMA is headed by the Prime Minister of India.[7]

State Disaster Management Authority

SDMA approves the state plan in accordance with the guidelines of NDMA. Also, it coordinates all the activities in the implementation of the state plan, provides funds for mitigation and preparedness measures. The Chief Minister of the State head s the SDMA. State Executive Committee, headed by the Chief Secretary to state government, is constituted to assist SDMA.[8]

District Disaster Management Authority

The Chairperson of District Disaster Management Authority (DDMA) will be the District Magistrate or Deputy Commissioner of the district. DDMA is supposed to coordinate and monitor the implementation of the policies and plans laid down by the state authority.

Funding Mechanism

Each state has a corpus of funds, called State Disaster Response Fund, administered by a state level committee headed by the Chief Secretary of the State Government. The size of the corpus is determined according to the expenditure normally incurred by the state on relief and rehabilitation over the past ten years. In case the State Disaster Response Fund is not sufficient to meet the specific requirements, state governments seek assistance from the National Disaster Response Fund a fund created at Central Government level. Both these funds, as the names suggest, are meant for relief and rehabilitation.

Role of Public / NGO / Media

The local community usually responds first and calls for help in any disaster. Local community best knows its resources, traditional knowledge of coping with such events in the past and relevant counter measures regarding disaster management. The best approach is to work cordially as a team. The local community, volunteers, non- governmental organizations and media along with government machinery should work together to deal with the disaster. NGOs along with local volunteers work towards rescue and mobilization of the survivors, provision of basic amenities and health care to the victims.

Citizen's Role in Disaster Management[9]

There are various ways by which well-informed

citizens can reduce the fear, anxiety, and losses that are bound to occur after a disaster. Sometimes, they need to evacuate their homes, confine to their/ neighbors' home, stay in government shelters, and take care of their basic medical needs on their own. Many a times they can even save each other's' lives by supporting each other.

The important step in preparing for any disaster is to find out which hazards could strike the community. It is important to consider the dangers that natural hazards present when choosing a new home as well. If possible, home buyers should avoid buying in areas that are prone to floods and hurricanes. As a protection against financial loss, homeowners should purchase insurance on their home and its contents. To warn their citizens in time of an emergency, some communities use alarms or loudspeakers; while some officials and volunteers go door to door to give messages broadcast by local TV or radio stations. Hundreds of times each year, transportation or industrial accidents release harmful substances, forcing thousands of people to leave their homes and go to a safer area. More frequent causes of evacuations are fires, floods, and hurricanes. Evacuation can last for hours, several days, or even longer after a major disaster. During this time, citizens may be responsible may have to manage their own food, clothing, and other emergency supplies.

Disaster kits should contain the supplies listed below in an easy to carry covered containers;

- Drinking water for all family members and food that will not spoil like biscuits.
- One pair of clothes and blank ets, or sleeping bags.
- A first aid kit that includes the family's essential medicines.
- A battery operated radio, a flashlight with batteries.
- Sanitation supplies.
- Special items like feeds for infant, medicines/ dentures for elderly or disabled family members.
- Cash and credit card.
- Matches in a water proof container.
- Signal flare.

For the survival and cope with the disaster, number of preparedness activities can be done.

- Responsible family members should know where, when, and how to disconnect electricity, gas, and water at main, so as to prevent the home from unnecessary damage like leaking of gas, explosions etc.
- Smoke alarm should be installed in each home to prevent and take necessary steps during disaster.
- At least each of the family members should know how to perform ABC in emergency situation and how to use fire extinguisher.
- People who all are living in the home should know all the alternative escape routes in case fire. Emergency evacuation drill is needed to practice periodically.
- People who all are living in Earthquake prone area should not put heavy object hung nearby their bedrooms or any object that block their way to escape.
- Encouraged people to learn first aid and Cardiopulmonary Resuscitation (CPR).

[10]Citizens may help voluntary health agencies by donating money, so that they can provide quality care during disaster. People get voluntarily involved with health agencies and supportive management as it is the best way to involved. The voluntary Agency can provide training, guidance, and can help the volunteer find meaningful work whether it is in the disaster mitigation period or disaster preparedness, response or recovery period. Appropriate goods which are required should be donated to support a disaster relief operation. Good coordination with an organization is necessary as it helps in the shipping, receiving and distributing the goods.

Role of Nurse in Disaster Management

Nurses play an important role in all phases of disaster- cycle.

Disaster Preparedness

- Nurses play as liaison with community
- Nurses collect the information about vulnerable groups within community
- Nurse makes and leads the preparedness plan
- Nurses should have thorough understanding of community resources
- Disaster nurse must be involved in community organization

Disaster Response

- Nurse takes active part in assessment of the losses, further potential risks for the community
- Nurse participates in triage and first aid of the disaster victims
- Nurse works as a member of assessment and surveillance team

- Nurse informs all the stakeholders of disaster management team

Disaster Recovery

- Plans for recovery and rehabilitation
- Imparts need based health teaching
- Extends psychological support
- Refers the victims to health facility as and when needed
- Remains vigilant for environmental health
- Nurse must be attentive to the potential danger of the future disasters

Major Role of Nurse in Disasters

- Determine magnitude of the event
- Define health needs of the affected groups
- Establish priorities and objectives
- Identify actual and potential public health problems
- Determine resources needed to respond to the needs identified
- Collaborate with other disciplines, governmental and non-governmental agencies
- Maintain a unified chain of command communication.

Conclusion

Disaster disrupts normal life and puts the developmental targets out of gear. Disasters can result from natural or man-made causes or a combined effect of both. The impact of disasters are felt more strongly when the affected community is more vulnerable, either in terms of physical exposure or vulnerable socio economic conditions. Therefore, disaster management is a public administration issue, since disaster mitigation has to be achieved in time through public policy. Disaster management needs to be seen in a developmental context and pre-emptive action needs to be taken to reduce the impact of disasters.

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[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540-7.

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