Raising the nursing profile: the case of the invisible nurse

Jane Salvage

Major reform of nursing and midwifery is a key aspect of the health transition in the CCEE/NIS. Although it does not make the headlines, as do other measures, such as the commercialization of medicine or the emergency supply of drugs, this reform could arguably have a greater long-term impact on health services. It entails nothing less than the mobilization of over 2.5 million health workers.

That 2.5 million is an impressive figure. Yet even as I write it, I hesitate, because I am not really sure it is accurate. Yet if the WHO European Regional Adviser for Nursing and Midwifery does not know the right answer, who does? No other organization is able to collect this information for the entire European Region, and to my knowledge none has tried.

This realization prompted the initiative outlined here: to develop a simple information base on the current state of nursing and midwifery in the European Region, with special emphasis on the CCEE/NIS. This article describes how the initiative began, its progress, future plans and the issues arising. Although it focuses on nursing and midwifery, the experience and the issues may also be relevant to other fields.

Background

Reform of the health care system is fairly high on the agenda of each of the CCEE/NIS, driven by financial crisis, poor standards of care, consumer dissatisfaction and ideology. Member States are trying to create more effective and efficient systems at a time when money is short. Human resources (as opposed to financial ones) are not in short supply, but the realization is growing that many health care professionals are inadequately trained, and therefore unable to maximize their contribution to health. Since human resources account for a big chunk of any health budget, this means poor value for money — a strong imperative for change — and, since nurses usually comprise around two thirds of the workforce, the need for nursing reform is unquestionable.

Nurses themselves welcome this opportunity for reform, for which many in the CCEE/NIS have long argued. They have a difficult legacy: the Soviet health service model, despite its strengths, downgraded care and neglected the development of its "middle-level personnel": nurses, midwives, feldshers and other professionals allied to medicine. Now these professionals want to reorient their practice towards primary health care, reform their education, establish roles alongside rather than below the doctor, and provide a client-centred service (1).

This has opened up new vistas for the WHO Regional Office for Europe, and for its Nursing and Midwifery unit in particular. Even before the changes of 1989, the unit had good contact with nurse leaders in many CCEE, and had undertaken some country-based projects, as well as involving the leaders who spoke English in intercountry programmes. The new landscape of Europe, however, demanded far more attention to the CCEE/NIS, both as a region with many common features, and as individual countries with unique needs and wishes. To cite two examples, Romania wanted to introduce a new nursing education system, having abolished nursing schools in 1978. The central Asian republics of the former USSR sought to improve the competence of nurses, midwives and feldshers in maternal and child health. Many other countries requested help with nursing development.

The birth of the country profiles

I took up my WHO post in mid-1991, eager to help tackle this monumental challenge. Apart from brief visits to the USSR and Hungary, and voracious newspaper reading, I had little knowledge of the CCEE/NIS. When my first assignment came up, to Romania, I requested all the information available, and was shocked to find that our unit database consisted of a few files bulging with assorted scraps of information, much of it out of date, some of it illegible, part of it in Romanian. Most other units in the Regional Office had no information relevant to nursing, and the health for all database, while providing a good country overview, lacked detail. This confirmed my experience that nurses, so visible everywhere in hospitals and communities, become statistically invisible.

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a Regional Adviser for Nursing and Midwifery, WHO Regional Office for Europe.

b Nursing is a general term used to describe the caring professions. Terminology and definitions vary in the CCEE/NIS, and the term should be understood to include all health workers doing nursing work, including nurses, midwives and feldshers. For brevity, I refer throughout simply to nurses and nursing.
It seemed that the Nursing and Midwifery unit and indeed the Regional Office as a whole had not yet had time to revise their information systems in response to the new demands. Furthermore, our partners in the CCEE/NIS were no better off. Chief nurses in ministries of health and directors of nursing colleges told me they did not have access to data; often the data did not exist, and nursing leaders mistrusted official figures. The Soviet system had emphasized the collection of statistics but they were often inaccurate and were rarely fed into the system. Nursing leaders lacked key information for workforce planning, education reform, project development and all the other activities of a flourishing nursing system. Both the countries themselves and the agencies charged with assisting them, including WHO, were working in the dark.

Nursing leaders, meeting in Hungary in 1991, said workforce data would be invaluable to Member States, and asked the Nursing and Midwifery unit to facilitate information exchange. We therefore decided to develop simple profiles of nursing and midwifery in the CCEE/NIS, starting with a list of countries with which we had more active links. This did not seem too big an undertaking, since we already had piles of raw data and willing country contacts. The complexities became apparent only as we plunged deeper into the work.

By the following spring, we had developed a rudimentary computer-based framework for the profiles and the previous Regional Adviser had entered some data. We proposed that a group of nursing leaders assess a draft minimum data list and sample profiles, since we wanted the profiles to be as useful to the Member States as to WHO. The leaders (from nine countries, east and west) said that a completed country profile would give them a comprehensive planning base and a powerful information source to help them prepare analyses and proposals and negotiate for resources. It would also help them to structure the somewhat haphazard data collection methods currently in use.

The tool should be simple and flexible, they said. Terminology and practice varied from one country to the next, and they wanted broad all-purpose headings to guide the collection and compilation of data, rather than rigid categories based on international classifications. None of the CCEE/NIS leaders had access to computers, so a complex on-line database, with multiple codings, cross-references and so on, could not be used, however desirable it might be in future. The minimal human and financial resources of our unit meant that we, too, favoured the low-tech approach.

We then amended the minimum data list and sent it to our nursing counterparts in the CCEE/NIS, asking them to gather what information they could (Box 1). Meanwhile we set up a skeleton profile for each country on the computer system in the Regional Office and began to feed in our own quantitative and qualitative data. We checked what was available in other units, especially the Epidemiology, Statistics and Health Information unit, whose new "highlights" — summaries of the state of health of people in a particular country — were an important source of information and validation. We also consulted reports by other agencies, which confirmed the invisibility of nursing. Sections headed "Health personnel" usually described only the numbers, practice and education of doctors.

Compiling the profiles took far more time and energy than foreseen. Much information was contradictory and there were huge gaps, so we became obsessive investigators, triumphantly unearthing gems in unlikely places. Most countries participated enthusiastically, taking great trouble to provide treasure troves of information. Some of it arrived in local languages (the profiles were initially compiled in English only) and had to be translated. This raised the vexed question of terminology: Romanian "infirmieri", French "infirmières" and Italian "infermiere" are not the same.

Achievements and plans

What we now have, after many months of work, is a nursing profile of each of the CCEE/NIS (Box 2). It looks deceptively simple: a computer-based record, available outside the Regional Office in hard copy only. A profile is usually about 10 pages of information that describes the country in general terms, the health and health care, and the current situation in nursing and midwifery. For some countries, the profiles are reasonably comprehensive and accurate; for others, much more double-checking and filling of gaps remain.

We have already found the profiles useful in a number of ways. They give us quick access to data that were previously buried, unsorted, in files. We can make additions and corrections quickly on the computer screen. The printed document is a simple way of checking information during duty travel — instead of writing copious notes, I scribble on the profile and revise it later on screen.

We also give the profiles to our consultants, other agencies and researchers. One of their uses is to help consultants working in an unfamiliar country to avoid asking endless basic questions of the

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1. General country information

1.1 Capital city
To include resident population

1.2 Geography
To include geographical position; area of country; climate; and administrative divisions.

1.3 Demography
To include current population; predicted population in the year 2000; birth and death rates; fertility rate; age structure; and urban/rural population.

1.4 Economics
To include national debt; inflation rate; GNP per caput and main exports.

1.5 Politics
To include current political situation.

1.6 Language
To include the official language(s) of the country; any other languages which are widely spoken; and the most common language for communication with foreign visitors.

1.7 Ethnic and religious profile
To include breakdown of population by religious and ethnic background.

1.8 Education
To include information on the country's general education system (not health care), for example, source of funding; ages of compulsory school attendance; average number of years spent at school; description of the higher education system; number of students attending tertiary education establishments; adult literacy rate.

2. Health and health care

2.1 Vital health statistics
To include such data as life expectancy; infant and maternal mortality rates; main causes of death; lifestyle information, such as smoking, alcohol intake and diet; HIV prevalence; numbers of people using some form of contraception; abortion rates; number of industrial accidents.

2.2 Health promotion
To include national health education campaigns, services, etc.

2.3 Health care
To include control of the health system; public/private mix; number and type of primary health care facilities and hospitals; number of primary health care contacts per person per year/catchment population; percentage of population receiving inpatient care; average length of hospital stay; bed occupancy.

2.4 Human resources/workforce
To include number of doctors, dentists, nurses, other professional staff, support staff; recruitment and retention of staff; current vacancy levels and short-ages; absenteeism.

2.5 Budget
To include percentage of GNP spent on health care and the proportion of this allocated to primary health care; system of resource allocation; fund-holders.

3. Nursing profile

3.1 Regulatory frameworks
To include existing legislation on nursing practice, malpractice, working conditions, private practice and registration of nursing staff; current professional registration systems, type of staff included on register, updating of register; official approval of training establishments, curricula and supervision of professional training; terms and conditions of employment, including working hours, salary compared with national average, annual leave, maternity leave.

3.2 Human resources/workforce
To include number of nursing and midwifery personnel; number of staff by specialty; number in training; ratios of qualified to unqualified staff; gender ratio; recruitment and retention issues, staff turnover; geographical distribution of staff throughout the country.

3.3 Role of the nurse
To include brief descriptions of the role/functions/job content of the nurse (hospital, community, mental health, etc.); the midwife, other staff groups, other staff involved with nursing duties; relationships with other health care staff; potential for extending the nurse's role and increasing autonomy; relationships with other carers such as the family; public image.

3.4 Leadership
To include description of senior nursing/midwifery posts which exist at ministry, district and local hospital/community level, in education, research and professional institutions; involvement in policy-making; management structures; education/development programmes offered to leaders; qualifications required (if any) for senior posts.

3.5 Education
(a) General nursing, midwifery and other basic training programmes. For each programme, include national institution which controls training; curriculum, orientation of programme (for example, medical- or nursing-based); setting of education (for example, school of nursing or higher education), length of programme, entry requirements, educational materials and techniques, assessment procedures and qualifications awarded; language used in schools, teachers' qualifications and backgrounds; ratio of students to teachers; funding for training and student salaries/bursaries.

(b) Post-basic education, including curriculum, entry requirements, assessment procedures and qualifications awarded; the education infrastructure; funding for training; student remuneration, etc. as above.

(c) Continuing education and in-service training, including availability, funding, responsibility, etc.

3.6 Research
To include current research programmes in nursing practice, management and education; funding available for research; research courses available; general statement on research awareness and use of research to improve practice.

3.7 Clinical practice
To include examples of good practices in nursing (care, education and management); care of groups...
mission-fatigued recipients of our services. The profiles are always welcomed, and they have the added value of publicizing our unit. The countries like them and some are translating them into their own languages; we have translated some of the NIS profiles into Russian. They provide information that many senior nurses and health service officials have never seen before, and give nursing and midwifery more visibility in countries where good, accessible information is like gold dust.

The success of the initiative has stimulated plans for the future. First, we need to make the profiles for the CCEE/NIS as complete as possible. Meanwhile, other Member States have requested their own profiles, and have sent information, so with external help we hope eventually to have a profile of every country in the Region (50, at the last count), a rich and unique data set. Then we can undertake a comparative analysis of nursing in Europe, start to track trends, and perhaps design indicators of national nursing development. Countries are keen to measure themselves against others as well as to mark their own progress.

We are already finding the data useful in building firmer foundations for our own projects. One example is assisting countries in the development of national action plans for nursing, recommended as a priority by the World Health Assembly in 1992. Assessing the current situation is the starting point of this strategic planning process. Another example is the LEMON Project, which aims to provide learning material on nursing to all nurses in the CCEE/NIS; we therefore need to know the number of nurses, the location of nursing colleges and other information, and the profiles point us in the right direction.

**Learning from experience**

Finally, this initiative has raised many questions that are relevant to our colleagues in WHO and countries. Like all new ventures, it has brought both satisfaction and frustration. Some of the latter stems from resource constraints, since much of the work has been carried out between other activities by staff with more urgent priorities. The workload issue is critical in our unit, which has only one permanent professional and two administrative staff, and we have learned that core activities such as this, which build our own infrastructure, nevertheless have to be planned and funded as specific projects.

Ironically, of course, the popularity of the venture has created demands that we have difficulty in meeting — from growing numbers of people and organizations wanting copies, from newly emerging central and eastern Member States wanting their own profiles, and from other countries who want theirs, too. Then there is the question of updating; ideally we would like to include information on ongoing projects and other time-specific issues, but realistically we have to confine ourselves to data that do not change often. Even that is a challenge, given the rapid transformations taking place in the CCEE.

The quality of the information is a delicate issue. Wherever possible we use official data, but these have limitations where nursing is concerned. We emphasize that the information is as good as we can get, but that we cannot guarantee accuracy. We regard a profile as a working document and request everyone who uses it to notify us of any new information or existing errors. The profiles are only as good as the information we receive.

Language and terminology are also difficult. We cannot deal with information that is not in the

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* Salvage, J. National action plans for nursing: from vision to implementation. Copenhagen, WHO Regional Office for Europe, 1993 (Document ICP/HRH 301 (V) Rev.1).

1. General country information

1.1 Capital city
Bishkek (formerly called Frunze), population 620,000, situated in the Chu region.

1.2 Geography
The Republic of Kyrgyzstan is bordered by Kazakhstan and Uzbekistan to the north, Tajikistan to the south and the Xinjiang province of China to the east and south. It covers 198,500 km² in the Alai and Tien Shan mountain ranges. The overall population density is only 22 per km² — over 90% of the people live on less than 10% of the land. About half the population lives in a horizontal belt across the northwest, and the other half around the central-western plateau surrounding Osh. The country is divided into six administrative regions (oblasts) - Osh, Jalalabad, Narin, Talass, Issikul and Chu. These are subdivided into 42 districts, or rayons.

1.3 Demography
Kyrgyzstan had 4.4 million inhabitants in 1991. The population growth rate is 2.2% annually. The birth rate is 29.3 and the crude death rate about 7 per 1,000. The fertility rate in 1990 was 2.6 for urban and 4.7 for rural areas. About 60% of the population live in rural areas. The population is relatively young, with about 37% under 15 years (former USSR 25%), over 50% between 15 and 59 and the rest over 60.

2. Nursing profile

2.1 Regulatory frameworks
2.1.1 Job classification
The main groups of “middle level medical personnel” have remained the same for many years: the general nurse, the midwife and the feldsher. There are many other legally recognized postbasic specialties, including all branches of medical specialization in nursing and other fields. There are also two types of support staff called assistants and auxiliaries. This variety, combined with the lack of an overall strategy for professional health care education, is recognized as a major problem needing urgent attention.

2.1.2 Terms and conditions
There are widespread complaints of poor working conditions and low salaries, leading to staff wastage and lack of motivation. The nurse’s working week is 41 hours over 6 days, although some working in poor conditions may have a limited working day of 5.5 hours. Legislation limits the working day to 12 hours. Annual leave is 24 days per year. Salaries are very low compared to other professionals.

2.1.3 Human resources/workforce
There are 42,500 middle-level staff and 3,000 midwives (1992). The low salary of nurses (and doctors) is forcing many to leave the profession, creating the impression that it is only the “weak” who cannot adapt to the new conditions of life who stay in health care. Especially in smaller towns and villages, health services cannot recruit qualified staff, so they employ auxiliaries and attempt to give them some in-service training.

2.2 Role of the nurse

2.2.1 General nurse
Nurses work according to the instructions of physicians, providing a service to other professionals as opposed to patients. Nursing is therefore dependent on, and subordinate to medicine.

By law, nursing duties are listed as follows: caring for patients; care of the body, diet, bedding; assistance in emergencies; observation of weight, pulse, temperature, respiration, skin colour, excretion, psychological condition; carrying out medical instructions regarding drugs, intramuscular or subcutaneous injections, lavage, probing, preoperative preparation, monitoring of anaesthesia, dressings; assistance in therapeutic and diagnostic activities; collaboration in pre-and post-therapeutic intervention; health education; maintenance of medicotechnical equipment.

2.2.2 Midwife
Midwives provide obstetric and gynaecological care under medical control. All abnormal cases are referred to the district hospital. In feldsher-midwife posts, where feldshers are in charge, the midwife is responsible for antenatal and postnatal care, (sometimes) normal deliveries and all health education relating to maternal and child health. She assesses and gives advice to all pregnant women and keeps records of those at risk.

2.2.3 Feldsher
The feldsher is more independent and more senior than the nurse, performing preventive, diagnostic and therapeutic tasks. In rural areas feldshers traditionally provide all primary health care and manage all staff at the feldsher-midwife posts, in a role similar to the nurse practitioner in Canada, the United States of America and some developing countries. They assess, diagnose, prescribe treatments and some drugs, and refer patients to physicians if they do not improve after three days. They may also work in emergency services and in factories, where their role is oriented to prevention and public health. Preventive care is an important aspect of feldsher training.

2.3 Leadership
Nurses make up a large proportion of the health care workforce, but have few opportunities to participate in policy-making or management. There are few recognized nurse leaders and the environment does not favour the development of leadership qualities. However, there are chief nurses in oblasts, hospitals and departments whose role could be developed and who have a network.

2.4 Education
2.4.1 Basic training
Nursing education is conducted under medical control as part of “middle-level health personnel” training. Directors of the 10 training institutions are physicians; nurses and feldshers make up only a very small part of the teaching staff. Traditionally nursing has been a route into medicine, with up to half the graduates moving on to train as doctors. Nursing is not seen as a worthy career in its own right.
The minimum age for admission to nursing school is 17, after 11 years of schooling. The training then combines general and nurse education - for nurses it takes 2.5 years, for feldshers and midwives 3.5 years. There is no upper limit on age for entry. All candidates have a medical examination and an entrance examination. At the end of the course they take a state examination, and if their marks are high enough they can enter medical school without taking further tests. If the marks are too low they can enter after two years' practice.

In 1988 a USSR Ministry task force was established to reorient the curriculum towards a more modern and autonomous nursing role. Nursing leaders in Kyrgyzstan are keen to reform the education system and some changes were introduced in 1992, but much of the curriculum is still taken up by general, non-nursing subjects.

Most of the schools are poor, with little equipment and no computers. Medical College No. 1, in Bishkek, has some video equipment and one computer, used for tests. Teachers are poorly trained. Lecturing is the main method, with very little use of modern student-centred approaches. There are no textbooks; students learn for hand-copied cards or charts prepared by the teachers. Everything now has to be translated into the Kyrgyz language.

2.4.2 Midwifery
Midwifery education is separate from nursing, but follows the same principles for admission, educational techniques, etc.

2.4.3 Community nursing
Feldshers perform the community nursing role, following a three-year training with an emphasis on prevention.

2.5 Professional organizations and trade unions
Following the first republic nurses' conference, a national nurses and midwives council was established in 1991. Contact has been made with ICN and ICM via WHO/NUR.

2.6 Key contacts/institutions
Chief Nurse and Chief Midwife, Ministry of Health.

2.7 Current priorities for nursing/health development
The deputy health minister has recently stated publicly his awareness of the need to develop nursing and midwifery services. According to the Chief Nurse, the needs include:
- develop nursing leadership at all levels;
- clarify roles and functions;
- create proper clinical career structure with appropriate salaries;
- improve professional image and status;
- tackle social conditions, pay, women's needs;
- reform nursing education;
- provide modern learning materials;
- in-service training in key topics such as family planning; breastfeeding, primary health care;
- develop professional organizations and interest groups.

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Summary
The reform of nursing and midwifery is a key concern of health services in the CCEE/NIS. This major change will be impossible without accurate and up-to-date information made readily available to nursing leaders and to people helping them with the reforms. At present, however, such information is hard to come by and nurses remain statistically neglected - the case of the Invisible Nurse. The WHO Regional Office for Europe has launched a project to tackle this through the develop-
ment of nursing and midwifery profiles. Such profiles were created for each of these countries, and they have proved useful to nursing leaders, WHO staff and consultants and other agencies and researchers. Despite the problems arising from limited WHO resources, the quality of the data collected and differences in terminology, the success of the profiles has laid the foundation for future work: completing the profiles for the central and eastern countries and answering the demands for profiles for other Member States of the European Region. The data thus compiled would enable a comparative analysis of nursing in the Region to be made, with the tracking of trends and perhaps the design of indicators of nursing development in countries.

Résumé

Améliorer le profil des infirmières: le cas de l'infirmière invisible

La réforme des soins infirmiers et obstétricaux est l'une des préoccupations essentielles des services de santé dans les PECO/NEI. Cette mutation majeure ne sera possible que si l'on met à la disposition des responsables des soins infirmiers et de ceux qui doivent les aider à procéder aux réformes des renseignements exacts et à jour. Or, pour l'instant, il est difficile d'avoir accès à cette information et les infirmières restent statistiquement de quantité négligeable — on a là affaire à l'infirmière invisible. Le Bureau régional de l'OMS pour l'Europe a lancé un projet pour s'atteler à ce problème en établissant des profils pour les infirmières et les sages-femmes. Ces profils, mis au point pour chaque pays, se sont révélés utiles pour les responsables des soins infirmiers, le personnel et les consultants de l'OMS ainsi que divers organismes et chercheurs. Malgré les problèmes liés aux difficultés budgétaires de l'OMS, à la qualité des données recueillies et aux différences de terminologie, les excellents résultats obtenus avec les profils ont permis de jeter les bases de travaux ultérieurs: achever les profils pour les PECO et répondre aux demandes formulées dans ce sens par d'autres Etats Membres de la Région européenne. Les données ainsi rassemblées devraient permettre de faire une analyse comparée des soins infirmiers dans la Région, en repérant des tendances et, éventuellement, en mettant au point des indicateurs de l'évolution des soins infirmiers dans les pays.

Reference - Référence