Nursing practice around the world

Nursing/Midwifery
Health Systems Development Programme
World Health Organization
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Executive summary

In his welcome to the WHO Expert Committee on Nursing Practice, which met in Geneva from 3 to 10 July 1995, Dr Hu Ching-Li, Assistant Director-General, noted that “People are increasingly demanding high-quality, accessible and affordable health care,” but “Responses to growing demands for health care may be constrained by lack of resources for health.” Therefore, he concluded, “For services to offer the best value for money, the efficient use of resources is essential. Nursing has to be considered alongside the work of other health care professionals and the cost-effectiveness of nursing interventions must be taken into account”. This is consistent with The world development report 1993 issued by the World Bank in 1993, which suggested that the most efficient way to improve the health of populations is through essential public health services and a package of primary care services, most of which could be delivered by nurses. Clearly, a range of nursing services will be required to respond appropriately to the health needs of all countries. Nurses have roles in acute and rehabilitative care, but they also have a major role in providing the essential health care services of the primary health care approach adopted by WHO in 1978. For nurses to play their appropriate roles in countries at various stages of economic development and with varying health care problems and needs, however, there must be a broad understanding of the current nature and scope of nursing practice, the factors that enhance or constrict nursing practice, and the potential for nurses to expand their practice in providing essential health care services.

Unfortunately, until recently the work of nurses was poorly understood and undervalued almost everywhere, and even now, when nurses are the largest number of health professionals worldwide and nursing is a key component of health care in every type of setting, many people have no idea what a nurse actually does. This report describes the current practice of nursing throughout the world. The chapters making up the report were orginally prepared by the regional nursing advisers in the six regions of the World Health Organization as background papers for the WHO Expert Committee on Nursing Practice which met in 1995. The chapters, however, not only provide background information for that report but give a detailed picture of what nurses do in different countries and different situations. This richness of detail makes them especially informative. The chapters focus on the crucial aspects of nursing in the six WHO regions; thus the reports are not identical in scope or focus. Further, while each chapter provides an overview of nursing practice in the region, reflecting the variety of situations found in the different countries of the region, there are no complete pictures of any one country or any one region.

Each chapter begins with a brief description of the current context for nursing practice in the region, drawing on information provided by the regional nursing advisers and information in The world health report 1995
(WHO, 1995). This context includes not only the demographic, social and political environment in which nurses practice, but the major health problems and broad health care initiatives of the region. Chapters then describe the current levels and categories of nurses in the region, the settings in which nurses practice and the roles that nurses currently play. All the chapters discuss issues in the preparation of nurses for practice and the legislation affecting the scope of practice. Some chapters also discuss more generally the factors that enable or constrain appropriate nursing practice. Other chapters focus on particular issues of importance to the region, such as maternal and child care. Each chapter concludes with a discussion of the challenges to the region in developing appropriate nursing services. A concluding chapter pulls these discussions together and examines them in relation to the final report of the WHO Expert Committee on Nursing Practice and its recommendations for WHO and Member States. It is hoped that this collection of chapters on practice today will provide the foundation for a clearer understanding of the nature of nursing worldwide and more comprehensive discussions of the directions nursing needs to take in the future.
Nursing practice – an overview

Introduction

One of the greatest challenges for nurses has been to clarify and define the complex processes which form the art and science of nursing. It is perhaps for this reason that there is a proliferation of theories developed by nurses to explain the philosophy and ethos of nursing. The reports prepared by nurses in the WHO regions confirm the diversity of practice in nursing, the different places in which nurses work, and the variety of educational preparation for nursing. In addition, the title “nurse” may be used by those people who have undertaken a diploma or degree in nursing, or by those who have six months’ task-based vocational preparation for their role.

The WHO Study Group on Nursing beyond the Year 2000 (WHO, 1994), meeting in Geneva in July 1993, reported that the development of nursing tends to be influenced by three forceful elements: power, gender and the medicalization of health services. Many countries have registration authorities for nursing, which decide the scope of nursing practice and the appropriate educational preparation for that practice. However, the lack of power for nurses in policy making, the effect of gender and the transference of tasks from medicine to nursing, may be far more influential in defining the nature and the scope of nursing practice, than either the registration body, or a theory of nursing.

In reviewing the papers prepared by the WHO regional offices, it is clear that nurses work in many different settings in roles which vary from that of medical assistant to the only health care professional in a community, providing comprehensive health care services. Obviously, nurses strive to meet the health needs of their communities and countries by being flexible and responsive, but inevitably this approach defines nursing by what is done by nurses: the role becomes infinitely changeable, and it is no longer possible to say with any certainty when a nursing role has been changed so much that it becomes something other than nursing, or whether the heart of nursing practice today is its flexible response to changing needs and realities.

The task of the Expert Committee on Nursing Practice is to consider, in a global context, the essential nature, or core, of nursing practice and, following on from that, the appropriate scope of nursing practice in countries with different health needs.

The purpose of this paper is both to summarize reports about the nature and scope of nursing practice compiled in the six WHO regions and to present related nursing theory and research when it is relevant, to inform the discussion.
Defining nursing

Probably the most widely known definition of nursing originates from 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 a 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 regain independence as soon as possible. (Henderson, 1961)

While Henderson's definition remains valid in a wide range of circumstances, it does not describe the important roles of nurses in working with families and communities, in education, public health and health promotion activities, and in providing, sometimes, a full range of curative and preventive services in primary health care. Nurses functioning within the broader concepts of nursing are crucial in making health care accessible to millions of people, and in achieving the aims of health for all through primary health care. Indeed, it has been argued that:

Primary health care is an objective that has always been a fundamental driving force for nurses, a natural extension of nursing practice, especially in community health. (WHO, 1987)

In exploring three definitions of nursing from well-known nursing theorists, it is clear that the philosophy of primary health care is consistent with these nursing philosophies:

Nursing is the science that observes, classifies, and relates the processes by which persons positively affect their health status, and the practice discipline that uses this particular scientific knowledge in providing a service to people. (Roy, 1984)

The goal of nursing is that individuals achieve their maximum health potential through maintenance and promotion of health, prevention of disease, nursing diagnosis, intervention and rehabilitation. (Rogers, 1970)

Nursing is deliberate action to bring about humanely desirable conditions in persons and their environments. (Orem, 1985)

In Nursing in Action (Salavage, 1993), nursing is functionally defined as:

to help individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. This requires nurses to develop and perform functions that promote and maintain health as well as prevent ill health. Nursing also includes the planning and giving of care during illness and rehabilitation, and encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying.

Nurses ensure the active involvement of the individual and his or her family, friends, social group and community as appropriate in all aspects
of health care, thus encouraging self-reliance and self-determination. Nurses also work as partners with members of other professions and occupations involved in providing health and related services.

Nursing is both an art and a science that requires the understanding and application of the knowledge and skills specific to the discipline. It draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences.

The nurse accepts responsibility for and exercises the requisite authority in the direct provision of nursing care. She is an autonomous practitioner accountable for the care she provides. (pp 15-16)

This functional definition, said to be “nursing’s mission in society”, in no way contradicts any other definitions, but rather extends the focus of nursing to include families and groups, as well as individuals. Explicit in the mission is a commitment to encouraging people to participate in determining and meeting their own health needs, and to working with others to achieve these aims.

The nature of nursing

What lies at the heart of nursing practice, without which the role holder could not be described as a nurse? Nursing encompasses notions of caring for people, which at times means undertaking physical tasks for their comfort and well-being. Nursing also has an educational dimension, to promote self-sufficiency and health. However, nurses are not the only health workers who would thus describe the nature of their practice: is it possible to identify what is unique about the nature of nursing?

It is important to be able to name what it is that constitutes nursing, because nursing will then be recognizable as a profession, and the contribution of nursing to the totality of health care will be more easily described and, where appropriate, reimbursed. In the last fifty years, nurse scholars have constructed many different models to represent the nature of nursing: the models are not the same because they have been developed within different environments and with various patient or client groups. However, all the models define the components of the nursing paradigm – the “heart” of nursing – and it is, helpfully, these components which the models have in common. Briefly stated, they relate to the environment and its impact on the human condition, and to the recipient of nursing care, either individual or group; the nature of health is considered and defined; and nursing is described as a process which can harmoniously integrate the relationship between these other components. The difficulty with this theoretical perspective is that it is still not specific enough to differentiate nursing from the work of other health professionals.
Benner (1984) recognized that much of the knowledge base required for nursing was embedded in practice and acquired not only through theories learned, but also by learning how to be an effective practitioner. In other words, a way of constructing a theory of nursing is to watch what it is that nurses do, and to ask them to reflect on their practice, and then to define, from the practice-based information, the nature of nursing.

Building on Benner's work, Bryczynski (1989) described, through observational research, the nature of nursing practiced in primary health care settings in the USA. She identified six domains of nursing practice in this setting, and these are adapted, compared and combined with data from the regional papers to offer a framework for the consideration of the nature of nursing.

**Management of health and illness status**

This domain includes assessing, monitoring, coordinating and managing health status over time. The nurse detects acute and chronic disease, instigates and interprets investigations, selects and monitors appropriate therapeutic interventions and does this within a supportive and caring relationship, so that she can also attend to the experience of illness with the patient.

**Monitoring and ensuring the quality of health care practices**

Within this domain fall the responsibilities associated with professional practice, such as self-monitoring and seeking consultation with others as appropriate. The nurse, as an autonomous professional practitioner, ensures not only that she is a safe and effective practitioner, but also that her colleagues, including physicians, are too (exactly as physicians do for nursing). This domain also covers the mastery of problem solving skills which nurses demonstrate: for example, nurses are capable of assessing what could be added to, or omitted from, medical orders. Nurses feel able to give constructive feedback to others on the quality of their practice.

**Organizational and work role competencies**

The competencies within this domain are about self-management and management of the health care system. Included is the setting of priorities with individuals, families and communities to ensure that multiple needs are met in a timely fashion; coping with staff shortages; dealing with bureaucracies; building and maintaining a therapeutic team; and obtaining
specialist care for patients as necessary. The nurse works intersectorally in a range of settings, including community clinics, hospitals, schools and workplaces. Nurses can influence health policies at a strategic level, locally, regionally or nationally, through setting priorities, being actively involved in health programme planning and the allocation of resources, and through preparing and submitting reports at all levels.

The helping function

In this important domain lie the characteristics of caring in nursing. It includes the ability to establish a climate for healing, providing comfort, being with a patient, whether individual, family or community, in distress, and being committed to a healing relationship within nursing care. The helping role should ensure that the individual, family and community has maximum participation in all health care planning, treatment and care giving. On an individual level, pain management is an important part of this domain, with the nurse helping to interpret pain and, with the patient, select appropriate strategies for management.

In working with families and groups, the nurse can facilitate the development of a healthy community or family, through helping to set appropriate goals, teaching (see below too), and by providing emotional and informational support, especially in helping patients and carers to understand disease processes and symptoms.

The teaching-coaching function

Within this domain are included competencies in teaching for health. In order to motivate people to change, the nurse has to capture readiness to learn, and to provide information in an appropriate way. In addition, the nurse should teach for self-care. To do this, the nurse has to demonstrate a readiness to understand the person’s or group’s interpretation of health and illness, the realities of their social and economic situations, and the nature of their environment.

Effective management of rapidly changing situations

Not only must nurses be skilled in everyday “ordinary” situations, they must also know how to deal with emergencies. To do this they have to be able to understand the problem, and sometimes institute immediate treatment. They should also be able to manage a crisis situation in health care through appropriate allocation of resources to meet rapidly changing
demands. For nurses in some countries it may be war or natural disasters which cause the situation changes, and response may be needed on a large scale; one example is the organization of health care services to meet the needs of a sudden immigration of refugees.

Other rapid changes may be directly related to health and illness. In epidemic situations, for example, there will be a need for emergency planning and allocation of nursing resources. For individuals and families, nurses must be a resource to help them cope with a changing illness/health trajectory.

Together, these six domains provide a helpful description of nursing practice, because they can be appropriately applied to a number of settings. The domains of practice were generated by observing nursing work, and therefore, not surprisingly, describe the role of the nurse in direct care giving, health promotive activities, educational work, disease prevention and in offering these skills within a relationship characterized by a commitment to caring, and to a partnership with the person or group who is the recipient of nursing care.

In addition, the domains of practice can be linked to levels of competency. For example, a novice practitioner, or a health care assistant with a limited knowledge base for practice, would need some support and direction in implementing practice, which might vary from actual clinical supervision, to protocols to guide practice. An expert, on the other hand, who is practising from a broad and deep knowledge base in nursing, and has integrated nursing theory with practice, could be creative and innovative, would be able to deal with uncertainty in clinical and societal situations, and able to research and develop nursing practice, within the context of working with others. These differences in levels of practice may be echoed in educational qualifications.

The uniqueness of nursing practice lies in the ability of the nurse to integrate all the domains of nursing practice in a way which is responsive to the needs of individuals, families and groups, and which will therefore be different for each situation. The truly expert nurse will be able to use a wide range of competencies within each domain, while the novice practitioner, or the health care assistant with only a limited knowledge base, will not possess all the competencies in each domain, and will function in a less flexible way. Expert nursing practice is built on knowledge, experience and the ability to reflect on, and research, practice.
The global picture of nursing

Vivid descriptions of nursing throughout the world have been offered in papers from the WHO regional offices. What nurses do, and the level of qualification required for practice, varies so much that, at first glance, it is difficult to see what can be special or unique about nursing practice. In this section an attempt is made to analyse the information from the regions into a framework of the domains of practice described in the previous section, and into different levels of practice.

Management of health and illness

In many island countries such as Kiribati, nurses (registered nurses and medical assistants) are the only health workers in the rural areas and on the remote outer islands. In these situations, nurses are truly multipurpose health workers, providing the full range of primary health care services - preventive and curative. Nurses diagnose and treat patients on a regular basis; dispense medications; manage emergencies as well as chronic conditions; provide all MCH care including deliveries; provide some dental care; perform minor surgical procedures; keep statistics (in Fiji nurses even do the census); and provide community outreach services. (WPRO)

Here is an example of the need for expert nursing practice, in a situation where resources are scarce, and nurses must take on extensive clinical management. However, in terms of defining nursing practice this situation exemplifies the potential for overlap with other health care professionals, most notably physicians. In this situation, the overlap offers no threat to the professional practice of either physicians or nurses, because there is no "competition" about who should be the care givers. The question for nursing is whether this type of clinical and public health practice lies legitimately within the nursing role; if, as suggested by the domains of nursing, it should be there, then it is valid to identify the constraints to all nurses practising in this way. At present it is assumed that nurses only take on a full clinical and public health role when lack of other resources dictates the necessity for this scope of practice: if nursing includes such a broad role as a legitimate part of practice, then it becomes necessary to clarify the roles, responsibilities and relationships between nurses and others.

The report from the South-East Asia Region (SEARO) gives examples of nursing practice which do not realize nursing's full potential in this domain:

In general, nurses practice in a direct service role in hospital and other institutional settings. ... They provide mainly curative and rehabilitative care for individuals. ... The organization of nursing care in the wards is generally task-oriented. Their functions in the wards would also include
supervision of nursing and other personnel such as housekeeping staff; considerable managerial activities, such as maintaining inventories of linen, drugs and other supplies and even cleaning reusable equipment; and administrative or clerical activities in support of nursing care.

The role described here is clearly that of a novice practitioner who is not being given the opportunity, because of the restrictions on the scope of practice imposed by the health care system, to practise nursing to its full potential. The nurses who fulfil these roles have diploma-level training following about 10 years of general education.

From the paper on the Region of the Americas (AMRO) comes the following information:

Studies have shown that appropriately prepared nurses can deliver as much as 80% of the health care, and up to 90% of the pediatric care, that is currently provided by primary care physicians at equal or better quality and at less cost. In Chile, according to the Ministry of Health, 92% of nearly 4 million child health visits were provided by nursing staff. (In one study in the United States, costs-per-episode were 20% less when nurses provided initial care than when physicians did. A recent estimate projected that under-utilization of nurse practitioners in the United States costs the nation as much as $8.75 billion annually.)

It is apparent that there are economic and quality of care imperatives to considering the acknowledgement of a broad scope of nursing practice.

**Monitoring and ensuring the quality of health care practices**

Although there were examples from many countries of initiatives in quality assessment and assurance, it would appear from the regional papers that this is a level of autonomous practice to which most nurses cannot yet aspire. Where nurses practise alone they have to ensure that their own practice is effective and that they can refer to a physician when necessary. One example comes from the Western Pacific Region (WPRO) paper:

The level of medical support which nurses have varies tremendously, depending on the number of doctors in the country, the location of the nurse and the availability of transportation and communication. ... In Kiribati where nurses provide virtually all the health care available outside of the capital city, nurses may not be able to obtain medical consultation when needed. Some of these islands are very remote, and the HF radios – if in fact they are working – may be located far from the health facility. ... Nurses working in these situations are very much on their own.

In contrast, the following description comes from the paper from the South-East Asia Region:
Most nurses do not have autonomy in their practice. Much of their work concerns carrying out doctor's orders for treatment procedures; accompanying doctors on their rounds to maintain the charts; assisting doctors with procedures, etc. The authority to initiate nursing actions independently is limited.

These two examples demonstrate practice at two different levels of skills and knowledge: how effectively and efficiently are the skills of the nurse used in the latter situation? It would seem to make better economic and practical sense to have nurses who understand the health gain which can be achieved by nurses, can think strategically, understand the need for planning human resources, and can be in charge of the organization and quality of nursing practice. In this way, nurses at all levels learn to set standards for themselves and the people with whom they practice, and the quality of health care will improve.

The paper from the African Region (AFRO) discusses at some length questions relating to the quality of nursing interventions, and makes the following recommendation:

Quality assurance systems to assess and monitor the quality of nursing and health care should be developed as a matter of urgency. This area is one of the weakest in the African Region.

The AFRO report makes specific reference to the need for nurses to be concerned not only about their own practice, but also that of their co-workers. The following example is given:

In [an] evaluation study ... [on Maternal and Child Health] 40% of the health workers did not perform the tasks correctly or even at all. In many urban settings in developing countries, it was observed that although women attended antenatal clinics and gave birth at maternal facilities, their mortality rate did not significantly differ from those who had not been assisted by trained personnel. Similarly, national evaluations of the causes of maternal deaths revealed that as many as 93% of such deaths were preventable. Failure to diagnose or correct case management by doctors or midwives, accounted for 40% of the maternal deaths, shortcomings in the facilities account for over 10% and neglect or failure by women seeking care was noted in over 50%. Only 7% of the deaths were considered unavoidable and over 50% of the problems could have been detected during antenatal care.

This raises questions about the quality of care recipients of maternal health and family planning services receive. ... This has implications for nursing practice.

Exemplified in this account is the ethical dimension of monitoring quality in oneself and others: as a professional, a nurse must surely have a responsibility to ensure that care is effective, and as good as it can be in any set of circumstances.
Organizational and work role competency

This domain is related to the previous domain, in that it concerns self-determination within one's own practice. Those nurses who work in isolated areas, as described in the above, clearly must develop, or be taught, skills in setting priorities and meeting multiple needs through the health system. In addition, they must be skilled in using appropriate and available technology in a range of circumstances.

One example of well-developed skills in this area comes from the paper from AMRO:

In 1994 PAHO [Pan American Health Organization] offered an award to an individual who had been responsible for the success of the immunization programme in the countries of the Region. Two nurses, one from Guyana and one from Peru, were honoured for their commitment and tireless efforts on behalf of the populations of their countries to achieve high levels of immunization coverage under extremely difficult conditions.

In this example, the nurses needed to have a range of skills, including the ability to coordinate care, work with a team and find an effective way through bureaucratic demands.

On the other hand, the Regional Office for the Eastern Mediterranean (EMRO) identified that:

[nurses are not represented] on decision-making committees relating to resource allocation, nursing personnel and other key organizational issues. ... Bedside nurses are not empowered from the decision-making process in planning, implementing and evaluating nursing actions. (WHO-EM/NUR/303-E/L)

This lack of self-regulation in nursing practice, and of participation in policy making, was perceived as detrimental to the development of clinical and public health nursing practice in the Region.

The professional practitioner of nursing must clearly be able to make decisions about the care she carries out, and to be effective in using the health care system in the interests of individuals, families and groups. If the nurse is not respected as a professional, then this control will not be allowed. If the nurse is not educationally prepared to make autonomous decisions, she may not have the ability to identify the issues relevant to effective organizational decision making.

In some situations, nurses are in positions of caring for whole populations, and their ability to prioritize problems and interventions is crucial. One such example comes from the Western Pacific:

In Western Samoa, the Solomon Islands, and Vanuatu, it is nurses who essentially manage the district health services. Nurses in Vanuatu also
manage certain clinical programmes, serving as coordinators in the
following programmes: malaria, tuberculosis/leprosy, control of
diarrhoeal diseases, etc. Nurses in both Vanuatu and Solomon Islands are
the primary health care coordinators.

Nurses are clearly able to practise at a strategic level, where they must
organise themselves and others to achieve maximum health gain. Is this a
core domain of practice which could benefit nursing and populations as a
whole, if all nurses can function in this way? And what are the changes
needed in the system to enable them to do so?

The helping role

Interestingly, although most nurses would assert that care is a vital
component of what nurses do, it is not explicitly mentioned in the papers. It
is however hinted at, especially in the ways that nurses work in partnership
with people, and where they are culturally sensitive to people's needs.

One example of this comes from AMRO:

Nurses adjust their approaches and services to different cultures and
socioeconomic levels adapting policies and procedures to the values and
customs of the community.

Another allusion to this aspect of the nursing role comes from the
AFRO report:

Nurses and midwives, unlike any other health professionals, are found at
the smallest and most peripheral as well as in the tertiary institutions
which are usually furthest removed from the influences of families and
communities. In all these diverse settings of varying degrees of
complexity, they bring in their broad understanding of the human
experiences and conditions of health and ill-health.

The helping role of the nurse is implicit in much that has been written
about nursing, but it is not made explicit. There could be a number of
reasons for this: in situations where there is poor health care coverage, or
overwhelming health or social problems, the helping role may have to be
secondary to meeting immediate health care needs. It is also difficult to
research the helping role in nursing, while describing the components of a
role is easier.

The report from EMRO suggests that:

In hospitals, the organization of nursing services frequently follows
distribution of tasks. ... Although it assures delivery of fragmented
minimum physical patient requirements, this approach does not have a
comprehensive and holistic approach to the patient and his family's total
physical, emotional and spiritual needs; the "caring" component of
nursing services is lost. (EM/RC41/11)
Nursing is an interpersonal activity, and the totality of nursing interventions may be compromised if nursing practice is reduced to the performance of tasks only. Barber (1991), a senior clinical teacher in nursing, specializing in interpersonal skills, reflects on his own experience of undergoing a major operation, and the nursing care he received. He comments that, based on what he observed at this time, nurses denied their feelings in order to protect themselves and avoid stress. The result of this was that they failed to identify patients' needs and did not establish therapeutic relationships with the patients or their families. Nurses everywhere continue to experience stress in their work. This may be because of external factors, such as fear for safety or living in poverty, or there may be contributory factors in the nursing situation. How are nurses supported in stressful situations? Would increased support facilitate the development of more therapeutic relationships in nursing, or are those relationships in existence, but unreported?

The teaching-coaching function

This appears to be one of the most important domains within the global diversity of nursing practice. Examples of nurses' involvement in educating individuals and groups are to be found world-wide in many settings, and many reports commented on the appropriateness of nurses in the role of educators. However, from the EMRO report comes the following salutary comment:

In this Region, public health nursing services and community nursing care are not well established. As a result the predominant activities of nurses are curative in nature with an emphasis on physical care and activities related to the execution of medical prescriptions. Nursing interventions that contribute to health promotion and disease prevention such as health education, case finding, follow-up of defaulters in programmes such as family planning, and individual's counselling ... are carried out on a limited scale.

In ... schools, industry and health centres, nursing services ... are curative in nature. Nurses attend to the sick and injured and are seldom involved in formal and informal health education activities. (EM/RC41/11)

The report from AFRO gives a contrasting picture of the practice of nursing, which:

more than three decades before the 1978 Alma Ata Declaration on Primary Health Care, ... in almost all countries of the African Region included the provision of curative, preventive, promotive and rehabilitative care to individuals and families that catered for all age groups from birth to death.
This picture of the inclusion of education as part of nursing practice is confirmed by the AMRO report, which states that nursing "care includes health promotion and disease prevention as well as the treatment of common diseases and rehabilitation".

A specific example of the development of a role in nursing as health promoter, comes from the South-East Asia Region:

In six countries (Bangladesh, India, Myanmar, Nepal, Sri Lanka and Thailand), there are Public Health Nurses (PHN) posted in community settings where they are seen as having a community role. Expansion of the roles of these PHNs to include health promotion or direct service in villages or communities is being attempted in some countries but is only at beginning stages. For example, in Myanmar the newly posted Township Health Nurses are being trained to promote self-care at home, involving families, communities and NGOs.

Of course, it is not difficult to see the enormous potential which nurses can have when they incorporate an educational perspective (and skills) into their practice. It seems not only apt, but also vital, that this important contribution to health for all people should be fostered.

**Effective management of rapidly changing situations**

It has been stressed previously that nurses competent in this domain have to be able to respond to a number of changes – in the physical, mental, social or emotional condition of an individual, family or group – or in the environment. This may be due to war or natural disasters. A vivid description of the effects of war comes from the AFRO report:

Conflict and war situations in the African Region have not only diverted funds from national health and other social sectors to defence and other forms of ammunition, in addition, countries have been plunged into debt and foreign reserves levels have not enhanced investment. This has not only affected the cash flow and food security at the household level, it has also shifted family health seeking behaviours and practices to food gathering and income generating activities. The impact of these contextual factors on national health care systems and nursing practice cannot be accurately quantified, yet it cannot be ignored as it has complex and wide ranging implications for the integrity of the environment in which nursing practice is operationalized.

In terms of managing changing political situations, nursing still has to overcome great difficulties, as the example from the EURO report describes:

In the Newly Independent States nurses make up a large proportion of the health care workforce, but have few opportunities in policy-making or management. It is not acknowledged that nurses have a legitimate role; there are few recognized nurse leaders and almost no formal educational opportunities for senior nurses, who therefore lack professional
knowledge and skills in management and leadership - which in a vicious
circle then acts as a barrier to managing the changes in the health care
system.

Other examples of nurses' responsiveness to changing situations comes
in their very effective involvement in and management of epidemics.

In conclusion . . .

Any attempt to summarize the global diversity and complexity of
nursing practice, as exemplified in the regional papers, would be
inadequate. What is clear is that nursing practice offers care which is
responsive to local needs and conditions, which is sometimes constrained by
externally imposed restrictions, and which often makes health care
accessible in places, and to people, where it would otherwise not exist.

It is equally evident that the complex and varied scope of practice can
be difficult to quantify or describe. This is partly due to the invisibility of
some aspects of nursing. By using a framework developed from observing
nursing practice, it is possible to see that the domains of nursing are broad,
and require both depth of knowledge and experience of practice.

The next section attempts to summarise some of the restrictions on the
scope of nursing practice, identified in the reports.

Influences on the scope of practice

It is apparent from the regional reports that the scope of nursing
practice differs between countries, and that often the reasons for these
differences may lie outside the direct control of nursing.

While each region, and indeed each country, has particular
constraining and enabling factors, there are several common influences on
nursing practice worldwide. These commonalities tend to be related to
cultural factors which international nursing shares. Chief among these is that
most nurses are women, and so the position of nurses in society and the
power they hold, the respect in which they are held and the value which is
given to their work, is usually closely aligned to the position of women.
Inevitably, if nursing work is not respected and valued, nurses will be
denied positions of influence in health care planning and implementation.
Education for nursing will not be seen as important and deserving of
resources if nurses' work is seen as women's work, when women's
contribution to the development, culture and maintenance of a society is not
perceived as significant. In common with all female-dominated professions,
nursing attracts low salaries, and often poor working conditions.
Historically, nursing's relationship with medicine has been one of subordination, especially when medicine has been a profession dominated by men. This has resulted in nurses accepting tasks transferred from physicians into nursing practice, as well as taking on a role which has been traditionally that of a woman, encompassing the “housekeeping” (ordering stocks, cleaning, providing food, loving and caring) for the scientific, decisive and highly respected man. Unless this relationship is successfully challenged it remains dominant in the health care system, and the result is that nursing's scope of practice is dictated by medicine. One example of this from the UK concerns a technical procedure: diagnostic endoscopy. This procedure was a part of medical practice until 1995, when it was discovered in one hospital, that nurses, if trained in the procedure, could be as effective as physicians. Now there is a national debate about the development of specialist nurses whose role encompasses this procedure. There are many examples like this, of task transference between medicine and nursing; is it appropriate for nursing's scope of practice to be influenced in this way? Does a nurse bring something additional to a procedure which she undertakes instead of a physician, or is she acting only as a physician's substitute?

This raises a further question about the influence of financial constraints on nursing practice. If nurses are trained to carry out one procedure – in this case endoscopies – is this a “cheaper” option than employing a technician, with a restricted training, role and scope of practice, who is paid less, but who can do less? What is the most effective and efficient way of giving patients appropriate total care?

Nursing is known to be cost-effective in a range of settings, and yet the global picture of nursing, as presented in the reports, is of a profession still undervalued and not empowered to reach its full potential in the planning, organization and delivery of health services. Specific examples follow, drawn from the reports, to illustrate the common constraints faced by nurses worldwide, as well as those factors which enable nursing practice to flourish.

**Education for practice**

Of all the factors reviewed in the regional reports, nursing education receives the most comprehensive coverage. It is, of course, a crucial element in developing nursing practice, and should reflect the philosophy and content of a country's nursing work. The report from AFRO states that:

Nursing education has responded to the changing needs of patients and communities by integrating concepts of primary health care, public health practice and community health care in basic, post basic and
graduate programmes. ... Conceptual frameworks for both nursing and midwifery programmes were broadened to include concepts and content of PHC [primary health care].

A similar picture emerges from WPRO:

The three year nursing education programmes in the South Pacific have strengthened the primary health care concepts and included field experience in the local situation.

This paper points out, however, that, even if the nurses are prepared with primary health care skills, there may be few positions for them in the workforce.

The report from AMRO describes a trend to involve nursing services in curriculum planning and collaborative approaches to clinical practice, including involving a community as an area of practice, so that the community participates in planning, and receives a full range of health care.

Many of the reports make reference to the need for nursing education to be “upgraded”. The paper from EMRO says:

Nine years of preparatory education do not provide the student with the necessary knowledge of basic sciences or general education needed for studying modern nursing ...

Furthermore, students would only be 15-17 years old at graduation – too emotionally immature to cope with the responsibilities of caring for the sick ... or dealing with the health problems of families in the community. (EM/RC41/11)

The paper also points out that young nurses faced with such stress will often leave the profession.

It is suggested in many papers that a different type of nurse is needed to respond to the changing needs and realities of life today. The AMRO paper suggests that: “A more assertive, analytical and broad-minded nurse should be trained”.

There seems to be no lack of will to change nursing education, but rather of resources needed to do so. These resources required vary from qualified teachers to learning materials, such as books and journals. Without commitment at central government level, it is difficult to envisage how nursing education can be developed in an integrated way to support practice.

There are many different levels of nursing education described in the regional papers. Nurses are prepared in programmes of study which vary from two to four years, and result in qualified practical nurses (enrolled nurses), through nurses qualified at diploma level, to nurses who are
graduates on qualifying. There seems to be a global trend to more academic qualifications for nurses.

It is simply impossible in this section to reflect adequately all the information which is given regarding nursing education in the six reports. It is recommended that the reports themselves are read in conjunction with this short summary.

What is heartening is that nursing education is the most enabling of factors in the development of nursing practice, perhaps because it is the factor over which nurses have most control. The WPRO paper has an evocative summary:

Schools of nursing in all countries of the Western Pacific Region are committed to the improvement of health through education and community service. Graduate, undergraduate and continuing education curricula aim to reflect the changing health needs of the country's unique society.

The availability of postbasic education opportunities for nurses differs widely throughout the regions. The EURO report says:

In some countries ... advanced nurse training is institutionalized and very important for the nurse's career; in other countries, such as Croatia, postbasic training opportunities are scarce.

Some postbasic education offers training in specialist areas, in both primary health care settings and in hospitals too. The WPRO paper says that the courses in that Region:

develop skills in health problem assessment, analysis of needs, application of interventions, planning and managing client/community health programmes and evaluation.

Unfortunately, this is not the situation everywhere, and for some nurses even attendance at conferences, to update their knowledge, is rare. Life-long learning is a concept new to nursing, but there can be no doubt that by improving the availability of postbasic education in nursing, the quality of nursing care will improve, as well as the motivation and retention of staff.

**Nurses' working conditions**

A recent survey of nursing personnel resources worldwide showed that, for developing countries, there was a significant shortage of nurses in the public sector, especially in rural areas. (Hirschfeld, et al., 1993). It was reported in the survey that the reasons for nurses leaving rural areas included the poor working conditions and lack of pay incentives to stay. Nurses are often enticed into the private sector with the promise of better pay and conditions.
With so few nurses in key positions to influence policies regarding the employment of nurses, it is little wonder that, globally, nurses endure poor working and living conditions. The nature of nurses' working conditions emerges from the regional reports, and is inevitably linked to the status of women: the EURO report says that "only 5-10% of the [nursing] workforce is male, except in Italy, Spain and Malta, where men comprise at least a quarter of the workforce." However, even when men are substantially represented in nursing, salaries are only around, or below, the national average. A recent report of a WHO study group suggested why this is so:

Nursing everywhere is women's work and shares the characteristics of other female-dominated occupations - low pay, low status, poor working conditions, few prospects for promotion and poor education. For example, nurses' salaries in a third of the world's countries are lower than those of other occupations that require a similar level of education, and in some of the least developed countries salaries are actually decreasing. (WHO, 1994, p. 9)

In most regions, nursing has a low status, and wages reflect this. The EURO paper comments that "In Newly Independent States...the social status of nurses is approximately equivalent to that of unskilled workers".

The AMRO report suggests that:

Because nurses receive very little pay they must sometimes hold two or three jobs in order to provide for their families. Studies of health and working conditions of nursing personnel have demonstrated the serious deficits and the results in terms of poor health for nurses and their families.

Inevitably, working conditions affect the recruitment and retention of nurses, as well as the quality and availability of nursing services. For example, the report from AMRO points out that: "when incentives are provided for work in remote areas, it is easier to recruit and retain staff".

This would seem to be stating the obvious, and yet there appears to be no regard for such factors in the deployment of nurses. This is despite the knowledge, exemplified in all the regional reports, that nurses in the least developed countries provide crucial health services in the most remote areas, where physicians are not available. The report from EMRO says this:

Linked to shortage is the question of the deployment of nursing personnel in the various health care services. It is estimated that approximately 90% of the nursing workforce in Member States is employed in hospitals. This leaves preventive and promotive health services understaffed and exacerbates the shortage of nursing personnel in the community. Therefore people in greatest need of nursing services and comprehensive care, the poor and rural populations, are underserved, with lesser qualified nursing personnel assigned to their service.
The AMRO report also urges consideration of the reasons for the distribution of nurses:

Nurses practise where there is a need for nursing care, but in many countries, because of the serious shortages, there are not enough nurses to meet the needs.

Nurses are concentrated in the large urban areas and in large institutions. In Canada, for example, where there are more than 260,000 registered nurses, about 500 work in the Yukon and Northwest Territories while almost 104,000 live or work in the most populated province of Ontario.

In the wake of a growing and expanding private sector in many developing countries, nurses are leaving the public sector attracted by higher pay, better working conditions, enhanced professional recognition and more benefits.

The report from SEARO adds this information:

A major constraining factor in nurses' deployment in community settings, especially in rural areas, is the lack of adequate housing and security. This is particularly a problem for young female nurses, especially if they are not married. A few countries have addressed this problem by training a limited number of male nurses specifically to work in rural and other difficult areas. However, this solution has not proved entirely satisfactory as many of the male nurses want to migrate to urban areas where career prospects are better and where school and other facilities are available for their families.

The WPRO report echoes these concerns, and that:

Finally, it is difficult for nurses posted in the rural areas not to feel that they have been forgotten, especially in Cambodia, China, the Lao People's Democratic Republic, Philippines, Viet Nam and isolated Pacific Island areas. The shortage of drugs, equipment and supplies in many countries; the lack of transport in most countries; and the deteriorating health facilities in many rural areas make work difficult and discouraging. This cannot help but affect their practice.

All of these reports point out that the reasons nurses do not practise in remote areas are not linked to the suitability of nursing practice in these settings, but rather to financial and social constraints, which render the posts unattractive. For health policy makers, the question should be about the cost-effectiveness and quality of care provided by lesser skilled workers. Would it be better if nurses' aides worked in hospital settings, supervised by qualified nursing staff, rather than unsupervised in community clinics?

If working conditions do not generate and encourage the recruitment and retention of nurses, then the result will be a shortage of nurses and this in turn can lead to:

an influx of unqualified persons and the employment of expatriate nurses by some countries. While these actions solve the immediate problem of shortage, they can create longer-term problems and
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difficulties. Low quality of services and increased demand for supervisory posts to guide and control unqualified personnel are the results of the employment of unskilled workers. Inability to communicate with patients and their families due to language barriers and lack of cultural understanding are often problems associated with an expatriate workforce that lead to the practice of nursing as a mechanical activity. (EMRO - EM/RC41/11)

It is clear that nurses' working conditions are far from satisfactory. This is linked to the status of nursing, in turn linked to the association of nursing with women's work, and the low status of women. The result of this is that nursing practice develops where it can, and not necessarily in those places where the most health gain can be made by the neediest people. This is despite research evidence which exists to show how effective nursing care is for the poorest and sickest of people. (Molde & Diers, 1985)

Nurses as policy makers

One of the important components of the nursing role has been identified in this paper as influencing local, regional and national health policies, through a range of strategies. The report from EURO makes this point explicit:

Making policy is the essential starting point of any health care programme. Nurses, as the largest group of health care workers, need to be involved in the overall health care policy at all levels and to lead the development of policy that relates to nursing.

Although the World Health Assembly has urged Member States to reinforce the position of nursing and midwifery personnel at all levels, so that they can fully participate in health care planning, there are few places where nurses are able to influence policy formation and implementation at all levels. The EURO Report states:

In some countries policy-making is not seen by government as an appropriate nursing role (Albania and Romania); in others the role of the nurse is limited to providing advice on nursing issues (Slovenia).

One of the reports from EMRO identifies that the countries of the Region have many of the same problems:

- Lack of authority and power at all levels, to change practice. ...
- Exclusion of nurses from policy making,
- Non-representation on decision-making committees relating to resource allocation, nursing personnel and other key organizational issues. (EM/NUR/303-E)

A positive example of changes in the influence which nurses have, comes from the report from WPRO:
Nursing is the most suited to proposing, refining and implementing health care policy as it relates to nursing care. To participate effectively, they need skills to dialogue effectively with policy-makers. Old management styles and traditional power-plays and the lack of understanding about how to influence policy decisions often blocked, and still does, nursing participation.

Though in the past, in both developed and developing countries this was a dilemma throughout the Region, we are seeing in nursing groups a move from health policy ignorance to more national policy consciousness. Nursing groups have moved from passivism to activism, and collaborate in community action to demonstrate for better health care.

This is a particularly interesting example because it shows that nurses can take control of some of the influences on their practice, through greater political awareness, and by renouncing out-dated professional behaviours.

“Old management styles and traditional power plays” may also mitigate against the development of strong leadership in nursing, identified as a factor which prevents nurses having a greater influence in policy-making. This is expressed explicitly by the report from EMRO:

There is generally a lack of strong cohesive leaders that can raise policy issues and develop focused strategies to strengthen nursing services which has reflected negatively: on the professional status of nursing; the progress and development of the profession, and, more importantly, the quality of service delivery.

The reasons for such a situation can be attributed to the lack of: continuing educational opportunities for the nursing profession; power and autonomy resulting in reduced ability of leaders to make policy-decisions; systems of accountability. (EM/NUR/303-E)

The EMRO report suggests that a “lack of leadership [in nursing at government level] can reflect in the manner and focus in which nursing services are developed” (ibid.). This is a theme repeated in many reports. From the EURO report comes the following:

Most countries of Central and Eastern Europe have established a Chief Nursing Officer post at the Ministry of Health or equivalent and most have nurses and/or midwives working at ministry level. However, their formal functions and influences vary widely, and in nearly all they feel that it is extremely difficult to ensure that nursing issues are taken seriously. There are exceptions: in Hungary the new ministry nursing department has a Chief Nursing Officer and 10 staff, making it the second largest Ministry nursing unit in Europe. It is responsible for all nursing affairs except higher university education, which is handled by the Ministry of Education.

The value of nursing to improving health status is becoming more widely recognized internationally: the World Bank identified nursing as “the most cost-effective resource for delivering high quality public health
and clinical packages” (World Bank, 1993), while the World Health Assembly resolution WHA45.5 identified the need to demonstrate commitment to nursing and midwifery as essential services in all countries, for the development and improvement of health-for-all strategies. Despite this recognition, nursing’s major problem, in terms of influencing policy to strengthen nursing, may be that nursing “does not grab the headlines like other measures such as the commercialization of medicine or the emergency supply of drugs, (but) could arguably have a greater long term impact on health services.” (EURO)

Failure to be influential at policy levels has many consequences for the recruitment and retention of nurses, levels of basic and postbasic education and working conditions, but crucially, there may not be adequate legislative support for nursing practice. The scope of nursing practice can be regulated by law, ensuring safe standards of practice through systems of educational preparation and registration. One of the reports from EMRO states that:

It is important for governments to appreciate that the main focus of legislation is to safeguard the welfare of the public through the establishment of a code of conduct which specifies minimum standards of practice. Without such legislation it is impossible to establish a uniform system of accreditation and validation of standards of practice. Currently, no such system exists within the majority of countries in the Eastern Mediterranean Region and, where they exist, they do not necessarily reflect modern nursing practice and the demands of health systems.

The report from WPRO claims that:

A well-written law on nursing provides guidance to the profession, anticipates and allows for future growth, and empowers nurses to undertake health delivery roles with proper training to address important health needs of a country. ... However, from a practical point of view, most nurses do not see how the laws regulating nursing practice affect their day-to-day work. The introduction of these concepts into basic nursing education are still very much needed.

The changes needed for nurses to reach their potential in contributing to a health care system are complex and related: first, the political will is necessary within a country, to recognize the valid contribution which nursing makes to health care; in many places, powerful politicians are men, who do not wish to acknowledge the importance of what they may perceive as low-status women's work. Secondly, nurses themselves have to have the knowledge and skills to become policy-makers at all levels; thirdly, nurses at all levels have to have skills of leadership; and fourthly, nursing education, at the basic level, must incorporate teaching about the importance of policy formation in nursing, and the need for leadership throughout the profession.
Management in nursing

Emerging from the regional reports are three important factors which influence the effectiveness of nurses who manage nursing affairs. The first of these - the influence of nurses in policy formation and implementation - has already been discussed. Its importance to nurse-management is related in the report from EMRO:

The centralization of decision-making processes at all levels of the health infrastructure inhibits the ability of managers to initiate change and introduce innovative approaches to improve the quality of practice.

(EM/NUR/303-E)

If nurses are given managerial responsibility without corresponding power to make and implement decisions, then the management position is only a token gesture and will not, in reality, make a difference to the scope, quality and effectiveness of nursing practice.

The report from EURO suggests that:

The degree of autonomy and influence which nurses enjoy when managing nursing and/or nurses is closely linked to the nature of nursing's relationship with other disciplines, and its status. Nurses are expected to carry out a housekeeping role in many countries and this may also be reflected in the type of tasks the nurse manager carries out. Apparent seniority in the health service hierarchy may not be reflected in input to decision-making.

Even if nurses are in management positions, and have a degree of influence, they will only be effective if they have management skills: this is the second major issue, in relation to management, to emerge from the reports.

The report from WPRO is uncompromising:

Many nurse leaders are not effective managers. Most have had no management training and run the nursing services in a top-down management style based on seniority and a variety of personal factors. As a result, the younger, better trained nurses are unable to fully utilize their skills and quickly become demotivated. Even in countries where there are strong nurse leaders and managers, nurses tend to be isolated from the rest of the ministry, included only when strictly nursing matters are discussed. Further, because they are not included in broad planning activities and in major policy decision-making, they become even more narrow in their thinking and have little understanding of the whole picture. Therefore when they ARE consulted, they may have little to offer.

This rather unhappy picture is confirmed by the EMRO report, which states that:

There is a tendency to assign individuals to managerial positions based on seniority or degree qualification. There is not necessarily a
concomitant level of managerial skill development. ... This situation has been perpetuated by the very limited opportunities for the training of nursing personnel in management in EMR.

... [Management] systems that can enhance the process of change and improve the quality of service delivery, such as problem-solving, research-based learning, total quality management and quality assurance, are not an integral part of current management practices.

The report from EURO tells of the establishment of a post of Chief Nurse to Almaty City Health Board in Kazakhstan: this nurse leads the city's 10 700 nursing staff, and yet has no management training. She says that her main problem is acceptance by other professionals.

For nurse managers to facilitate the development of nursing practice, they have to be educated for, and supported in, their role.

The third issue of concern in management in nursing is the availability of information systems, which can collect and collate data relevant to nursing. Sometimes these data may be directly concerning the number, type and distribution of nurses, and therefore highly relevant to the deployment of the workforce.

The report from EURO describes the NUR/EURO information project, which was set up in response to a dearth of information about nursing and midwifery. The report states:

Nurse leaders lacked key information on 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.

This new project is fully described in the report. It parallels and informs the work on setting up information systems being undertaken by the Chief Scientist for Nursing, WHO Headquarters.

The availability of this type of information about nursing is crucial for managers, so that they are able to make informed decisions about how nurses can best be deployed to meet health needs.

The report from WPRO confirms the need to develop information systems:

Information systems which enable administrators to make effective decisions about the role and cost related to nursing often do not exist and if they do exist, the raw data is not transformed into "information" using understandable format which reaches the decision-making level.

There is an emerging recognition of the value to an organization when employees at the operational level are concerned about costs, quality and outcome issues. Today, countries have programmes to increase the
responsibilities and capacities of nurse managers making them accountable for handling of resource utilization.

Information about outcomes of nursing care are vital to convince policymakers and resource allocators of the value of nursing. The AMRO paper reported that:

considerable research indicates that hospital mortality rates decline as the percentage of RNs on staff increases. In some 13 studies reviewed, hospitals with higher percentages of RNs on staff compared to other nursing personnel such as unlicensed aides, had lower than expected mortality rates, after adjusting for the severity of the patients' conditions.

If information such as this can be produced by managers, or nurse researchers, through the use of adequate information systems (and a knowledge of research methods), it can empower nurse managers and others who influence health policy to compete with demands for more high technology rather than more nurses.

Data can also be collected to illustrate what it is that nurses do: this is often constrained by the need for a classification system for nursing interventions. (Work on developing an international classification system is currently in progress by the International Council of Nurses.)

It is much easier to describe and quantify tasks than it is to quantify therapeutic communication. This may be one reason why the helping relationship was so seldom mentioned in the regional reports. However, the nature of the therapeutic relationship between nurse and patient, family or community may influence the success of all other interventions, so should it not be acknowledged?

It is through nursing management systems that nurses have an advocate, giving them “voice and power” (WPRO). If these systems are weak, for whatever reason, then nursing practice will also be weakened.

A brief conclusion

The factors affecting the scope of practice which have predominated in the regional reports will come as no surprise. They stand alone as influential, and are inter-related.

There is a great richness of information in the regional papers, which cannot be represented here, but which will serve as a firm foundation for the deliberations of the Expert Committee on Nursing Practice.

Nursing practice everywhere is changing in response to society’s needs, and as medicine becomes increasingly technocratic and based in secondary and tertiary care settings. Nurses are working in primary health care, often
as the only worker, when physicians are unavailable, and provide care which is curative, preventive and health promoting.

All of these momentous changes have to be reflected in appropriate legislation, which allows a safe yet unrestricted scope of nursing practice. Nursing education needs also to respond to the changes by designing new curricula and incorporating teaching methods to prepare problem-solving, knowledgable, assertive and autonomous nurses.

The factors which still mitigate against the development of nursing practice are not new: they include the continued subordination of nursing to medicine, so that power remains with doctors not only in practice, but also in policy-making. Perhaps most important of all, nursing still suffers from gender discrimination, as do women everywhere.

Nursing takes place in environments and societies which are themselves in flux. It is important to examine nursing in this context, but also to accept the challenge to find the heart of nursing, without which only an empty set of tasks remains.
Nursing practice in the African Region

Introduction

The African Region now comprises 46 countries. Africa has 29 of the world’s 47 least developed countries, and the remaining 19 Member States are all developing countries. From 1950 to 1990 the population of sub-Saharan Africa increased from 170 million to 500 million. Women have an average of six children, 45% of the population are under age 15 and elderly people of 60 years and older constitute about 5% of the total. Most women still go through childbirth without trained assistance, and maternal mortality rates range from 62 to 1000 per 100,000 live births. Over half of the population still lack safe water and two thirds are without proper sanitation. There is evidence that 50 million preschool children suffer from protein-energy malnutrition.

In recent years there have been growing numbers of emergencies associated with natural and man-made disasters, ethnic conflicts and a deteriorating socioeconomic environment. In 1993 close to 16 million Africans were refugees or displaced with attendant health problems, including disease outbreaks and malnutrition; one million of those suffered severe malnutrition. Of the 46 capital cities in the region, 19 have recently experienced civic unrest, seriously disrupting health services.

Two major initiatives have been launched in the region – the “district health for all” package and “Africa 2000,” designed to sensitize the international community to the need for adequate water supplies and sanitation. The polio-free zone in eastern and southern Africa is expanding, and progress has been made toward eliminating leprosy and dracunculiasis. For many countries, however, falling immunization coverage in recent years has resulted in increases in the incidence of several diseases.

Epidemiological data point to continuing large increases in HIV infections. Thus, during the 1990s and into the next century, increasing numbers of AIDS cases and deaths can be expected. It is projected that by the late 1990s there will be about two thousand AIDS deaths per day in sub-Saharan Africa. We know now that world-wide, two-thirds of all HIV infections are due to sexual transmission and this will increase to 75% or 80% by 2000. As of today, HIV-infected women have given birth to almost a million infected children, over half of whom have developed AIDS or have died, while another almost two million uninfected children are already or potential AIDS orphans. Most of these children are in sub-Saharan Africa. In addition, AIDS is compounding the problem of tuberculosis. In some African countries, cases of TB have doubled or even tripled since 1985 and
these countries now face parallel epidemics of tuberculosis and AIDS. Families and communities are disappearing fast.

Access to health care is generally poor. The region lacks human resources for health, and there has been a constant brain drain which is exacerbated by the economic recession in most Member States. Conflicts and wars have diverted funds from national health and other social sectors to defence and ammunition and plunged countries into debt, and developed countries have lost confidence in the region and thus have not invested in businesses. This has shifted family health seeking behaviours and practices to food gathering and income generation. The effects of these factors on national health care systems and nursing practice cannot be quantified, yet they have complex and wide ranging implications. Health infrastructures are underfunded and poorly managed; coverage, while increasing, remains inadequate. Policies, strategies and financial initiatives for primary health care have been accepted in principle by Member States, but they are often difficult to implement.

**Nursing personnel and practice**

Nursing and Midwifery personnel constitute 60-75% of the workforce in national health care systems in Africa. They are the most widely distributed groups and have the most diverse roles, functions and responsibilities in the primary health care team. They plan and carry out direct patient care activities, public health and community health practice. They are responsible for providing preventive, sanative, promotive and rehabilitative care. They are also unit, programme and department managers and in most Anglophone countries they are members of ministerial planning teams. Nurses work at district, intermediate and national levels of care though their practitioner, education, research and management functions vary in intensity from country to country. Nurses and midwives, unlike any other health professionals, are found at the smallest and most peripheral level as well as in the tertiary institutions which are usually furthest removed from the influence of families and communities. To all these diverse settings of varying degrees of complexity, they bring their broad understanding of human experiences and the condition of health and ill health.

Any act that constitutes provision of health care to individuals, families and communities has been defined as an integral part of “nursing care” and nursing practice. It is partly as a result of this way of viewing and operationalising nursing practice, that more than three decades before the 1978 Alma Ata Declaration on Primary Health Care, the practice of nursing in almost all countries of the African region included the provision of
curative, preventive, promotive and rehabilitative care to individuals and families in all age groups, from birth to death. Nutrition care, health education, maternal health, patient education and immunisation of infants and children against communicable diseases have all been functions and responsibilities of nurses and part of the discipline and practice of nursing. Nursing has therefore earned itself an unique place in the national health care systems in the African Region.

In recent years many of the Francophone and Lusophone countries have created a number of single line trained sub-professional groups such as clinical officers, medical assistants, dressers and dispensers to meet the needs of patients for curative and preventive care for a variety of tropical diseases. These single line trained sub-professionals work under the direction of medical doctors where doctors are available, and under senior clinical officers or senior medical assistants where doctors are not available. Some countries consider this a useful way to provide direct care for particular problems. Most countries in the region, however, view “nursing practice” as a broad-based service designed to respond to the changing needs of patients and the social environments in which health care is provided.

Unfortunately, though nursing is a discipline that cuts across health care services provided at district, intermediate and national levels, nurses tends to miss the opportunity to draw up concrete nursing plans of action and end up featured under the column of “actors” and “collaborating” groups only. In most countries nursing practice has remained static and has not quite developed into a comprehensive and dynamic discipline targeting the diverse needs of individuals, families and community groups. Nurses' associations and nursing councils are either non-existent or at rudimentary stages of development. Nursing personnel are notably absent at senior ministry levels and practice-based clinical nursing research is lacking. In some countries the provision of services to children with psychiatric disorders is particularly limited and inadequate. Nursing accountability for the quality of nursing care is limited.

Attempts to identify the core of nursing practice as well as the scope of practice in the countries of Africa must recognise the physical, socioeconomic and situational factors which provide the context for nursing in this region. It is not clear to what extent nursing practice and primary health care can make a difference to the lives and health of individuals, families and communities living under overwhelmingly desperate socioeconomic conditions. The individual’s state of health as well as that of families and communities is first and foremost the outcome of a dynamic relationship with the social and physical environment. Nursing and primary health care services cannot control or manipulate many physical,
socioeconomic and other environmental factors, or determine the availability of and access to basic requirements for human survival and development. In addition, some countries suffer from a shortage of nurses and a decreasing supply of registered nurses. Problems in increasing the supply include rigid health care systems, inadequate recognition for nurses, vague job descriptions and inadequate supervision. Many nurses have left health services as a result of frustration and problems with practise. In addition, the public lacks knowledge of nursing and recruitment strategies are inadequate.

With the district health for all initiative, national health care systems in the region have been decentralised into manageable units made up of districts in which health and other social structures interact in a much more people focused milieu. Nurses, other health professionals, development, agricultural and other groups plan together using a district health plan which is based on an assessment of health needs, defined criteria for priority setting, classification of health needs, objectives, targets, monitoring and evaluation of progress in relation to targets and objectives, including programming and budgeting. A minimum package of services that are considered basic necessities for the health of individuals, families and communities is developed by the district health and other social development teams. This approach attempts to take into consideration the anthropological, sociological and psychological dimensions of community organization for social action at the grassroots level. The district health package incorporates all the eight components of primary health care and includes any other activities needed to meet health problems encountered in particular districts.

Nursing education

Nursing education has responded to the changing needs of patients and communities by integrating concepts of primary health care, public health practice and community health care in basic, postbasic and graduate programmes while nursing practice has continued to redefine and expand the scope and parameters of nursing to meet the requirements and dictates of primary health care-oriented national health care systems. Both nursing and midwifery programmes have been broadened to include concepts and content of primary health care (PHC). Postbasic and graduate programmes have been developed for Nurse Clinicians, Family Nurse Practitioners, Advanced Midwifery and Maternal and Child Health and Family Planning Practitioners, Community Health and Community Mental Health Practitioners to prepare nurses to provide quality nursing care and health care to individuals, families and community groups with a variety of
nursing and health care problems and needs. Cognisant of the need for nursing leadership and management in the provision of patient care, nursing administration and management and clinical nursing research programmes have also been developed and implemented at the basic, postbasic and graduate levels. These efforts have taken into consideration the need for excellence in clinical practice, administration and management of care. Further, education in leadership and management development has been expanded to include critical skills required for the management of change. Similarly, the beliefs and value system of nursing have been modified. Work continues to explore ways of improving the quality of health care provided by nursing and midwifery personnel.

Continuing education programmes have been designed to update the knowledge and skills of nurses for expanded immunization programmes, maternal and child health/family planning (MCH/FP) programmes, safe motherhood initiatives, health education, management of childhood diseases such as diarrhoea, acute respiratory infections and control of malaria, leprosy and tuberculosis. Nurses are managers of some of these programmes.

In responding to the dictates of PHC and the needs of patients and clients, educators have done much to equip nurses and midwives to discharge their clinical functions and responsibilities as well as to assume their leadership role in patient care. Admittedly, however, a number of these changes have been haphazard and therefore effected in a patchwork fashion without any systematic research. There is a desperate need to prepare nurses to act as agents of community change who can help people work on clean water and sanitation projects while also helping to combat malnutrition, maternal and child mortality and communicable diseases. Roadblocks to adequate preparation of nurses include inadequate teaching facilities, libraries and teaching aids. In addition, clinical facilities tend to be minimally staffed and they often use students for service rather than seeing to their learning needs. Nursing education is now moving away from hospitals to communities and to universities and other institutions of higher education. It is hoped that this move will enhance both the quality of nursing practice and the status of the profession so that it is commensurate with nurses’ functions, roles and responsibilities in African national health systems.
Maternal health and quality of life –
an illustration of current issues for nursing practice

The WHO Study Group on Nursing beyond the Year 2000 recommended that WHO should review current strategies for providing basic health care, especially to vulnerable populations, and identify gaps in services in order to provide care needed in the future. The basic approach to public health practice emphasises the identification of vulnerable groups and the factors that determine their vulnerability, as well as the most effective interventions to meet their needs. However, nursing practice in its traditional form has not focused on “targeting” vulnerable individuals and families. For some reason, nursing practice has tended to define itself in the context of an illness or an observed problem rather than planning to circumvent potential problems. The quality of care provided women and children illustrates the problems of this approach.

Nursing practice in Africa has focused on the provision of midwifery, including maternal and child health and family planning services, since long before the 1978 Declaration on Primary Health Care, yet women in the reproductive ages have never been regarded as a target group for health care and nursing interventions in a systematic manner. The focus of nursing practice and health care has largely been centred around pregnancy and the birthing process including contraception. Defined goals, objectives and monitoring indicators have been developed around the themes of pregnancy, labour and delivery. Review and evaluation studies, carried out to assess the quality of care provided, have tended to focus on the numbers of live births and maternal deaths. Demographic and health survey reports record contraceptive prevalence rates, neonatal and maternal events, but hardly any other information about women as a vulnerable group is documented. Yet national and world statistics show that the services that nurses and midwives concentrate on are not making a difference in the quality of life of women and their families.

In 1993 a report on Maternal Child Health and Family Planning: Current Needs and Future Orientation, noted that while wider access to family planning has been realised almost globally, the overall situation in many developing countries – especially in Africa – has worsened. WHO estimates that between 1983 and 1993 maternal morbidity increased by 3% and 9% in some regions of Africa. It is further estimated that African women aged 15-44 years have a life time risk of maternal death of 1-23. Recent data from a few urban centres in Africa and Asia showed maternal mortality rates ranging from 200-500/100 000 in spite of the fact that in the areas under study prenatal and child birth care services were being provided by trained attendants who were thought to be adequate.
A separate evaluation study cited in the same report found that 40% of the health workers did not perform the tasks correctly or even at all. In many urban settings, it was observed that although women attended antenatal clinics and gave birth at maternal facilities, their mortality rate did not significantly differ from those who had not been assisted by trained personnel. Similarly, national evaluations of the causes of maternal deaths revealed that as many as 93% of such deaths were preventable. Failure by doctors or midwives to diagnose or correct case management accounted for 40% of the maternal deaths, shortcomings in the facilities accounted for over 10% and neglect or failure by women seeking care was noted in over 50%. Only 7% of the deaths were considered unavoidable and over 50% of the problems could have been detected during antenatal care.

The maternal mortality figures for Botswana, Malawi, Uganda, Zambia and Zimbabwe range between 200 and 350 deaths per 100 000 live births even without the threat posed by the AIDS epidemic. In 1993, WHO estimated that a pregnant woman in sub-Saharan Africa was 75 times more likely to die than a pregnant woman in Western Europe. In countries like the Gambia where the risk is highest, the difference is 100 fold. In Burundi between 1986 and 1989 the prevalence of HIV in pregnant women rose from 16% to 20%, while in Rwanda the prevalence rose from 18.1% to 30% and in Kampala from 14% to 24%. For the recipients of MCH/FP services in Africa, pregnancy will remain a risk for decades if drastic changes are not effected.

Demographic and health surveys conducted in Botswana, Malawi, Uganda, Zambia and Zimbabwe have recorded some increases in contraceptive prevalence rates. However, some studies conducted in these countries have shown that many couples discontinue use of contraceptives for a number of reasons. In 1991, the Government of Botswana and UNFPA mission conducted a Programme Review and Strategy Development exercise and noted that there is evidence that the quality of FP care may be affecting the rate at which women accept and discontinue contraceptive use. The level of discontinuance suggests that service providers may not be taking appropriate action to resolve individual complaints regarding FP use. Nursing and midwifery personnel are the key providers of these services in Africa.

Further, almost four years after countries became aware of the AIDS epidemic and the prominent role of unprotected sex in the transmission of the virus, there is no evidence of increased condom use and spermicides as contraceptives of choice or as a form of protection for women and men against contracting as well as transmitting the HIV virus. The lack of comprehensiveness in both the content and process of MCH/FP services is a predominant feature of our health care systems. Women's health and development do not seem to be treated as the goal of our services.
Women attending antenatal or postnatal care or family planning services do not necessarily have access to a full range of STD screening detection, treatment and counselling services. More often than not they are referred to some other facility for further management. This forces women to disclose their personal problems to a number of providers, a situation which most pregnant women find unacceptable. This incompleteness of women's health services has contributed to a high default rate in this area. While the MCH/FP record will show that the client has been referred for either detection, diagnosis or treatment of STD, this information does not always get used as a basis for promoting the use of condoms (even during pregnancy and post-natally) as a protection against sexually transmitted diseases. Similarly, although health providers are aware of reports on the increase in the prevalence of breast, cervical, stomach and uterine cancer among young women in Africa, most countries have not established adequate cancer screening, early detection and diagnostic services. Even the reported cases do not reflect the extent of the problem. Ironically, most women attending MCH/FP, and those seeking other health care services, are not being taught simple skills for detecting lumps in their breasts. Similarly, education and counselling on their susceptibility and vulnerability to cancers of the breast, cervix and uterus are not part and parcel of the MCH/FP services received by women.

Further, women's health is still interpreted as pregnancy, delivery, postnatal and family planning services. This definition excludes a wide range of females whose health is in danger. Disabled women and adolescents are receiving little health care attention despite their special health needs. Similarly, the health needs and problems of the elderly are hardly comprehended let alone provided for.

This discussion has focused on only one of the eight components of primary health care for which nursing and midwifery personnel have responsibility. There is an urgent need for nurses and midwives to focus on vulnerable groups. In order for nurses to make an impact on the quality of life for those to whom they provide care, they must take into consideration the demographic, socioeconomic, epidemiologic and situational issues impinging on the population they are dealing with. This is a basic public health principle that nursing should adopt. Nurse scientists may argue that the nursing assessment provides for this. While this is a fact, nursing practice continues to ignore the effects of the environment on the health situations of individuals, families and communities. Midwifery and maternal and child health nursing practice illustrates these weaknesses. The challenge for nursing in Africa is to carry out public health and primary health care principles.
Conclusions

Most of the eight components of primary health care are not outside the realm of nursing practice. Indeed, they have been integral parts of nursing practice since the 1950s in most African countries. Nurses served as clinical supervisors as well as team leaders long before the 1978 Alma Ata Declaration on Primary Health Care. The primary health care approach stresses the concept of a health team at national, intermediate and district levels, and this approach has been adopted by all countries in the African Region. National health care systems have been organised into district, provincial and national health teams. It is in these teams that a nursing practice should justify its role, worth and existence. Ironically, it is in the area of working with others that nurses are not strong.

For example, a study that evaluated nursing and midwifery training in Botswana found that although nurses demonstrated competence in acting on patients’ expressed behavioural needs, most nursing and midwifery students who were about to be absorbed into the health care system within a few weeks were rated below average in competence in behaviours that entailed establishing relationships with other disciplines, contributing to health team planning, participating in staff meetings that reviewed progress in programme implementation and planning for the future.

Nurses in the African Region have mastered a number of new skills in recent years and acquired a wide range of primary health care knowledge. However, nursing education in Africa has not been able to effectively incorporate concepts for the development of skills for social mobilisation in health care. Community education strategies which have an empowering effect on families and community groups have not been adequately elaborated. Research has shown that if people are not sensitised, mobilised and motivated enough, the number of improved facilities, services and trained doctors, nurses and other health workers, provision of drugs, availability and accessibility of facilities will neither eradicate disease nor improve the quality of life of patients and families. Education programmes that prepare nurses in the African region have to pay special attention to the development of skills for promoting community participation at all levels. One of the weaknesses of contemporary nursing education in Africa is the failure to translate the concept of family-focused care into an educational tool for the development of people-oriented skills in nurse graduates. As a result, nursing and midwifery personnel do not have the requisite interpersonal skills to successfully work with families and communities.

Cognitive, interpersonal, personal and managerial process, strategic planning and consensus building skills are crucial for nurses and midwives in the African Region, if they are to work with others in a collaborative and
goal directed manner. In addition, quality assurance systems to monitor the quality of nursing should be developed as a matter of urgency. This area is one of the weakest in the African Region. Many national health programmes in immunizations, family planning, diarrhoeal disease and acute respiratory infections, malaria, tuberculosis and HIV/AIDS have put in place systems for monitoring progress, effectiveness and impact of programme interventions and activities. Nurses are providing leadership in both the planning and implementation of these programmes. It is time for nurses to do this more broadly, and put into place quality assessment, quality control and other procedures to monitor the quality of nursing services being provided to patients, families and communities. This is a major challenge facing nursing in the region.

Already nurses in the African Region are beginning to see examples of serious ironies and antitheses in situations where nursing is seen as pivotal to PHC yet nurses hardly get involved or participate in executive decision making. They are considered the powerhouse for PHC yet in many countries they are a “play house” when it comes to considering them for providing direction at executive levels.

National health care systems need to take a hard look at models for planning, training, deployment and utilisation of nursing resources for health, relative to other health professions. It has become abundantly clear that investment in the development of nursing and midwifery personnel pays dividends. Countries in the region have been able to diversify nursing programmes to meet the changing needs of communities; patients and clients receive services at all levels, or referred to the next level.

The fundamental issue is what nurses should do, not only as health care providers but also as activators of a myriad of social development activities within the communities they serve. Assuming that countries in the region will someday reach the levels of nursing human resources they require, further development will require a management system that takes into consideration the conditions for optimum functioning, growth and retention of nursing personnel and other human resources for health. The answers to questions about the manpower needed for primary health care can no longer consist simply of lists of various levels or categories of workers to perform specific tasks.

The availability of financial, human and material resources is a precondition to achieving quality nursing and health care. Without a budget, human resources for health and the materials essential for coverage and quality are not achievable. Health care systems with severely constrained resources can neither achieve coverage nor deliver quality care. This calls for setting priority strategies for priority problems. Balancing resources and needed activities and matching strategies to costs, benefits and outcomes
require that nursing education include economic and business management principles to prepare nurses for health planning and resource management roles.

The core for nursing practice and education in Africa has to take its cue from all the issues that have been discussed. Proactive research designs need to be developed along the key concepts identified, to deal with the problems and gaps in knowledge and practice. Research should focus on how nursing practice, nursing education and primary health care interventions can be made more responsive to the needs of individuals, families and communities. Some questions to be asked are in the areas of empowering individuals, families and community groups for managing their lives through self-care. Other issues that need to be addressed are related to increasing the capacity of nursing programmes to turn out graduates who can facilitate community participation, family development in health care, etc., and improving the capacity of nurses for directing national health care systems. Nursing education should promote practice-based research as a tool for identifying gaps in nursing education content and instruction strategies. And nurses in practice should use research to improve the quality of primary health care.
Nursing practice in the Region of the Americas

Introduction

The Region of the Americas is extraordinarily diverse and characterized by great inequities. The income of the richest fifth of the population is 28 times that of the poorest fifth. In Latin America and the Caribbean, nearly half the population live in poverty and many of them have no access to even basic health care. In contrast, the United States and Canada have extremely high per capita incomes and the most sophisticated health care technology in the world – in the U.S., however, where health care is primarily private, this care is not available to many of those who are uninsured. In spite of inequalities, death rates have been declining throughout the Americas for the last decades. Yet death rates differ even within countries, reflecting social and economic inequalities and the tendency to provide care to certain social groups while neglecting vast segments of the population.

Throughout the region cities are growing at a rapid rate, creating serious environmental, social and health problems. The cholera epidemic in Peru and other Latin American countries in 1991 is an illustration of the problems. Urban violence is also an increasing problem and HIV/AIDS is epidemic in the U.S. and growing in Latin America. Health development efforts are focusing on decentralization and strengthening of local health systems, efforts to improve living conditions, lifestyles, food and nutrition, and environmental improvements, especially drinking water and sanitation. This paper provides an overview of nursing practice in the Region of the Americas, reflecting the variety of situations found in the different countries, but without giving a complete picture of any one country.

Levels and categories of nursing personnel

Most countries in the Americas have at least three categories of nursing personnel – professional, auxiliary, and nursing aides or community health workers.

Professional or graduate nurses have three to five years of formal, post-secondary education. The preparation of a professional nurse follows three educational pathways:

Baccalaureate degree (e.g. B.Sc.) with four or five years of university education.

Associate degree (general nurse or nurse technologist) with two or three years of education at the university or community college level.
Diploma programmes with three years of education at the hospital level.

Auxiliary nurses have nine months to a year of formal training, frequently, but not necessarily, post secondary school. This training is usually connected with a health establishment, controlled by health ministries and occasionally, as in Ecuador, offered at the university. Guyana prepares a nursing assistant in a two-year programme.

Nursing aides have less than six months training – usually on the job, following three to five years of primary school depending upon the educational level of the country. Community health workers, with similar preparation, are sometimes considered nursing personnel.

In countries with shortages of professional nurses, there is a tendency to use unconventional methods to convert aides to auxiliary nurses and auxiliary nurses to associate degree nurses. In the Caribbean, nursing assistants prepared in two-year programmes may receive specialty training with general nurses in midwifery or psychiatric nursing.

Some baccalaureate programmes at university level (Argentina, Mexico, Venezuela) offer a lateral exit after three years of education, with the possibility of continuing to study for a baccalaureate degree immediately or after some years of work. There are still some complementery baccalaureate programmes for nurses with diploma degrees or associate degrees. The trend in Latin America is to have one category of professional education, while Canada and the United States continue to prepare two levels of professional nurses: the associate and baccalaureate degree levels.

Where nurses practise

In spite of efforts to place more emphasis on health promotion and protection, in almost all countries as many as 80% of nurses work in hospitals, and mostly in large urban centres. They are frequently found in out-patient departments, emergency rooms, and critical care units.

Several changes, however, are having an impact on the settings where nurses practise or will practise in the future. Restructuring of health care establishments, decreases in hospital beds, emphasis on a continuum of care stressing primary health care, and concern about costs mean that relatively more opportunities will be created in community-based settings such as school nursing, home health nursing and public health. In developing as well as developed countries, new opportunities are likely to be found in ambulatory and community settings.
School nursing involves not only primary care services but also population-based interventions to address problems of teenage pregnancy, sexually transmitted disease, nutrition, hygiene, drugs, alcohol and suicide. Programmes in schools are being expanded in Brazil, Canada, and the USA and strengthened in Colombia and Cuba.

In home health, services are provided to the maternal/child population, including high risk pregnant women and premature infants, as well as to chronically ill and dying patients. These services include intravenous administration of drugs including antibiotics and chemotherapy; rehabilitation for stroke and care of head and spinal cord injuries; and support for terminally ill patients at home. In some countries in Latin America, however, home visits to seriously ill patients are not routinely scheduled or they are initially made by physicians with auxiliary nurses providing follow-up visits.

Core functions of public health nurses are assessment, planning, implementation, surveillance, monitoring and evaluation. Other functions include policy development, quality assurance, licensure and regulation, identification of health problems, education and training and care coordination. Public health nurses are also involved in community advocacy and intersectoral collaboration particularly as they relate to solving priority health problems of high risk populations. Public health nurses, therefore, are trained in population-based services, epidemiology, biostatistics, community assessment, case management, and the ability to write grant proposals.

In Costa Rica, Colombia, Cuba, Mexico, and some sites in Canada, Chile, and the USA, nurses work in all types of industry and businesses to improve and protect the health of the work force. These occupational health nurses have three clients – the individual, the employee group and the agency/employer itself. Occupational health is prevention-based and includes health education, health promotion and wellness as well as primary care for acute and chronic illnesses and for injuries.

In birth centres nursing personnel deliver basic health services. In the United States there are free-standing birthing centres run by certified nurse midwives, and on the Family Islands in the Bahamas health centres with maternity beds are run by nurses with midwifery training. In some Latin American countries, nursing auxiliary personnel under supervision by doctors or nurses handle normal deliveries in health centres with maternity beds. In other areas deliveries are attended by professional midwives or by trained birth attendants.

Canada and the United States have been developing nursing centres which are directly reimbursed, primary care practices. For example, the Abbotsford Center in Philadelphia is located in renovated apartments in the
Abbotsford public housing facility. Patients receive 100% of their care from nurse practitioners; a physician visits once a week or so. The Center serves approximately 2100 persons including 600-700 under a managed care arrangement. Data show that Abbotsford managed care patients use the Emergency Room only one-seventh as much as other Medicaid patients, and the cost of inpatient and outpatient care is about 50 per cent less. Policy decisions are made by the Center's Management Committee, on which Abbotsford residents have majority representation. Effectiveness depends upon the dedicated services of three full-time outreach workers who canvas the community to find individuals who need care the most and encourage residents to take advantage of the services provided by the Center.

This nursing centre model shares some characteristics with health centres and posts in Latin America and the Caribbean in the primary care services provided by nursing personnel, the effective use of community health workers and the participation of the community.

Nurses are now also assuming responsibilities in organizing and managing care in all types of health care organizations, including health maintenance organizations (HMOs).

**What nurses do**

Nurses provide health and nursing care to individuals, families, groups, and the community based upon the identified needs of the population. Care includes health promotion and disease prevention as well as the treatment of common diseases and rehabilitation once an illness has passed the acute phase. Nurses are also involved in the long-term care of persons with chronic and degenerative illnesses and provide palliative care to the terminally ill. Nursing care is provided to clients throughout the life cycle.

Most commonly, nursing personnel are the primary care givers throughout the maternity cycle, for routine gynaecological care and family planning services as well as for prenatal care, labour and delivery management and post-partum follow-up, including well-baby care in routine low-risk cases. Many countries have established norms which recommend how routine visits are assigned to nursing personnel as key members of the health team. Nurses also provide care to school age children and adolescents, especially in health promotion and protection.

Nurses are increasingly involved in community organization and political action for solving health problems, sometimes participating in discussions about health reform and acting as advocates for underserved, vulnerable populations. Nurses are in the forefront of programmes and
initiatives directed at extending health care and health promotion efforts to communities most in need, and they adjust their approaches and services to different cultures and socioeconomic levels, adapting policies and procedures to the values and customs of the community. In 1994, for example, the Pan American Health Organization (PAHO) offered an award to an individual who had been responsible for the success of the immunization programme in the countries of the Region. Two nurses, one from Guyana and one from Peru, were honoured for their commitment and tireless efforts on behalf of the populations of their countries to achieve high levels of immunization coverage under extremely difficult situations. Nurses work closely with traditional health practitioners to improve the linkages between traditional and occidental health systems; this is particularly important in countries where the indigenous population is large or makes up a significant proportion of the most vulnerable groups. In Guyana, for instance, community health workers work closely with groups in the deep rural hinterlands.

As countries look for ways of controlling the cost of health care, nurses are taking on new roles in managed care. Nurses have also been important resources in the rise of ambulatory surgery centres in some countries, another strategy to reduce hospital costs. They provide patient teaching before the procedure and monitor post operative progress at home. An example is the work of nursing personnel in the University Hospital in Cali, Colombia. At the other extreme, in Guyana, the doctor is the person who provides patient teaching before surgical procedures. Usually there is no system of notifying staff in outpatient facilities about post-operative patients, and hence there is no routine care given post hospitalization. On occasion, the nurse may be informed about a post-operative patient by someone in the community during a home visit; or sometimes the post-op patient visits the health facility for a dressing change or other nursing procedure.

Shortages of nursing personnel in many countries continue to affect the quality of health care and limit the potential of nurses to deliver services. Because of these nursing shortages, especially in Latin America, direct nursing care for even the most seriously ill patients in hospitals and for families with complex problems in the community is frequently provided by auxiliary and often untrained workers. In these situations nurses are primarily involved in managing personnel and supervising the care provided by others. During evening and night shifts, professional nurses play a supervisory role, in charge of several wards or sometimes an entire hospital.
The level of responsibility and autonomy

Generally speaking, nurses have a lot of responsibility but they do not have an equivalent amount of authority over their practice. Although nurses have some autonomy in practice in some of the developing countries, since practice is poorly regulated, other professionals often intervene in decisions about the scope of nursing practice. However, some think that nurses could have more authority over what they can do but, for reasons of tradition in deferring to the physician or perhaps because of cultural norms tied to gender, nurses do not assume that authority.

To a certain extent, the situation reflects the institutions – often centralized and bureaucratic – in which nursing personnel practise. Nurses are not expected or permitted to make decisions about the care of patients and in some cases they deliver only the care which has been ordered by others. In other cases, head nurses and supervisors are expected to resolve all patient care and administrative problems for the nursing staff. At the same time, nurses are expected to provide care for patients continuously. Complicating the situation is the fact that, in spite of the responsibilities, nurses are frequently poorly paid.

In some cases new management models are being tested, particularly as health systems move towards more local control and decision making. Shared governance has become fairly common, at least in the US, where some form of shared governance is in place in about one-sixth of hospitals. Shared governance is an organizational structure and process which legitimizes professional nurses’ control over their practice and extends their influence to administrative areas previously controlled by management. Both authority and the expectation of participative decision-making in clinical and administrative areas are institutionalized at the staff-nurse level. Shared governance has been credited with improved quality of care, strengthened professional values and organizational culture, enhanced professional autonomy, empowerment, staff morale, and job satisfaction and improved job retention. Potential drawbacks are a slower decision process to produce consensus, protracted implementation time, high costs and diminished nursing time at the bedside. In future, with decentralization, it will be important to consider how shared governance models can be relevant in situations where there are few professional nurses delivering direct care because of their small numbers.

What nurses could/should do

Research-based nursing care and care based upon new nursing and health care models are in the early stages of development in many countries
of the Region. It is important for nurses to systematize and document their practices so that models of care and nursing theories can be built from an analysis of what professional nurses actually do. For this to become a reality, however, at least in Latin America, it will be necessary to resolve the critical shortage of professional nurses, which limits their involvement in direct care.

Nurses could assume greater responsibility in the organization and management of health care as well as the provision of care to the population. Nursing care is holistic; therefore, nurses could help reorient the health care system toward more emphasis on health promotion and disease prevention and on follow-up after the acute phase of an illness.

As stated by the World Bank in *World Development Report 1993: Investing in Health*, nurses could provide most of the primary health care services recommended for the basic public health and clinical packages. Non-physician primary care providers such as nurses and midwives have been shown to be cost-effective. Furthermore, nursing personnel are easier to attract to rural areas than physicians and usually communicate more effectively with patients. In many countries, however, it will be necessary to create incentives to attract nurses to some rural communities where working conditions are sometimes dangerous and often very difficult.

Studies have shown that appropriately prepared nurses can deliver as much as 80% of the health care and up to 90% of the paediatric care that is currently provided by primary care physicians at equal or better quality and at less cost. In Guyana, nurses and allied professionals deliver as much as 80% of the health care. In Chile, according to the Ministry of Health, 92% of nearly 4 million child health visits per year are provided by nursing staff. In one study in the United States of America (USA), costs-per-episode were 20% less when nurses provided initial care than when physicians did. A recent estimate projected that underuse of nurse practitioners in the United States costs the nation as much as $8.75 billion annually.

As most countries are faced with a growing population of persons aged 65 and above, nurses can be cost-effective providers for the range of services needed by the elderly – care in the home for well elderly, care for those who are chronically ill or homebound, and care for elderly who suffer from dementia or other cognitive or physical problems and require assisted living or nursing home care.

One issue which limits the scope of nursing practice in some countries is that of authority to prescribe drugs. Prescription authority depends upon current legislation or regulations and is generally only provided to physicians, though it is argued that nurses can be granted or delegated prescription authority in three different situations:
a. Initial prescribing of medication or dressing from a limited nurse formulary list.

b. Group protocol prescribing in which nurses administer drugs predetermined by a medical practitioner within the terms of a mutually agreed upon written protocol detailing the drug and the situation in which it would be used. Immunizations, TB control drugs, treatment for venereal disease, treatments for respiratory and diarrhoeal diseases are examples.

c. Time and dose prescribing in which nurses work within patient-specific protocols to alter the time and dosage of specified medicines prescribed by a medical practitioner. This category is primarily for people with learning disabilities, psychiatric problems, diabetes and terminal illness.

As the questions of what nurses can and should do continue to be addressed, it will be important simultaneously to clarify the roles, responsibilities and relationships between nurses, midwives, physicians, physician assistants and other caregivers.

Areas of specialization

There are two basic types of nursing specialization in the Region: postbasic level (after the Diploma or Associate Degree) provided through short courses of up to one year, and postgraduate level (after the Baccalaureate). The postgraduate level offers two tracks: master’s degree and specialization. The master’s degree is oriented to academics and research, while specialization is more oriented toward clinical practice. In Canada and the USA, in addition to other master’s degrees, there are master’s level clinical specialists and nurse practitioners. A study of graduate nursing education in Latin America and the Caribbean has revealed that, especially in Latin America, schools of nursing are offering graduate programmes not only in nursing but also in other health areas which are open to various health personnel.

The most common areas of specialization are midwifery, community health, administration, operating room, central supply, anaesthesia, critical care, dispensing and, more recently, oncology and mental health. Guyana prepares health visitors with one year postbasic training as a midwife and then one year as a health visitor. Relatively few countries have graduate degrees in nursing and only Brazil, Canada and the USA have a doctorate in nursing. The Caribbean countries have implemented a family nurse practitioner programme and more recently a psychiatric nurse practitioner programme. Guyana has a MEDEX Programme which is similar to the
physician assistant programmes in the US. However, most MEDEX graduates also have preparation in nursing.

The responsiveness of nursing practice to changing demography and changing health care needs

Although nurses are trying to develop innovative practice models, the organizations in which nursing practice takes place limit the possibilities for nurses to expand to more non-traditional sites. This means that nursing practice is primarily involved with the treatment of disease rather than health promotion and protection, and primarily involved with mothers and children with little attention to healthy non-pregnant adults or the elderly.

However, there is evidence of nursing's response to changing health care needs. In the case of the cholera epidemic in Ecuador, Peru and other Latin American countries, nurses were responsible for a broad range of actions which reduced the number of deaths and helped to control the disease.

In some countries, nurses have been involved in programmes to address the special needs of refugee populations. Nurses have contributed to a reduction in maternal and infant mortality through community advocacy, health promotion and programme management. They have also been involved in promoting family planning, initiating care for a growing elderly population, working intersectorally to address problems of nutrition and violence, and expanding follow-up for persons with chronic disease. While nurses practise where there is a need for nursing care, in many countries, because of serious nursing shortages, there are not enough nurses to meet the needs. An important factor in this has been the reduction or freezing of vacant posts due to macro policies which prioritize high tech development.

Nurses are concentrated in the large urban areas and in large institutions. In Latin America, few professional nurses are found in rural areas except in countries which require a year of public service in repayment for low cost or free education. In Canada where there are more than 260,000 registered nurses, about 500 work in the Yukon and Northwest Territories while almost 104,000 live or work in the most populated province of Ontario. There are, however, a few examples of programmes which have been developed to prioritize human resources for health in areas of shortage, such as those found in Northeast Brazil, Colombia, Peru and more recently in the FASBASE project of Ecuador.

In the wake of a growing and expanding private sector in many developing countries, nurses are leaving the public sector attracted by
higher pay, better working conditions, enhanced professional recognition and more benefits. Argentina and Chile have reported serious shortages in public facilities as the private sector absorbs a greater number and proportion of qualified professionals.

The appropriateness of basic and continuing education

Nursing education in many countries continues to be disease-oriented rather than community and primary health care oriented. Many leading schools, however, have made fundamental changes in their curriculum to focus more on the health care needs of the population and community. There is also a trend toward involving nursing services in curriculum planning and in implementing collaborative approaches to clinical practice. Many schools, in conjunction with services, have selected a community as an area of practice where they assume responsibility for providing continuous health services with community participation, for example in Brazil, Chile, Colombia, Ecuador, Honduras and Mexico. This training should lead to more assertive, analytical and broad-minded nurses. Some countries in Latin America, such as Argentina, are developing innovative projects on professionalization of nursing personnel as a means of increasing the number of professional nurses. Mexico is working towards the professionalization of nurses from diploma to baccalaureate degrees. However, more nursing posts must be created at the community level since the major employer of nurses is still the hospital. Continuing education has been very limited in scope, directed more toward skills development, often without the feedback provided by evaluating the impact on personnel activities. One area that needs to be emphasized in Latin America is the development of strong continuing or permanent education. Nurses in general do not have opportunities to participate in continuing education programmes which will update their knowledge and skills and solve the problems that arise in their practice, nor do they have opportunities to learn to develop appropriate services that will have an impact on populations.

The enabling and constraining factors for appropriate quality nursing practice

One factor which may be both enabling and constraining for nursing practice – depending upon the involvement of nursing – is health sector reform. In Canada, for example, the context of reform provides ample opportunities for nurses to play an important role in the debate about reform and the reformed system. The context of reform is equally relevant to other countries, regardless of their level of development; it includes
- a refocus on health promotion and disease prevention
- shift from hospital care to community, out-patient and home care
- cost-effectiveness of programmes and personnel at all levels
- restructuring of hospital governance, funding and administration
- management of the supply of health personnel to support reform
- creation of self-regulated professions such as midwifery and the review of rights and responsibilities among existing professions.

In the area of basic nursing education, countries have sometimes created new categories of nursing staff based upon special circumstances. Dominica, faced with a serious problem of out migration of professional nurses, has trained community nurses, a category which is considered professional but is composed of nurses who will only work in the community. Bolivia, Ecuador and Paraguay have prepared community auxiliary nurses with a similar intent. These examples point to future trends in countries’ efforts to meet human resource needs.

In graduate nursing education, an important limiting factor has been the lack of demand from the services for nurses with master’s degrees. In Latin America, even where there has been a relatively long tradition of offering graduate courses, nurses are not expected to have graduate preparation except when they are faculty in nursing schools.

Other limiting factors include the lack of validation of these graduate courses by health services, which do not have career plans and corresponding salary increases for personnel. This situation does not stimulate professionals to seek to improve their competence.

In the countries of the Caribbean, successful completion of prescribed educational programmes is required for upward mobility and career development, and for performing certain specialist functions such as midwifery, teaching, critical care, anaesthetics, and mental health, among others. Depending upon the duration of the educational programme, the nurse may be required to enter into a future employment agreement with the government as a condition of participation.

Other aspects of working conditions (salary, career prospects, housing, safety, adequacy of health care facilities, transport, availability of necessary equipment, supplies, drugs, etc.) are obvious limiting or enabling factors. For example, when incentives are provided for work in remote areas, it is easier to recruit and retain staff. Also, because of the socioeconomic situation in many countries, the places where nurses work – hospitals, public health centres and communities – have shortages of health personnel including professional nurses. Because nurses receive very little pay, they must
sometimes hold two or three jobs in order to provide for their families. Studies of health and working conditions of nursing personnel have demonstrated the serious deficits and the results in terms of poor health for nurses and their families. Furthermore, it is difficult to provide safe and effective nursing care when the necessary equipment, supplies and drugs are not available.

Concerned about the continuing shortages of nursing personnel in many countries, the Pan American Health Organization's (PAHO) technical cooperation is directed at supporting efforts to deal with shortages in the short and medium term and to strengthen management and leadership at all levels. Many countries have developed strategic action plans for nursing in general while others have focused on nursing in local health systems. In some instances new methodologies such as prospective analysis have been developed to facilitate changes in education of nursing personnel as well as in practice as part of health system reform.

Many activities to improve the quality of nursing care have been developed through cooperative efforts between countries, WHO collaborating centers, nursing associations, other institutions, and PAHO. Leadership has been promoted by means of conferences, faculty exchanges, seminars, visits, etc. Projects and experiences of primary health care are being promoted and exchanges of information and material are in process. Research is being encouraged, with some collaborative research projects already underway; technical and bibliographical data bases are in progress, and efforts to increase information exchange among nurse researchers are ongoing. Continuing education courses are being developed, and arrangements have been made for several professors to spend their sabbatical in other countries. Possibilities are increasing for nurses from developing countries to study for their master’s and doctoral degrees in their countries or abroad.

Health services research could have a great impact on the delivery of quality nursing care through the dissemination of the results of research and/or by replicating studies which have been carried out in different contexts to see if the results are the same. For example, in the United States, considerable research indicates that hospital mortality rates decline as the percentage of registered nurses (RNs) on staff increases. Hospitals with higher percentages of RNs on staff, compared to other nursing personnel such as unlicensed aides, had lower than expected mortality rates, after adjusting for severity of patient condition. A study of infant mortality in hospitals in Argentina found that the number of physicians at ward level was less important for the outcome of care than the number of nurses. The author concluded that the number of nurses, without regard to their
educational background, is an important ward resource related to better outcomes.

One external factor which influences the scope of nursing practice is the relative number and distribution of physicians. In Canada and the United States, the ratio of physicians to nurses is one to three, but in Latin America the ratio is reversed with at least three (and as many as 10) physicians to one professional nurse. This situation affects not only how nurses are utilized in the delivery of health care at all levels but also how the work of auxiliary personnel is assigned and supervised.

Nursing practice in the Region is clearly dependent on numerous external and internal factors. The appropriate adoption and utilization of new technologies in health care are ongoing challenges. New roles and models of care require changes in nursing care, in ability for decision making, leadership and management for change. As we approach the Year 2000, it will be important to consider how nursing practice can be adapted to make even greater contributions to meeting the health needs of the population.
Nursing practice in the Eastern Mediterranean Region

Introduction

Member States of the Eastern Mediterranean Region share many common features – ethnic composition, language, religion, political tradition, social values and customs. Thus social behaviour and mores tend to affect the health of individuals and communities in similar ways. Yet a wide variety of political institutions exist in the region and countries vary greatly in their socioeconomic development. At one end of the spectrum are politically stable and rich countries with steady, well coordinated development; in the middle of the spectrum are less well-off countries that have nevertheless been able to sustain reasonable advances; and at the other end are the poorly endowed and less stable countries where unsettled political situations and civil strife hamper national development.

In recent decades inflation and unemployment have seriously affected the living standards and health status of most people, especially in the less developed Member States. A rapidly growing population exacerbates the problems. Further, rising military expenditures in a number of countries take resources away from development. Nevertheless, life expectancy has risen dramatically in the last decades. The average infant mortality rate dropped from 97 per 1000 live births in 1958 to 71 per 1000 in 1994. The mortality of children under five also dropped. Progress in the control of many communicable diseases was in part responsible for the rapid drop in mortality. Deaths from malaria, EPI-target diseases (except TB) and other infectious diseases are decreasing. Activities for promoting primary health care are ongoing in all countries, and most have initiated reforms of the health systems. However, despite noted improvements in health throughout the region, a large burden of premature mortality and disability remains. In some of the region’s countries infant and maternal mortality remains high, and while the incidence of infectious and parasitic diseases is decreasing, acute respiratory infections and diarrhoeal diseases are still prominent causes of mortality. In some countries wars and civil strife in recent years have caused great loss of life, displacement of populations and disruption of health delivery systems. At the same time, economic development, demographic changes and social and cultural changes are producing a shift in the disease pattern away from infectious and deficiency diseases toward cardiovascular disease, cancer, diabetes mellitus and other chronic non-communicable diseases. Accidents and mental illnesses are also on the increase and the threat of AIDS is growing. In some countries, tuberculosis has become a major health problem.
Even before the Declaration of Alma Ata on strategies for health for all, the EMR recognized the need for nurses in primary health care and for community-oriented curricula to prepare them. However, efforts to strengthen the role of nurses and midwives in primary care suffered from the low status of nursing in the health field and in society, and nurses' lack of power and roles in decision making in the health system. Since nursing was a predominantly women's profession, the low status of women in many Member States, especially in rural areas, compounded the low status of nursing.

In recent years governments in the EMR have taken a number of initiatives to improve the status and image of nursing and to attract both males and females into the profession and retain nurses in the workforce. The resulting progress in strengthening nursing and midwifery in the region has been enormous. This progress can best be seen against the backdrop of history. Traditionally in the EMR the nurse was seen as a maid for patients and a handmaiden for doctors. Nursing schools simply trained students to carry out physician orders.

In 1950 there were only 40 schools of nursing in the entire region and no degree programmes. Only girls were allowed to become nurses. Nursing did not exist as an organized profession, and salaries and working conditions were deplorable. By 1965 the number of nursing schools had increased to 144, and 60 of these accepted males as well as females. Two countries had started degree programmes by 1960, and by 1984 one country also had master's and doctoral programmes.

University education for nurses has now been established in nearly all Member States to prepare well qualified nursing personnel with leadership capabilities. A number of countries have developed or are planning advanced degree programmes. Mass media campaigns have been launched to increase public awareness of the nature of nursing and the value of nursing services to the nation. Training and education opportunities have been provided for nurse educators and managers. Several countries have established nursing positions in the Ministry of Health. Incentive schemes for nursing personnel have been instituted to reduce attrition among employees, and training opportunities have been provided for preparation of nurse educators and managers. Despite these efforts, however, most countries of the Region are still suffering from major problems related to the delivery of nursing services that have impaired the effectiveness and efficiency of health systems and the implementation of national health strategies.
The nursing workforce

Undifferentiated use of different levels of nursing skill is prevalent in most countries in the Region. There are currently 22 levels of nurses and midwives in the Eastern Mediterranean Region. The range is from one to five per country and the mean is three per country. The use of personnel claiming the title “nurse” whose educational preparation ranges from almost nothing to graduate education adds to the confusion. Frequently nursing assistants and auxiliaries provide direct patient care without supervision or guidance. In addition, there is considerable evidence that the skills of nurses are misused in clerical work, laboratory services and other non-nursing activities. Unfortunately, very little reliable information exists on the numbers of nurses of different levels of skills available for employment or employed in the countries of the region. Despite the lack of information, however, it is clear that in almost all countries of the Region there is a shortage of suitably qualified nursing and midwifery personnel. Several factors have had direct effects in creating this shortage. They include the priority given to investment in developing large and technically complex hospitals linked to the rapid growth in medical specialization and subspecialization and imbalance in the ratios of physicians and nurses. In 1993 the average ratio of nursing/midwifery personnel to physicians in the EMR was 13-14:10, as compared to 26-42 nurses/midwives to 10 physicians in the Scandinavian countries. It is not uncommon to find junior medical staff undertaking nursing responsibilities, which is not cost effective and adds to the already high cost of care.

It is estimated that 90% of the nursing workforce in the region is currently employed in hospitals. As a result the poor and rural populations are often underserved, and lesser qualified nursing personnel are assigned to their service.

At the same time, an expanding health system infrastructure, increasing population, advances in the use of medical technology and greater public awareness of the importance of health care are increasing the demands for nursing services. In some countries expatriate nurses have been employed to make up for the shortage of national nurses. However, foreign nurses are generally unable to communicate with patients and they lack knowledge of cultural values: hence their care is technical only and often of poor quality. The use of expatriate nurses also leads to the migration of qualified personnel from the poorer countries of the Region to the richer Gulf countries or Western countries, depleting the supply at home. Some countries of the Region have used unqualified personnel to handle the demand for nursing services, but this leads to low quality of services and increased need for supervision to guide unqualified personnel. Some countries have not suffered from a shortage of nurses; indeed, a few
countries have had a surplus of applicants to nursing programs. Also, in a few countries of the Region shortage is created not by insufficient supply of nurses but by failure to fund a sufficient number of nursing posts in the budgets of governments.

The practice of nursing

Nursing services are delivered in Member States by a variety of nursing personnel and auxiliaries/assistants with various levels of education and competence. It is thus no surprise that the quality of nursing services ranges from excellent to poor. In special care units such as intensive care and units concerned with burns, cancer, coronary care, renal dialysis, etc., where nursing personnel have received appropriate training or the services are staffed by qualified expatriates, the quality of nursing care is high and the contribution of nursing staff to patient welfare is evident. However, in areas where nursing personnel have not been well prepared, they function as general staff nurses.

While competence plays a major role in determining the quality of nursing practice, several other factors also contribute. Inadequate staffing, lack of supervision, ineffective regulatory mechanisms, limited resources, the absence of procedure manuals, lack of standards of care, and absence of procedures for quality control lead to deterioration of the quality of nursing care. Interpersonal relationships among management and nursing personnel and communication between the medical establishment and the nursing workforce also tend to affect the performance of nurses as well as their professional image and status.

Nursing services in most countries of the Region are offered mainly in hospitals, out-patient clinics, health centres and, to a lesser extent, schools and the community at large. The majority of services available in the community are concentrated on maternal and child health. General public health nursing services and community nursing care are not well established in the Region. As a result, the predominant activities of nurses are curative, even in non-hospital settings, and the emphasis is on physical care and activities related to execution of medical prescriptions. Nurses attend to the sick and injured and are seldom involved in formal or informal health education. Nursing interventions that contribute to health promotion and disease prevention such as case finding, follow-up of defaulters in programmes such as family planning and individual counselling, etc., are carried out on a limited scale.

In hospitals, nursing services are frequently organized so as to distribute tasks such as medication administration, sterilization of
equipment, dressing and wound care, and patient investigation, etc., among the available nursing personnel. Although this assures delivery of care to meet minimum physical patient requirements, it is a fragmented approach to care delivery. In some Member States the practice of nursing is considered a technical service consisting of a series of nursing procedures and activities prescribed by the medical or administrative hierarchy of the curative health services. The “caring” component of nursing is frequently lost. Further, there is considerable overlapping of roles given the multiple categories of nurses and auxiliary groups. In some clinical areas there are as many as seven different categories of nursing personnel. Alternative approaches to management of nursing services such as patient care management, primary nursing care and team approach patterns to unit staffing are being considered and tried in some countries. However, in some countries nurses and midwives are excluded from many health promotive, preventive and therapeutic tasks. A shift in the focus of nursing and delivery of nursing services from being dictated by the medical establishment or hospital administration to the needs of patient and family will require establishment of standards of nursing care and nursing protocols emphasizing the nursing process. This will require reorientation of all personnel working in hospitals and appropriate in-service education and an appropriate system of nursing management and supervision.

The shortage of nursing personnel in most countries of the Region is the fundamental cause of low standards of nursing care. As the demand for nursing care outpaces the ability of countries to produce or provide additional personnel, the work load for existing nursing personnel increases, quality of care suffers, and morale among nurses declines, leading to high attrition in the workforce. Given the shortage of nurses, one would expect that, where available, nurses would be used solely for direct patient care and family support. However, studies in several countries of the Region have found that nurses spend a sizeable percentage of their time in non-nursing activities. For example, in Bahrain, a study revealed that 22.3% of nursing activities observed were personal clerical, indirect or training activities. A similar study in a university hospital in Egypt found that nurses spent more than two-thirds of their time in indirect care activities. In a study in Kuwait, only 60% of the activities of nursing personnel were patient centred. Nurses are often assigned to non-nursing jobs in laboratories, the X-ray department, pharmacy and administration, depleting the nursing workforce and affecting the quality of services.
Nursing management

Traditionally, nursing and midwifery have been “driven” by the medical profession. As a result, nursing and midwifery leadership has been slow to evolve. In part this reflects the status of women in many Member States, and in part it reflects the youthfulness of the workforce - the age at entrance to nursing school has ranged from 14 to 17 years, and high attrition has limited years of service. Further, the health system hierarchy has not been conducive to building nursing and midwifery leadership. The centralization of decision-making processes at all levels of the health infrastructure has inhibited the ability of managers to initiate change and introduce innovative approaches.

Managers of nursing services are often appointed to these posts on the basis of years of service, without educational preparation in nursing service management. Usually they are appointed in the institution in which they have been practising. Their management abilities may be limited and they tend to perpetuate the systems with which they are familiar. This limits the possibilities of introducing change in nursing practice. In addition, many senior nurse managers are overwhelmed with the daily burden of excessive administrative duties and they become distanced from the realities of clinical practice. This affects their ability to make focused judgements and provide the necessary levels of support to advocate changes in practice. For this reason the EMRO embarked some years ago on a programme of strengthening managerial capabilities of nurse managers through regional workshops on nursing management, support for national training activities for various levels of nurse managers and development of a training manual for in-country training in nursing services management.

Nursing education

Basic education

All countries in the Eastern Mediterranean Region have basic nursing schools, affiliated mainly with ministries of health, ministries of education, universities, military services or private organizations. In recent years all Member States in the Region have established more nursing schools and launched campaigns to attract young males and females to the professions of nursing and midwifery. However, many Member States still suffer from a shortage of qualified nursing personnel and from a confusing multiplicity of nursing categories.

Education programmes vary among countries and sometimes three, four, or more types exist in the same country. Several countries have three
different basic nursing programmes: a three-year programme for students who have completed 9 years of general education; a two-year or three-year associate degree programme following completion of secondary school; and a four-year Bachelor of Science in Nursing curriculum at the university. One country requires a year of internship after the Bachelor of Science in Nursing degree. Another country has two categories of registered nurses, one prepared in a four-year baccalaureate programme and one prepared with a three-year diploma, in addition to associate nurses prepared in a two-year programme and two categories of practical nurses, one prepared after 10 years of general education and one after 12 years. In one country, basic nursing education has developed at two levels: the diploma nurse and the B.Sc. nurse, though entrance requirements for the diploma programme vary in different parts of the country. Some countries have only a four-year university-level baccalaureate programme following 12 years of general education. One country requires only six years of general education for admission to a nursing programme.

These multiple types of programmes lead to multiple standards, with negative effects on the delivery of nursing services. In addition, in many countries the largest number of nursing students are attending programmes that require only nine years of schooling for admission. This is inadequate for preparation of the nurses of the future. Nine years of preparatory education do not provide sufficient knowledge of basic sciences or general education to study modern nursing, and many students drop out of the nursing programme. Further, when students graduate they are only 17 years old, too emotionally young to cope with the responsibilities of caring for the sick in hospitals or for families in the community. This leads to a high attrition rate, adding to the nursing shortage. Yet some countries place upper limits on students' age, preventing more mature candidates from enrolling.

Nursing curricula in most countries of the Region were founded on the medical model and they stress individual and curative hospital care. Thus graduates of many nursing programmes are not prepared to participate in the strategy of health for all through primary health care. In recent years a number of countries have adopted more community-relevant curricula, with emphasis on primary health care. For example, the new community-oriented B.Sc.N. programme in Iran is designed to prepare graduates who are sensitive to the health needs of the country, who have the knowledge and skills to preserve and restore health and prevent illness, and who have developed problem-solving attitudes. In Cyprus, the basic nursing programme now includes experience in caring for people of all ages and emphasizes the concept of primary health care in all areas of practice. In Bahrain the curriculum is being reoriented toward the concepts of primary health care, the problem-solving approach, and community participation.
However, in many countries efforts to implement more community-focused curricula have encountered problems arising from the affiliation of nursing schools with hospitals and the needs of hospitals for the services of students to make up for the shortage of nursing personnel. Also, teaching staff are not fully prepared to train students in the community, and in some programmes physicians remain a dominant force.

Educational resources vary widely. Few institutions have adequate numbers of qualified teachers, and the shortage of those with a primary health care orientation is particularly acute. Clinical teaching is also a problem in some countries because of the shortage of preceptors in clinical practice who can supervise students, the absence of role models and clear standards of nursing care, and the unavailability of equipment and resources. The tendency to isolate education from actual practice means that students are rarely provided opportunities to function as part of the health care team until after they qualify. Field practice in community settings is often lacking entirely. In addition, educational programmes sometimes fail to take into account the changes that are occurring in practice because educators have limited opportunities to follow recent research or update their skills and expertise. Thus students are sometimes trained in a vacuum or given an unrealistically narrow perception of the scope of practice.

The majority of nursing schools also have inadequate teaching-learning materials that are in national languages and culturally relevant. Some countries report a shortage of journals related to nursing in the college libraries. In an effort to tackle the problem of lack of materials in national languages, following the recommendations of the Regional Advisory Panel on Nursing, a series of textbooks in Arabic has been initiated, but only a few texts have been completed to date. This lack of resources compromises the quality of the education.

The quality of basic education is also compromised by lack of a systematic approach to the accreditation of nursing education programmes in almost all countries. While periodic curriculum reviews are carried out in some programmes, there is no system for assessing the implementation of nursing education against clearly identified standards.

In summary, basic nursing education in the Region is compromised by a lack of power and control by nurses over nursing education, a lack of standards, variation in entrance requirements – from six years of general education to 12 years, failure to attract or, in some cases, even allow males in the profession, upper age limits excluding adult learners, variation in curriculum length from 12 months to five years, curriculum content that is oriented toward hospital care with little involvement in activities related to health promotion and prevention of disease, inadequate teacher preparation and isolation of nursing education from practice.
Midwifery education in the region shares many of the problems of nursing education. In some countries, midwifery training programmes are offered following the completion of basic nursing training (Bahrain, Egypt, Jordan, Lebanon and the Syrian Arab Republic), while other countries offer midwifery programmes as a basic training programme (Djibouti, Islamic Republic of Iran, Morocco and Tunisia). There remains, however, a scarcity of midwifery training programmes and an inadequate supply of qualified midwives.

The Regional Advisory Panel on Nursing has recommended a number of steps to improve and standardize nursing education throughout the Region. Their recommendations are designed to produce nurses in sufficient numbers and with sufficient skills to provide quality care in all types of settings for all age groups. Further, the aim is to produce nurses who are not only practitioners but also are active as citizens of their communities, sensitive to political and social developments, and able to play a role in policy development and implementation. The long range goals are to improve the health of the people, develop nursing as a profession, and promote sustainable development in countries.

Postbasic education

Because of the increasing complexity of health services at all levels and the need for nurses with advanced knowledge and skills, some countries in the EMR are now developing postbasic training in specialized areas. However, like basic programmes, these programmes vary greatly in length and scope as well as entrance requirements. One-year postbasic courses are offered in some countries in a variety of specialized fields such as ward administration, teaching, cardiology, ophthalmology, community health, midwifery, anaesthesia, urology, and psychiatric nursing. One country offers four-week certificate courses in medical/surgical nursing and continuing education in mid-level management, ward management and clinical teaching. Another offers a master’s in nursing education and programmes ranging from nine to 12 months in length for specialization in a variety of areas, as well as short programmes in narrow areas such as kidney dialysis, burns, etc. Still another offers a two-year programme for nurses to become medical assistants and, in another, students who have completed the baccalaureate may be trained in three-year programmes as specialists in obstetrics, anaesthesia, radiology, therapy or biology. These graduates, however, are not considered nurse specialists but high technicians of public health.

In some countries, weak undergraduate programmes have been upgraded into specialty programmes as a short-term solution to acute needs
for particular health services. In other countries nurses have been used as the pool for training paramedics. Both of these developments raise questions about what constitutes specialist training and what constitutes a specialist nurse. Management of cancer patients, intensive care nursing, diabetic patient education, accident and emergency care, infection control, occupational and mental health nursing are among the specialty nursing fields which are needed in most countries of the Region. Yet training in many of these areas is not available in the Region, and opportunities for overseas training through fellowships are limited. Development of specialization in nursing is a major challenge for the Region. To avoid the chaotic proliferation of programmes in specialized areas, the Regional Advisory Panel for Nursing has recommended that countries systematically plan, develop, implement and monitor nursing specialization in a way that responds to the demands of the Region and at the same time assures the development of the profession.

Continuing education

There are numerous in-service educational activities available in all countries of the Region, directed by the health ministries. However, many of these programmes concentrate on re-education of staff rather than the development of new skills and knowledge to support changes in practice. Systems of continuing education for nursing personnel to update their professional knowledge and improve the quality of nursing services are lacking in some countries of the Region. During the first Gulf Nursing Conference held in 1993 in the United Arab Emirates, one participant indicated that this was her first participation in a nursing conference since her employment 15 years earlier. This is not unique; in fact, unfortunately, it is the norm rather than the exception in many countries. However, as noted above, some countries are beginning to offer short-term certificate courses, and others are developing longer continuing education programmes.

Factors constraining and enabling appropriate nursing and midwifery practice

Nursing is primarily a women’s profession and in many EMR Member states, the status of women leaves much to be desired. The low status of women compounds the low status of nurses, who are often portrayed as the doctor’s helpmate with no control over the health service rendered. Lack of power and prestige and the lack of a role in decision-making have contributed to low self-esteem of nurses and poor image of the profession. Many Member States are now, however, encouraging young men to join the
nursing profession, a viable strategy for addressing issues confronting nursing as a career for women.

The role of nurses in policy making is a major issue in the Region. While governments have stated policies and have initiated programmes advocating and implementing a primary health care approach, until recently the focus of nurse training and the deployment of nursing personnel were geared toward highly technical activities associated with tertiary care. Programmes have been initiated and terminated based on immediate institutional requirements rather than existing and projected needs of the population, and the result is numerous categories of nurses trained to varying standards and care that varies widely in quality. Nurses have not been sufficiently empowered at policy levels to refocus nursing education and practice in line with governments’ stated primary health care objectives.

Further, in many health systems nursing personnel are given only nursing jobs and they move only within the nursing hierarchy, which is often headed by non-nursing professionals. Until recently, senior management and policy-making positions were not open to nurses. A number of countries in the Region now have a unit, department or post for an adviser responsible for nursing services on a national level; and several other countries have nursing representation at the national level within the departments or units of manpower, training, primary health care or maternal and child health. Sometimes, however, positions have no clear job descriptions, and responsibility without authority creates frustration, high turnover in these posts and unwillingness of capable, independent nurse leaders to take such jobs. Few countries have a viable nursing directorate that functions across the spectrum of levels of health care. Further, many departments of nursing are within the framework of a curative division, neglecting the roles and functions of nurses in community settings. Clearly there is room for improvement in most countries. In one country in the Region, a qualified nurse serves as Director of Training in the Ministry of Health. If more such initiatives were undertaken by governments, they could have an impact in changing the status and image of nursing in the Region.

Another constraining factor in the Region is the lack of strong cohesive leadership in nursing that can raise policy issues and develop strategies to strengthen nursing and midwifery services. This lack of leadership is attributable to a lack of continuing education opportunities for nurses, lack of autonomy and power in health systems, and the dominance of the medical profession. However, with the rising level of education for women in the Region, there is increased interest in nursing as a career, as evidenced by the increasing numbers of applicants to nursing schools. Further, there is increasing political support for nursing and midwifery in Member States.
and increasing interest in upgrading nursing education and introducing postbasic nursing specialty programmes.

In recent years a number of countries have taken steps to systematically assess their needs for nursing and midwifery services and develop a structure for meeting these needs. For example, Lebanon initiated a study of nursing workforce and training institutions; Pakistan formed a task force of nursing leaders who analyzed issues and problems hindering nursing education and service delivery; in the Syrian Arab Republic a national conference of policy makers, health officials and nursing leaders was held to formulate a plan for upgrading nursing in the country. Bahrain, Egypt, Jordan, Kuwait, Sudan and the United Arab Emirates have developed national strategic plans for nursing and midwifery services. At the first Gulf Nursing Conference in 1993, leaders from the six Gulf countries adopted a strategic plan for nursing development in their region. In 1994, the WHO Eastern Mediterranean Regional Office held a consultation in Teheran on improving nursing practice throughout the Eastern Mediterranean Region, and participants proposed strategies for governments, nursing leaders and professional bodies to use in upgrading clinical practice. Some Member States have now established a comprehensive registration system with standards of practice to ensure that only staff with appropriate qualifications and skills practise nursing. The WHO Collaborating Centre for Nursing Development in Bahrain has begun to develop a management information system to help countries establish a database on the registration and deployment of nursing and midwifery personnel.

Conclusions

The Regional Advisory Panel for Nursing has recommended a comprehensive approach to quality nursing, based on a strong nursing structure in each country’s Ministry of Health, development of a strategic plan of action to meet the country’s needs for nursing and midwifery services, legislation to govern both nursing education and practice, a national database on nursing education programmes and utilization of nursing personnel, and a regulatory body to enforce legislation, provide direction to the profession and undertake validation and accreditation of training programmes. Within this framework, sound basic nursing education is needed which follows trends in nursing and health care and is based on approved standards. In addition, relevant and appropriate programmes for postbasic, graduate and continuing education are needed to prepare specialised nurses. At the working level, a sound management system is needed to define jobs and roles, specify working conditions and supervision and guarantee that nurses can practise what they have been taught. EMRO is
making efforts to assist Member States to develop this type of framework at both macro and micro levels, and the Regional Advisory Panel has recommended standards for basic nursing education and education of nurse specialists throughout the Region.

A number of countries have included in their target activities for the next five years activities to strengthen nursing and midwifery, such as the education of appropriate nursing personnel for primary health care, curriculum development in nursing, expansion of nursing and midwifery education, support for the development of nursing management and quality assurance in nursing services, implementation of the national nursing plan, development of continuing education for nursing personnel and expansion of the capacities of nursing and midwifery schools.

The full potential of nursing and midwifery services and personnel is still not fully used to implement national health strategies and achieve health for all in many Member States of the EMR. If properly developed, nursing and midwifery services can have a direct impact on health system delivery. Nurses and midwives can play an active and cost-effective role in health promotion, prevention of illness and delivery of curative services. Systematic planning is the key to addressing the problems and issues affecting the delivery of nursing and midwifery services.
Nursing practice in the European Region

Introduction

The 50 Member States of the WHO European Region (EURO) cover a huge area stretching from the western coast of Greenland to the Mediterranean and to the Arctic and Pacific coasts of the Russian Federation. 'WHO Europe' is a loose geographical definition, since it incorporates all the former Soviet republics including those in Central Asia. For most of the last 50 years the map of Europe was clearly drawn, with countries pursuing differing but fairly stable social policies. The late 1980s witnessed political change of unprecedented magnitude in the countries of Central and Eastern Europe and the former Soviet Union, accompanied by severe social and economic problems. Years later, many of those countries are still volatile and armed conflict has taken place in Georgia, the Russian Federation, Tajikistan, the former Yugoslavia, and elsewhere. The social costs of the move away from Communist hegemony continue to be high and it is impossible to predict where all the changes will lead. Moreover, the changes have had a major impact on the rest of Europe. Meanwhile the European Union has expanded despite considerable opposition within many of its Member States, and continues to grapple with the issue of extending membership to Eastern Europe.

The population of Europe is around 842 million and is expected to rise slowly. Fertility rates have dropped everywhere, marriage is becoming less frequent, and divorce is increasing. The population continues to age, with a notable increase in people aged 60-79. The economically active population is also aging. Cultural, social, political, and economic factors are all very diverse, making generalizations about the Region or about nursing in the Region fraught with difficulty and perhaps not very useful. However, such generalization becomes a little more meaningful if the Region is divided into subregions for analytical purposes, an approach which is adopted here.

EURO's Member States may be divided into three groups, as follows: the Countries of Central and Eastern Europe (CCEE) comprise Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia, the former Yugoslav Republic of Macedonia, and Yugoslavia (15 countries). The Newly Independent States of the former USSR (NIS) comprise Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan (12 countries; the three Baltic States are not included here but in the Countries of Central and Eastern Europe). The third grouping comprises the rest of Europe: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the
Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, Turkey and the United Kingdom of Great Britain and Ireland. For convenience, this grouping is often referred to as ‘Western Europe’, a Cold War term which is not geographically accurate but for which it is difficult to find an alternative, though not all the countries in this group belong either to the OECD or to the European Union. Here this grouping is termed the “Rest of Europe.”

These three groupings overlap to some extent with the World Bank's classification of economies by income and region. The CCEE and the NIS are all placed in either the upper or lower-middle income group. The Rest of Europe is placed in the high income group, with the exception of Turkey which is in the lower-middle income group, and Greece, Malta, and Portugal which are in the upper-middle income group.

In 1984 the WHO Regional Committee for Europe adopted a European public health policy framework which set out the improvements in health expected by the year 2000, and described strategies for achieving them through healthier life styles, improvements in the environment, and provision of high quality services for prevention, treatment, care and rehabilitation. The endorsement of this framework by all Member States was very encouraging and health policy development took a big step forward. Today virtually all the countries of Western Europe have adopted policy goals that shift health care delivery towards primary health care and closer to the community, workplace and home, with less dependence on institutional care. However, progress has been uneven and slow, and there has been no real progress towards the primary target of health for all – equity. Indeed there is a widening gap within countries and between the northern/western and central/eastern parts of the Region. Closing this gap, at least to the level of differences that existed at the beginning of the 1970s, is the current major challenge.

Health care reform is a major issue in nearly all the countries of the Region. There is much debate in CCEE and NIS about how far the Soviet model of health care, which dominated all those countries to a greater or lesser extent, can or should be adapted to new needs. Formidable problems are emerging from the efforts to achieve change quickly – often too quickly and with incomplete understanding of the policy options, not to mention poor resources. Concerns about how to find the right balance between public and private health care provision are echoed throughout the Region; many if not most countries are experimenting with different approaches to the financing of health care systems. This can create interesting innovations, but the overriding concern with financing and structure – which tends to focus on acute hospitals and the role of doctors – is detrimental to the development of primary health care. Nursing and midwifery are not seen as
key players in these debates and although many countries are aware of the
need to tackle such issues as staff recruitment and retention, education and
quality of care, they are not generally high on the political agenda.

The nursing workforce

Health workers doing nursing-related work include nurses, midwives
and feldshers. Terminology, definitions and practices vary greatly from
country to country; for example, some countries regard nursing and
midwifery as one profession while others have separate regulatory,
educational and professional bodies for the two occupations. Countries often
supply undifferentiated statistics or other aggregate information relating to
all staff doing nursing/midwifery-related work.

The nursing picture is complicated by the variety of staff grouped
under the broad heading ‘nursing personnel’, and the frequent lack of
differentiation between these different grades, qualifications and
competences in human resource planning and deployment. In most
countries auxiliary/unqualified staff perform nursing duties and comprise
50-90% of all nursing personnel. They are often included in statistics on
“nurses” even though they are not nurses. Aggregated country data also fail
to demonstrate the uneven geographical distribution of health care settings
and nursing personnel in most countries.

Nurses and midwives are fundamental to health care in Europe. They
are the largest group of health professionals in the Region; around five
million people work in the nursing services of the 50 Member States, half of
them in CCEE and NIS. They promote health, prevent disease and provide
care. This important contribution is increasingly recognized in Member
States and there is widespread agreement that nursing should be
strengthened and expanded in order to provide even better health care for
all Europeans. The cost-effectiveness argument which nurses have put
forward to justify their value is beginning to be heard, including by the
World Bank which identified nursing and midwifery personnel as “the most
cost-effective resource for delivering high quality public health and clinical
packages.” This awareness is growing, including in CCEE and NIS where
nursing has been a low status, neglected area for many years. Nursing
development stagnated under the burden of disease-oriented health care
systems based heavily on medical specialization and hospital care. (An
exception to this is the feldsher, who provides the backbone of primary
health care in rural areas in a role similar to that of the primary health care
nurse practitioner in the United Kingdom [UK], the United States of America
[USA] and some developing countries; this neglected group offers
significant potential for cost-effective development of PHC.)
After the fall of the communist regimes in Central and Eastern Europe and the NIS, health reforms were gradually introduced but often with no regard for their impact on health personnel. The need to cut costs led to many hospital bed closures, with corresponding cuts in staff. Yet, despite the widely acknowledged imbalance between the numbers of doctors and nurses, the opportunity was not used to cut medical numbers; rather, it was usually nurses who lost their jobs in local power struggles.

Following the dissolution of the USSR in 1991, reforms and substantial extra funds were required to enable the health sector of all Newly Independent States to cope with the problems and challenges. The health care system, starved of new resources and of money to maintain previous standards, has often been described as being in crisis; functioning of the health services has been severely disrupted by inadequate funding and by labour, capital and supply problems. The quality of care in state facilities has fallen, and has not been offset by the increase in costly, sophisticated treatment in private facilities. So-called “middle-level health personnel” are poorly deployed and utilized. A clear division of roles and functions among this group, which includes nurses, feldshers, midwives, nurses' aides and laboratory assistants, is impossible at present because of the lack of proper terminology, inappropriate registration systems, poor education and inadequate human resource development policy and practice. Furthermore, the low ratio of doctors to nurses has led to unclear division of labour, with doctors often performing functions which would elsewhere be regarded as nursing work.

In the Rest of Europe's established market economies, health care delivery, financing and – increasingly – health professional training are a mixture of public and private, making human resource planning even more complex. The percentage of registered nurses working in the private sector varies: in France it is 15% and in Finland 4% of the nursing workforce. Although public organizations and institutes are the main employers of nursing and other health care personnel in all countries, private practice is gaining in importance, a trend reinforced by economic recessions. With almost no exception, responsibility for health care delivery and financing in the public sector has been decentralized to regional and/or municipal health authorities, who are almost all under growing financial pressures.

The number of qualified nurses per 10 000 population shows enormous variation in the Rest of Europe, ranging from 8.6 registered nurses per 10 000 in Turkey to 137.4 per 10 000 in Norway. In general, ratios follow a north-south divide, with relatively more nurses per 10 000 in northern countries (mostly 70-90) than in the south (mostly 20-40). The number of nurses appears more closely correlated to income-related indicators, such as GDP per capita, than to health care need. For example, shortages of nurses,
especially in rural areas, are reported in Greece, Israel, Malta, Italy, Portugal and Turkey. Difficulties in recruiting qualified staff are common throughout the group, mainly due to poor pay, working conditions and lack of career opportunities. Only 5-10% of the workforce is male, except in Italy, Malta and Spain, where men make up at least a quarter of the total nursing workforce.

Starting points and initial conditions for reform differ widely between countries, and so do the responses, but it is nonetheless possible to discern some emerging trends. First (particularly in the United Kingdom and northern Europe), there is a deepening commitment to, and proficiency in, evaluating the outcomes of nursing interventions in order to provide more efficient and effective service. Second, there is growing interest in nursing education, with reform focusing on curriculum review and reorientation to primary health care; new programme development, especially in higher education; better teaching methods and better training of nurse educators; high quality educational materials; continuing education; and stronger links between education and service. Third, society's attitudes to nursing and its role in health care are slowly changing: the perception of nursing as a low-status occupation requiring minimal training, and the associated undervaluation of humanistic and psychosocial care are beginning to alter, although the process is very slow and uneven.

The effective delivery of nursing services is seriously hindered by a variety of factors. While these naturally vary from country to country, there is nevertheless considerable congruence across the Region; the influences on nursing development are remarkably similar. Factors include the absence of nurses from policy-making and decision-making at all levels of the health care system; shortages of well-trained staff relative to needs; insufficient resources for the work of nurses and their education and development; and undervaluing of nursing, with concomitant subordination to medicine. Despite great divergence in the extent to which progress has been made in overcoming these barriers, there is a growing tendency to recognize the need to appraise the role of nursing with a view to fulfilling its as yet unrealized potential.

A major factor everywhere is the gender issue. Nurses in all countries are still battling against a legacy of underdevelopment, domination by the medical profession and gender discrimination. Nursing everywhere is considered to be women's work and shares the characteristics of other female-dominated occupations - low pay, low status, poor working conditions, few prospects for promotion and poor education. Nursing development is therefore inextricably linked to women's development.
The practice of nursing

WHO policy states that good regulatory frameworks are essential for nursing and should be underpinned by legislation which recognizes the nurse’s contribution to the organization, development, and delivery of health care. Legislation should promote the ability of nurses to meet the health needs of the population and to practise safely. In some countries, nursing and midwifery practice is constrained by inflexible and out-of-date public service requirements which regulate employment and career pathways. Regulatory systems must be flexible so as to enable nurses and midwives to redirect their practice to meet changing health care needs.

As a consequence of their recent social and political reforms, most of the countries of Central and Eastern Europe have improved the legislative position of all health care workers, including nurses. Many countries have passed new laws on health care and/or health insurance which reflect the models of OECD countries and recognize nurses as professional health workers. In Slovenia, for example, the 1992 law established the scope of health care activity and introduced a medical chamber and a nursing chamber; the latter functions as a regulatory body. The newly established Slovenian Board of Nursing represents nursing at ministry level and must be consulted by the Ministry of Health.

Information on registration systems in Central and Eastern Europe is scarce. However, some countries have developed nurse registration systems, mainly registration of certificates, but no formal system exists in many countries.

In almost all Newly Independent States (i.e., the former USSR), legislation is still based on the old Public Health Law of the Soviet Union, although new and/or further legislation is under discussion in most. The old law deals with all categories of health workers - physicians, pharmacists, nurses, feldshers, midwives and laboratory physicians. They are defined as persons who have obtained the necessary qualifications to practise their profession, having completed appropriate studies and passed a prescribed examination. Nursing practice is restricted by this law, which prescribes a limited list of tasks: 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; and maintenance of medico-technical equipment.
In all the Newly Independent States, except for Estonia and the Russian Federation, there is no comprehensive or active system of professional registration. The Russian Federation has a state system of qualification verification which consists of an oral examination; if successful, this results in a higher grade and an increase in salary. A licence is obligatory for private practice nursing. Kyrgyzstan is attempting to establish a system of professional registration built on registration of certificates: the licensing of middle-level health personnel is outlined in a Ministerial Decree of August 1991.

Legislation on nursing practice exists in all of the Rest of Europe Group, except Portugal. However, the scope and content of this legislation vary widely. In some countries legislation on nursing practice is part of the overall law(s) on health care personnel (the Netherlands) and/or hospital practice (Belgium). Others have specific regulations for nurses' responsibilities, competencies and duties laid down in Nursing Acts (e.g. Italy, France, the Nordic countries). While in some countries central legislation and/or regulation of nursing practice is being strengthened (e.g. Austria), other countries are reducing the role of central government (e.g. the Netherlands). In several countries new legislation on nursing practice is being planned (e.g., Israel, Malta, Turkey).

All the Rest of Europe, except Austria and Turkey, have central nurse registration systems, mainly by certificate of qualification as a nurse. As a general rule, this certificate is also the licence to practise. In almost all these countries the title of nurse is restricted to persons who hold the official diploma in nursing. The licence to practise is granted by the Ministry of Health, the Ministry of Education or a legal national body, although the actual validation of the title is sometimes decentralized to lower administrative levels, for example in Greece and Italy.

Nurses' terms and conditions of work - such as pay, working hours, shiftwork, and employers' personnel policies - exert an important if indirect influence on the quality of nursing and health care in the Region. Unfavourable terms and conditions are frequently given as reasons why nurses leave the profession, and why recruitment is difficult in many countries. Women are the vast majority of the nursing and midwifery workforce everywhere (the percentage of men in nursing in Europe ranges from nearly zero to just over a third) and nursing in general shares the characteristics of other traditionally female occupations - low pay, low status, poor working conditions, few prospects for promotion and poor education.
In most of the countries of Central and Eastern Europe, nursing is generally seen as a low status job, rather than a career, and wages and working conditions are poor. Only the Czech Republic reports improvement in the status of nurses, reflected in legislative efforts and better pay. In Albania and Romania the status of nurses is comparable to that of unskilled manual workers.

All Newly Independent States report very low status for nurses, both in health care institutions and in society. Nurses work as doctors' assistants, rather than independent health professionals; in many cases doctors carry out nursing work, leaving nurses to do the work of the untrained auxiliary. The social status of nurses is approximately equivalent to that of unskilled manual workers.

The status of nurses varies significantly in the Rest of Europe, from reportedly low in Austria and Belgium to average in most other countries, that is to say, roughly comparable to other skilled public sector workers. In Ireland, Israel and the UK the nursing profession is held in high regard and enjoys a great deal of public support.

In most of Central and Eastern Europe, nurses' wages are reported to be "inadequate" or "poor", both in absolute terms (e.g. Romania, US$26-33 a month) and in relation to national averages (e.g. Hungary, US$130 a month, just above poverty line wages). Rapid inflation in many countries has further eroded the real value of salaries and many nurses cannot make ends meet on salaries alone, thus being obliged to do overtime, take an additional job or find informal ways of earning money. The situation is similar and often worse in the Newly Independent States, where income is reported to be low or very low. Health sector pay is mostly 50-75% of the national average and nurses earn relatively little compared to other health care professionals (who receive very low pay compared to other professionals). Extra payments are made to nurses working nights or in specialties such as AIDS. Nurses' low income is affecting morale and productivity; in the Russian Federation it generated unprecedented strike action.

In most of the Rest of Europe, nurses employed in the public sector are paid according to regulations or collective labour agreements between employers and trade unions. Wages are about the national average, or somewhat below (e.g. in the UK in 1992 a ward sister with a starting salary of US$ 20,500 earned 87% of the average wage). Often salaries are lower than men's salaries in comparably skilled jobs. The picture is quite varied from one country to the next, with variations in salary/career structures, differentials between grades/qualifications and so on. Nursing auxiliaries and assistants are often among the lowest paid workers in society. However, only Belgium reports low wages for nursing personnel. Wages in the private sector are generally higher than in the public sector.
Problems with matching supply and demand for nursing staff are reported throughout the Region. Shortages of well-educated nursing staff and difficulties in recruiting suitably qualified nurses are common in CCEE and NIS. Recruitment of new staff is extremely difficult in remote rural areas. The main reasons include low status, poor salaries, and bad working conditions, leading to migration and/or reduction of the nursing workforce; many people seek better jobs in the private sector. In some situations, especially in the NIS, auxiliaries are employed in qualified posts. Workloads can be very heavy – one nurse and three support staff caring for as many as 80 patients is not unusual. High turnover rates are reported in Azerbaijan, Belarus, Georgia, Moldova, the Russian Federation, Tajikistan and elsewhere.

Recruitment and turnover ratios vary significantly in the Rest of Europe and are highly correlated with status and working conditions, as well as with demographic factors, government policy and national and local labour market conditions. The picture can also change relatively fast, making generalization or mapping of trends difficult. Some countries report shortages of nurses and nursing students and high turnover rates (e.g., the Netherlands) while elsewhere cuts in health service spending, reducing the number of posts, have mopped up surplus staff – although recruitment for specialist posts may still be a problem.

The opening of Europe's borders, with some voluntary migration out of CCEE/NIS as well as the movement of displaced people (especially from ex-Yugoslavia) is creating new phenomena. Nurses in CCEE/NIS, who have the opportunity, often move to richer CCEE or the Western countries (especially Germany) to seek better wages and conditions. Some Western hospitals actively recruit overseas nurses even though locally qualified staff may be unemployed.

The role of the nurse

WHO has recommended that Member States should “identify their nursing and midwifery needs and, in this context, assess the roles and utilisation of nursing and midwifery personnel” (Resolution WHA45.5). Role clarity is crucial for successful multidisciplinary teamwork and for ensuring that nurses make their full contribution to health for all. However, a survey of the word used for “nurse” in different languages indicates that such clarity is very often lacking. In the Russian language, for example, the role of the nurse is obscured by the lack of an equivalent word: people giving nursing care are referred to under the generic title of ‘middle-level medical worker’, “doctor's assistant” or “medical sister”. The terminology also reflects the traditional view of the nurse as a handmaiden to the doctor.
and, indeed, nurses in many countries throughout the Region work according to the instructions of doctors and provide a service to other professionals rather than to patients. Nursing in most CCEE/NIS, and often elsewhere in Europe, is dependent on and subordinate to medicine, and most doctors believe that this is right and proper. In Russia and some of the NIS, nursing practice is legally restricted to a prescribed list of tasks. At the other extreme, nurses in Western countries often work as independent practitioners with considerable autonomy.

Formal or legal descriptions of the nurse's role and functions may bear little resemblance to reality. Moreover, depending on the presence or absence of medical staff, the nurse may find her role swinging between domestic and team leader in the course of a working day. Further studies which explore the actual job content of nurses in different countries and settings are urgently needed to provide a more accurate and realistic picture of the current state of nursing practice, especially in CCEE/NIS. The data in the following section must therefore be treated with caution.

**General nurse**

The role of the nurse differs significantly among the countries of Central and Eastern Europe. In the Czech Republic, Hungary and Slovakia nurses are beginning to be recognized as independent health care professionals, but in many countries the nurse is still subordinate to the doctor. Nurses are regarded as medical assistants, and their role is determined by doctors, particularly in Albania, Bulgaria, Romania and Poland. In Poland the role of the nurse is determined by the doctor in charge of the unit, who may give written permission for nurses to undertake certain tasks. In Romania nursing was a respected profession before 1978, when professional nursing training was abolished; the role then declined into that of medical assistant, which is in fact the most common term in Romanian to describe the "nurse".

In the NIS nurses work in a variety of settings including hospitals, polyclinics, maternity homes, children's homes and kindergartens. They work according to the instructions of doctors, providing a service to other professionals rather than patients. This creates major problems for the development of nursing; nevertheless fresh thinking is going on about professional roles and functions, and nurses are beginning to develop a new confidence and awareness of their potential. The need to improve the quality of nursing is widely recognized and it is seen that if nurses and feldshers received appropriate education they could provide cost-effective health care. Continuing education and an increase of responsibilities may also prove effective tools to improve the low status of nurses.
Generally speaking, in theory if not always in practice, nursing in the Rest of Europe is a professional, independent health care discipline complementary to the other health care professionals in multidisciplinary teams. Its stated purposes are to help people to adopt a healthy lifestyle, to enable people to cope with their health problems, and to care for people of all ages during illness in ways which promote health and healing and minimize disability, responding to the direct needs of the individual, family or community. The role, functions and competence of the nurse are laid down in nursing acts and/or policy statements by national governments. However in Greece, Malta and Turkey the role of the nurse is still to provide services to the medical profession. In all countries of this group general nurses work in institutional health care settings and the community. In most countries in hospital settings a team of nurses has responsibility for the total nursing care of the individual patient, and in a few countries the primary nursing method of delivery is used.

Some country examples may show the wide range of philosophies and approaches. In Finland, primary nursing is widespread, and throughout the Nordic countries nursing is a comprehensive caring and health-promoting activity. In Sweden, nurses are trained in five main areas – nursing care; health promotion and disease prevention; planning care; health education; and development of nursing skills. Nurses give holistic care to patient/clients using the nursing process approach of assessing care needs, planning, implementing and evaluating care provided. In Italy the nurse is responsible by Ministerial decree for general nursing care: prevention, cure, palliative care and nursing rehabilitation. The main functions are prevention of illness, care of the sick and disabled of all ages, and health education. Nursing in Spain has gone from a situation of complete dependence to one of much greater autonomy. No longer the doctor’s assistant with a purely curative function, the nurse has taken on tasks for the promotion of health and disease and accident prevention, as well as recuperation and rehabilitation. Nursing is moving from the medical model to a way of working based on patient-centred care and a problem-solving approach. In Turkey the role of the nurse is to give preventive, curative and rehabilitative nursing care, but nurses do not have a job description and roles are in urgent need of clarification.

Midwife

The role of the midwife in reducing maternal and infant deaths and improving the quality of the birth experience is crucial. Not all women have the services of a midwife, however, and progress still needs to be made in many countries to develop the role of the midwife as an independent, highly
skilled practitioner incorporating the skills of administration, management, critical thinking and leadership.

In most of the countries of Central and Eastern Europe, the midwife is restricted to providing obstetric and gynaecological care under medical control. She is not seen as responsible for normal deliveries. Nearly all births take place in hospital and the whole process is heavily medicalized and often unpleasant for the mother and baby. Some countries, however, have a strong midwifery tradition and the midwife is more highly regarded than the nurse, as in Bulgaria, while others have succeeded in enlarging the role of the midwife. In Albania the midwife is more independent than the nurse; she cares for women antenatally and postnatally, visits mothers at home, and conducts all normal deliveries. In Poland, community midwives are responsible for antenatal preventive care of women on their first clinic visit and three months later, as well as home visits during pregnancy; mother and child care until the sixth week post-partum; and a few deliveries. In the Czech Republic and Slovakia, the Chief Nursing Officer initiated a review of the role of the midwife and proposals were drawn up for overhaul of current legislation to allow midwives more freedom to practise; a new training programme of education; new delivery techniques; and independent practice.

In all Newly Independent States, the midwife provides obstetric and gynaecological care under medical control in hospitals, where most births take place. In feldsher-midwife posts, especially in rural areas, the midwife may be responsible for antenatal and postnatal care, normal deliveries and education relating to maternal and child health. All abnormal cases are referred to the district hospital, where doctors assisted by midwives deal with problem deliveries. In Uzbekistan the Ministry of Health describes the midwife's role as follows (1993):

Midwives must be able to take charge of normal births; dispense primary and secondary treatment to neonates; provide emergency care during complications in the course of pregnancy and to neonates, and initial emergency care in cases of acute disease and accidents; carry out simple resuscitation and use modern apparatus for anaesthesia and resuscitation. They must examine pregnant women, including simple investigations of urine and blood, and identify risk groups; and treat and care for women giving birth and gynaecological patients. Midwives carry out preventive and health education work, prescribe drugs, and monitor infant health and development in the first year.

In most of the Rest of Europe, midwives are in theory autonomous health care professionals, conducting normal deliveries and providing antenatal and postnatal care and health education. Care by midwives includes preventive measures and identification of abnormal conditions in the mother and child. Midwives may also provide essential treatment to
infants, and they play an important role in the health education of women, families and the community. Their work encompasses prenatal education, preparation for parenthood, family planning, neonatal care and gynaecological care. They may work in public or private hospitals, as freelance practitioners, in local health units or specialized centres, and in homes. Midwifery's relationship to nursing differs in these countries. In Israel, Norway, Portugal, Spain, Sweden and Switzerland, all midwives are registered nurses and then complete postbasic specialization. In other countries, such as Denmark, France, Germany, Greece, Italy, the Netherlands and the UK, midwifery is an independent profession with its own education, separate registration and licensing arrangements, and the possibility of direct entry to training. In the Netherlands 72% of midwives have their own practice.

Community nurse

The movement of nursing from the hospital into the community and the change from nurses being providers of health care to being a resource for clients have placed increasing responsibilities on community nurses, who include firefliers, health visitors, public health nurses, school nurses, occupational health nurses, and district nurses. As the largest group of primary health care workers they have an important part to play in the achievement of health for all.

In most of the countries of Central and Eastern Europe, community nursing is carried out by general nurses with postbasic training in health promotion, the prevention of disease and/or mother and child care. Most of the countries have a system of visiting nurses. The community nurse has more independence than nurses in other health care settings. In Croatia a new system of nursing stations for home care, with visiting nurses, started in 1993. The directors of the new stations are nurses responsible for the management of a multidisciplinary team including physiotherapists, occupational therapists, social workers and doctors. In Slovenia health technicians (technical nurses) care for sick and elderly people in the community. In Hungary home nursing activities are carried out by district nurses, while mother and child nurses undertake all community midwifery tasks, family planning and health counselling to all couples before marriage. In Albania home visits are performed by nurses and nurse/midwives alone or together with a doctor. In Romania the community nursing system was reportedly once excellent, but is now in need of development. Some nurses working in primary health care have no specialty training, and they carry out medical treatment and procedures. Some home visiting is undertaken, including clerical tasks, infant development checks, nutritional advice and some health promotion.
In all Newly Independent States the feldsher provides community care, including home visits. There are also district nurses who have undertaken postbasic training and work in people’s homes and in health centres and polyclinics. The feldsher is senior to the nurse, with more independence and additional skills; the feldsher does health assessments, provides diagnostic and therapeutic care, performs examinations, conducts tests, recommends treatment plans, provides first aid and may be allowed to prescribe medication, diagnose, and refer patients to physicians if they do not improve after three days. Feldshers 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. 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 USA and some developing countries. In Moldova there is little domiciliary nursing, but nurses and feldshers work in rural clinics providing health care, often without medical supervision. Recent discussion centred on giving feldshers the title of “deputy physician”, but this did not happen. The Ukrainian Red Cross provides a home visiting service to the elderly and employs over 4,000 visiting nurses. The Armenian Red Cross also runs a visiting nurse programme. The nurses face many difficulties, however, including lack of transport (the nurses walk to their patients), lack of communication (the telephones do not work), time spent searching and queuing for medicines, kerosene and heating, and inadequate supplies.

In the Rest of Europe, except Austria and Belgium, community nursing is undertaken by qualified nurses with an additional one to three years’ training. In many countries the health system is responding to the growing elderly population by making the development or maintenance of a comprehensive system of community nursing, including home visiting, a priority area. However both the way that community nursing services are organized and the role of the community nurse vary. In the UK, nurses provide services in the community such as health visiting, district nursing, family planning, school nursing, occupational health, psychiatry, mental handicap nursing, paediatric nursing and health education. All these roles require post-basic training. In the Netherlands these services are provided by a team of health professionals, including nurses, through municipal health services. An extensive system of visiting nurses also exists in Denmark, Finland and Iceland. In Finland one nurse is accountable to a community living in a geographical area; the nurse promotes and maintains the health of the population, prevents illness and provides rehabilitative care, as well as care for dying patients. In Italy, public health nurses are professional nurses with specific functions: safeguarding the health of the individual and the community, prevention and health education from a community perspective. In Belgium “social nurses” (broadly the equivalent
of visiting nurses) are employed by a variety of private associations, which provide services paid for by insurance schemes; clients are able to choose from the range of associations that provide care. Reportedly, however, this method of health care provision restricts social nurses to working with specific client groups, e.g., pregnant women, babies and school children.

**Mental health nurse**

Mentally ill and mentally handicapped people are scarcely differentiated in many European countries, with patients of all kinds often herded together for custodial care in large long-stay institutions. Many countries have no awareness of a nursing role in either field, and where training exists it is often very short. Care of the mentally ill in Europe is increasingly given in the community. In some countries psychiatric nursing is done by general nurses who have had some education in the care of the mentally ill in their basic training. Elsewhere some have postbasic training and in yet other countries the training is a separate basic programme with additional postbasic training for community psychiatric nursing.

In many countries the care of people with learning difficulties is also part of the nurse's role. However, responsibility often rests with social services or education departments; in Austria and Belgium care is undertaken by other professionals, mainly social workers. Only in the UK is there a separate training leading to registration for mental handicap nursing.

In most of the countries of Central and Eastern Europe the role of the mental health nurse is performed by the general nurse with minimal postbasic training. In Albania there is no role for nurses in mental health care. Caring for mentally handicapped people is not seen as part of the nurse's role in any countries of Central and Eastern Europe, although in practice many people with learning difficulties undergo nursing care in psychiatric hospitals.

In all Newly Independent States, except Moldova, psychiatric care is given by nurses who have undergone general nurse training. Mental health and psychiatric care is concentrated in institutions, and very limited in-service training is available. In Moldova caring for mentally ill people is not part of the role of the nurse; there is no basic or post-basic training. Care of mentally handicapped people is not seen as a nursing task in the NIS.

Secondary prevention and care of mental disorders is part of the nurse's role in all countries in the Rest of Europe. Mental health care is provided in psychiatric hospitals and/or psychiatric wards in hospitals, but the trend in some countries (e.g. Italy, the Netherlands, UK) is for mental health nursing to move from institutional care to the community, where the
nurse is a member of the multidisciplinary team. Changes in the way mental health care and social care are provided, with bed reductions in psychiatric institutions and the provision of more patient-oriented care outside (psychiatric) hospitals, are important developments. In many countries psychiatric nursing is a new specialty and most nurses are either general nurses or care assistants. The role of the community psychiatric nurse, where it exists, ranges from acute care, continuing care and rehabilitation to group therapy and workshops on alcohol and drug abuse. In Greece psychiatric care has been improved following the Leros incident and nurses now play a more active role, but in many countries there is considerable resistance to the community approach, from both health professionals and the public.

Children's nurse

Children's nursing training may be a direct entry basic training, part of general nurse training, or a postbasic speciality. In response to the trend toward caring for patients at home, some countries have a postbasic community paediatric nursing programme.

Children's nursing in most of the countries of Central and Eastern Europe is performed by general nurses, sometimes with further postbasic paediatric qualifications. In Bulgaria and Slovakia children's nursing is a separate branch. In Albania there is no specialist training available. The role of the children's nurse was abolished in Slovenia in 1984. In all Newly Independent States general nurses care for children. Children's nursing is part of general nurse training, though some postbasic paediatric specialisation is also possible. At feldsher-midwife posts, nurses specializing in child care give treatment and advice.

In all countries of the Rest of Europe, caring for ill children is part of the general nurse's role, with postbasic training available in most countries. In Germany and the UK, children's nursing is a separate nursing qualification. Care is mainly provided in hospitals, but in the Netherlands, the UK and elsewhere, as children spend less time in hospital, there is a growing demand for more paediatric community nurses providing primary and secondary prevention to children and parents. The nurse's role includes helping the family to understand their child's illness and teaching the family how to care for the sick child.

Nursing leadership

Making policy is the essential starting point of any health care programme. Nurses, as the largest group of health care workers, need to be
involved in overall health care policy at all levels and to lead the
development of policy that relates to nursing. This was recognized by
several World Health Assembly resolutions, which urge Member States to
"encourage and support the appointment of nursing/midwifery personnel
in senior leadership and management positions to facilitate their
participation in the planning and implementing their country's health
activities", and "strengthen managerial and leadership capabilities and
reinforce the position of nursing and midwifery personnel in all health care
settings". However, nurses play a full part in policy-making and
decision-making at all levels of the health care system in very few countries.
Even where health ministries have relatively large nursing departments,
nurses must continually fight to have their voice heard. This lack of formal
power at the top is reflected elsewhere, as in the lack of democratic
decision-making among members of health care teams in hospital and
community.

Policy-making

Many governments, but by no means all, appoint nurses to Ministries
of Health to advise on nursing and midwifery issues and/or to carry out a
range of executive functions. Sometimes nurses also work in posts in other
ministries such as education or labour. Government nurses may work in a
ministry nursing department, division or unit; they may work within the
human resources department where their supervisor may be a doctor; they
may be part-time or full-time; they may have a large budget or none at all.
The picture is varied and changes frequently but it is difficult to discern
trends.

The role of nurses in national policy-making differs among the
countries of Central and Eastern Europe, but nowhere is it fully developed.
In some countries policy-making is not seen by government as an
appropriate nursing role (Albania and Romania); in others the role of nurses
is limited to providing advice on nursing issues (Slovenia). The scope of the
policies in which nurses and/or nursing organizations do play a role ranges
from solely nursing matters (the Czech Republic) to broad health care
strategies (Poland). Nurses are beginning to demand a much more active
policy role, for example in the Baltic States, because they are now more
aware of how this works in other countries such as the Nordic countries, the
UK and the USA.

Most countries of Central and Eastern Europe have established a Chief
Nursing Officer post at the Ministry of Health or equivalent and most have
nurses and/or midwives working at ministry level. However, their formal
functions and influence vary widely, and in nearly all countries they feel
that it is extremely difficult to ensure that nursing issues are taken seriously. There are exceptions: in Hungary the new ministry nursing department has a Chief Nursing Officer and 10 staff, making it the second largest ministry nursing unit in Europe. It is responsible for all nursing affairs except higher/university education, which is handled by the Ministry of Education. Poland has a ministry nursing unit with a Chief Nurse, a nurse teacher who supervises training schools and a secretary. In Romania the ministry's deputy director of human resources has responsibility for nursing education and, with another physician, leads a small nursing unit of two, while a community nurse works in another department.

In the Newly Independent States nurses make up a large proportion of the health care workforce but have few opportunities in policy-making or management. It is not acknowledged that nurses have a legitimate role; there are few recognized nurse leaders and almost no formal educational opportunities for senior nurses. They therefore lack professional knowledge and skills in management and leadership – which in a vicious circle then acts as a barrier to managing the changes in the health care system and the development of nursing. Needs to improve networking and to develop nursing information systems have been identified as vitally important to enable nurses to share their experiences and learn from each other. There is growing awareness in many countries, e.g. Kyrgyzstan and Moldova, of the need to develop the role of nurses in policy-making; this need is recognized by ministers and other senior figures as well as by nurses themselves.

Many ministries in the Newly Independent States still have a "Chief Specialist for Nursing" as they did in the former USSR, or a similar post (e.g. Azerbaijan, Kyrgyzstan, Latvia and Lithuania). In all NIS, however, the post is low status and nursing affairs are usually under the direction of a physician. In Kyrgyzstan the duties of the Chief Nursing Officer include strategic planning for education, quality assurance, and the conditions of employment of all middle-level personnel. Other countries such as Tajikistan have recently established a Chief Nurse position. Kazakhstan and Uzbekistan had these posts but they are now vacant owing to the ministries' need to save money by reducing staff numbers.

The role of nurses in policy-making at national and subnational level varies in the Rest of Europe. In some countries nurses are actively involved in health care policy and take the lead in policy-making concerning their profession (e.g. Iceland, Spain, UK). However, the situation in many other countries is less favourable, and nurses only have a consultative function to government on nursing matters (e.g. France, Italy). Scandinavian nurses report significant difficulties in influencing policy.

The position of nurses at ministry level differs. Some countries have established the post of Chief Nursing Officer at the Ministry of Health, e.g.
Belgium, Denmark, Iceland, Israel, Turkey, Portugal, the Netherlands, and the UK. In general Chief Nursing Officers are very active in advising and influencing policy relating to nursing matters in their countries. In the UK, for example, the Chief Nursing Officer in each of the four countries has a permanent place on policy-making bodies at ministry level and in the National Health Service. However, in Austria, Germany, Italy, Malta, Norway, Sweden, Switzerland and elsewhere, the nursing function is weak or absent at ministry level, for various reasons: nurses are dispersed in different directorates; federal government structures mean a diminished role for the centre; or nursing is simply not seen as important enough to be represented.

**Nurses in management**

The degree of autonomy and influence which nurses enjoy when managing nursing and/or nurses is closely linked to the nature of nursing's relationship with other disciplines and its status. Nurses are expected to carry out a housekeeping role in many countries, and this may also be reflected in the type of tasks the nurse manager carries out. Apparent seniority in the health service hierarchy may not be reflected in input to decision-making.

The nurse manager's role varies significantly in countries of Central and Eastern Europe. In the Czech Republic and Slovakia nurses are managed by nurses, and responsibility for the quality of nursing care rests with senior nurses. There is a director of nursing in each hospital, and a head nurse in each department and ward. Elsewhere, nurses are more or less subordinate to medicine. The chief nurse of the hospital is expected to advise the hospital director (nearly always a doctor) rather than to lead on nursing matters. In Hungary, however, there is a chief nurse in each county and a director of nursing in all hospital and community services (in a team consisting of a doctor, a treasurer and a nurse, as stipulated in the 1990 Act). In Poland each voivodeship (administrative unit) has a chief nurse. There is a defined nursing structure in the hospital, with a director of nursing (who reports to the hospital director) and a head nurse at ward and department level. In the community the district nurse is responsible for all community nursing staff.

Based on old Soviet legislation, there is a chief nurse in each health care facility in all Newly Independent States, whose role is to assist the chief physician/hospital director. The post may be occupied by a feldsher but all candidates must have five years' experience and have completed a management course. The senior nurse in each department or ward reports to the doctor and organizes all nursing activities. Many republics have chief
nurses at oblast level who may be responsible for continuing education as well as nursing services. In the Baltic States, Moldova and the Russian Federation there is a growing awareness of the need for change, and increasing demands from nurses and midwives for greater autonomy and recognition. In Uzbekistan chief nurse posts have been introduced in municipal and district health departments with wide responsibilities including registration of middle level personnel, supervising the upgrading of qualifications, and continuing education. In Kazakhstan the post of chief nurse on the Almaty City Health Board was established in 1989 to lead the city's 10,700 nursing staff. She has a team of nurses working with her. The post-holder has no management training and says her major problem is acceptance by other professionals.

Throughout the Rest of Europe, except Malta, Turkey and Sweden, nurses are managed by nurses who have completed postbasic courses in management and clinical nursing specialties. The director of nursing is part of the hospital management team consisting of a doctor, a nurse and an administrator, or in direct line management to the hospital administrator, and is responsible for managing, coordinating and assessing services. She often has much independence in leadership and deployment of human resources – assessing nursing workloads, monitoring quality and organizing continuing education. In almost all countries nurses coordinate and cooperate with other health professionals as members of a multidisciplinary team.

Nursing education

Changing nursing practice requires changing nursing education in an equally fundamental, proactive way. In many countries nursing education is moving from vocational training to university education, with various stages between these extremes.

Generalist nursing education

In many of the countries of Central and Eastern Europe existing medically-oriented education systems are being thoroughly reformed to meet international guidelines and directives, notably those of WHO and the European Union. This has required a huge effort to shift low-level, vocational training for nurses that was often part of secondary education, and in which the curriculum often contained a large proportion of non-nursing subjects. The determination with which this has been tackled and advocated by nurses is one of the major achievements of the last few years. General nursing education is now mostly three to four years,
depending on the number of years of secondary education and level of nurse training. Entry requirements vary widely however; the minimum age of entry ranges from 14 to 18, and the minimum years of secondary education before entering training range from 8 to 12 years. In some countries students have to pass an entrance examination and be physically and mentally fit. There is a general trend to upgrade the entry requirements of nursing schools to make them equivalent to the requirements for university courses.

Despite the lack of strategies for health personnel education similar reforms are proceeding, though more slowly, in the Newly Independent States. Progress is being made in the Baltic States, Moldova and the Russian Federation. However, nursing education is still usually under medical control as part of “middle-level health personnel” training. Directors of the training institutions are doctors; nurses and feldshers make up only a small part of the teaching staff. Traditionally nursing has been a route into medicine, with a considerable number of nursing graduates moving on to train as doctors. In most countries the old Soviet system is still intact: students entering the middle-level training school after nine years' general education have a common first year of study (general and nurse education). Some 20% are rejected after the first examination; the rest, after a further two years, become general nursing students together with students entering after 11 years' general education. Following the third year the top 20% continue their studies to qualify as a feldsher. The level of knowledge and practical skills obtained in nursing schools is low. Nurses are not generally aware of the principles of primary health care, and the lack of learning materials in their own language remains a major obstacle.

The education infrastructure and curricula for general nurse training differ in the Rest of Europe. Although countries are strongly influenced by European Union directives on nursing, not all EU Member States strictly observe the agreements they have signed. Reform of curricula and teaching methods is widespread throughout western Europe, including Austria, Finland, France, Iceland, Ireland, Italy, the Netherlands, Switzerland, Turkey and the United Kingdom. In most countries, general nurse training takes place in separate schools of nursing or institutes of higher education, except in Greece, where training still takes place in hospital schools of nursing and technological institutions alongside other health professions. There is a trend to move responsibility for curricula from the health sector to education. Traditional hospital-based curricula are being reoriented to research-based curricula addressing health care needs and broad concepts of nursing in relation to holistic care of patients/clients within their living and working environment. Most countries follow the EU norm of three years' training, but the range stretches from one and one-half years in Finland and two years in Sweden (depending on the length of previous general education), to four years of higher level education in Iceland, Israel, the
Netherlands, Switzerland and Turkey. There are enormous variations in the entry requirements: age at entry ranges from 15 in Austria to 17-18 in most countries which use age as an entry requirement; and years of general education required range from 10 years in Germany to 13 years in the Netherlands. In many countries entry requirements are the same as for university, usually 12 years of general education. Ireland, Malta and the United Kingdom have additional entry requirements related to achievements and examination results from secondary school. In France additional tests must be passed in order to enter training.

Midwifery education

In Central and Eastern Europe entry requirements for general midwifery training vary widely. In Albania, Croatia, Romania and Slovenia midwifery training may be undertaken following graduation as a registered nurse. In Albania a six-month course replaces the former system of direct entry training. In Bulgaria, Poland and Slovakia midwifery training is separate and is offered as basic training, with the same entry requirements and education methods as general nurse training.

In all Newly Independent States, except Latvia, where obstetric and gynaecological care is included in general nurse training, midwifery education is separated from general nurse education, but is usually taught at the same schools and has the same entry requirements and the same teaching methods. The duration of midwifery training is two and one-half or three and one-half years, depending on the number of years of general education.

In the Rest of Europe, midwifery training is completely separate in Denmark, France, Germany, Greece, Iceland, Italy, Malta, the Netherlands and the United Kingdom and takes place in schools or academies of midwifery. Training normally lasts three years, except in Iceland (two years) and France (four years). In Belgium midwifery is a specialty course studied after a first year of general nurse training. In Austria, Finland, Ireland, Israel, Norway, Portugal, Spain, Sweden and Switzerland applicants must have completed general nurse training to become a midwife.

Community nursing education

Entry requirements and curricula for community nursing in Central and Eastern Europe show a diverse picture. In Bulgaria and Hungary, community nursing education is separate from general nurse education. The course to become a health visitor in Hungary or a feldsher in Bulgaria lasts three years. In Poland nurses undertake a three-month programme after
10 years of experience in general nursing. A new model of community nursing has been developed and three pilot courses were implemented in 1992. In Albania and Romania community nursing is performed by nurses and/or midwives with no specialist training. In Slovenia technical nurses (not-registered level) care for sick and elderly people in the community and in rural areas registered nurses/midwives additionally give antenatal and postnatal care to women.

In the Newly Independent States feldshers perform community nursing. Feldsher training in all countries, except Latvia, is separated from general nurse education, but takes place in the same schools and has the same entry requirements and teaching methods. The duration of feldsher training is mostly two and one-half or three and one-half years, depending on the number of years of previous general education. In Latvia community health studies are included in general nurse training. In Estonia community nursing is mainly undertaken by feldshers, but postbasic community nurse training started for qualified nurses in 1993.

In the Rest of Europe health visiting and community nursing is a postbasic specialization. Additional years of practical work experience are required to specialize as a community nurse in France, Germany, Ireland, Portugal, Sweden. In Iceland community nursing is incorporated in general nurse training. Separate professional training is given in Belgium for social nurses and in Finland for public health nurses. In Finland public health nursing also is a major subject in advanced studies at university level.

Postbasic nursing education

The availability of postbasic specialization courses varies widely throughout Central and Eastern Europe. In some countries (e.g., the Czech Republic) advanced nurse training is institutionalized and very important for the nurse’s career; in other countries, such as Croatia, postbasic training possibilities are scarce. In the Newly Independent States refresher courses for all middle-level personnel are compulsory every five years. They are mostly organized by one school in the capital city. It is not always possible for nurses to fulfil their legal obligation to attend; in practice, especially in rural areas, many people take courses only every 15 years.

In the Rest of Europe postbasic and/or continuing education programmes are offered to registered nurses in many specialties and activities. Postbasic specialties include, in most countries, paediatrics, mental health and psychiatry, public health, obstetrics, intensive care and emergency, medical imagery and radiotherapy, operating theatre nursing, teaching and management. Geriatric nursing is a relatively new field of specialist training offered in some countries in response to the growing
elderly population. Postbasic education takes place in separate institutes or in college/university, and in-service training is provided in hospitals and health centres.

Higher education

In many countries nurses and midwives are educated at university level; in some countries the trend is towards university education for all. In others, however, the trend is to educate a small core of professional nurses and a large number of auxiliary personnel. The move to higher education is therefore subject to various interpretations. In some of the countries of Central and Eastern Europe university courses for nurses have been established for many years (the former Czechoslovakia, Hungary and Poland). In other countries higher education possibilities have just been established, e.g. Albania and Slovenia, or are in the planning phase, e.g. Bulgaria.

Some of the Newly Independent States have recently established university nursing courses offering bachelor's and/or master's degrees. In the other countries there are no opportunities to study nursing sciences at university level, although some are planning to introduce university training. Nursing education is available at university level in most of the Rest of Europe. In some countries the opportunity for nurses to obtain a bachelor's degree, master's or PhD in their field is a recent development. In Austria, Germany and Switzerland, nursing studies are rarely or never taught at university level; nurses who wish to study at a higher level must major in an allied subject and take nursing as a minor subject.

Teachers of nursing

Ideally nurses should be taught by suitably qualified nurses, with doctors and other specialists giving input in clearly defined areas. This is far from the case in many countries, where doctors hold all the teaching posts. Nurses recognize the need for nurse teachers to have additional training in education and advanced nursing, and are slowly working towards the goal of an educated workforce of nurses able to direct and participate in the education of nursing students at all levels from basic to doctorate.

Most of the countries of Central and Eastern Europe report a trend towards better education of nurse teachers and specialists. The settings where nurse teachers are trained vary, as do the professional qualifications of nurse teachers. In the Newly Independent States approximately 95% of teachers are doctors; nurses and Feldshers on average make up only 5% of the teaching staff. Directors of the training institutions are always doctors.
The domination of doctors results in medically-oriented curricula. Short postbasic courses in education are available but there is no full diploma in nursing education. The reform of basic curricula and the introduction of new topics such as PHC and communication skills are highlighting the desperate need to train and retrain nurse teachers.

In all the Rest of Europe teachers at schools of nursing and university must be qualified health professionals with clinical and practical experience, and in most countries they must hold a teaching qualification. In Ireland and the United Kingdom all newly trained nurse teachers must have a bachelor's degree. In Israel all nurse teachers are required to hold a master's degree, while in Portugal after 1995 nurse teachers in top posts will have to hold a doctorate. In Finland since 1985 the education of teachers has been provided by universities leading to master's and doctoral degrees. In Norway 17% of nurse teachers hold a university degree. Nursing subjects are usually taught by nurses and other subjects by appropriate specialists. The directors of schools of nursing are mostly nurses, though the growth of corporate management ideology has opened the door for professional education administrators to direct institutions in, for example, the Netherlands and the UK.

**Education methods/materials**

Education methods vary among the countries of Central and Eastern Europe. In some countries the lecture format is still in use in all schools of nursing; other countries report student-oriented teaching with lectures, group work, modelling, case studies using the nursing process, and brainstorming. All countries lack modern textbooks written and/or translated into their language and applicable to their needs. In the Newly Independent States lecturing is the main method of teaching, with very little use of modern student-centred approaches. Estonia reports that some group work, using a problem-solving approach, has been introduced. In all countries, schools are short of resources and have little equipment or information technology. All lack (modern) nursing learning materials and textbooks.

A wide variety of methods and techniques is reported in the Rest of Europe, including lecturing and group work demanding active participation by the students. A modular approach is common. However, Greece reports that the shortage of nurses has led to the persistence of hospital-based training and task-oriented nursing care. Teaching materials and textbooks are up-to-date in most countries and learning materials are available in both mother tongue and foreign languages, mainly English. Information
technology is being introduced rapidly in all areas of health care and nurse education.

Nursing research

Nursing research has grown slowly in the Region. Everywhere there is awareness of its importance, but funds and education to promote and use it are lacking. Recently, Pan-European networks such as the Workgroup of European Nursing Researchers have been extended to Central and Eastern Europe, where nursing research is in its earliest infancy in most countries. Where university studies are established at nursing faculties or medical faculties, students undertake nursing research as part of their education. The faculties also run research projects and hold research conferences. However, funding opportunities for nursing research are limited. There is a history of nursing research at the universities of Zagreb (Croatia) and Ljubljana (Slovenia) but this has been interrupted by war. In the Czech Republic, the Commission for Nursing Research funds small projects. The Hungarian Nurses’ Association coordinates and promotes nursing research but lacks funds.

Except for Kazakhstan and the Russian Federation, where a few nurses have started to undertake research, there are no nursing research centres in the Newly Independent States. The WHO Collaborating Centre for Primary Health Care and Nursing in Almaty, Kazakhstan, conducts research. In the Russian Federation a few demonstration projects are under way with foreign assistance. In Estonia and Lithuania the inclusion of research is planned in the new university training programmes.

In the Rest of Europe research in nursing is established practice, though in some countries developments are slow. Nursing research is taught at university and/or post-basic courses. Most nursing research is carried out in universities, and research is mostly part of higher nurse education curricula. Funds for nursing research in all countries are scarce; earmarked funds are few and nursing research projects have to compete with other health research projects for grants.

Two of the most effective ways of spreading nursing and midwifery information and new ideas are professional journals and networking. Almost all the countries in Europe have a professional journal and some trade unions and ministries also produce printed information. Nurses in some countries make extensive use of the media to disseminate information about health.

In all of Central and Eastern Europe, except Albania, at least one nursing and/or midwifery journal is published. Although nursing journals
from other countries are available in some countries, there is no widespread or systematic exchange of written information. Estonia, Latvia and Uzbekistan have monthly nursing journals and Kyrgyzstan launched a new journal for health workers in 1993. Many countries are aware of the value of journals but lack money for paper or printing, as well as editorial and publishing skills. In the Rest of Europe an enormous number of nursing and/or midwifery journals published by nursing associations, hospitals, schools of nursing and commercial publishers. In most countries international and national professional journals are also available.

**Professional associations and trade unions**

In nearly all countries of Central and Eastern Europe, nurses are coming together to found or re-establish national professional associations. The new associations are reaching out to join, or in some cases rejoin, international organizations such as the International Council of Nurses and the International Confederation of Midwives. Most of the professional associations actively participate in or advise on national health care and nursing policy. In general they have recruited 5-10% of the nursing profession as members.

Only a few Newly Independent States have established professional nursing associations. Estonia, Latvia and Lithuania all have associations which are united to form the Baltic Nurses Association. In the Russian Federation the role of professional organizations is not clearly identified and their activities have had a slow start, but there are some attempts to establish local and regional professional associations. A Moscow Nurses Association has been formed and is receiving help from European nursing associations.

All countries in the Rest of Europe have professional nursing organizations. In all countries except Belgium and the Netherlands, the percentage of registered nurses who belong to at least one nursing organization is over 80%. Many countries have separate midwifery organizations; an exception is Ireland, where midwives are members of the Irish Nurses' Organization and the midwives' section of the National Council of Nurses. The percentage of midwives who are members of a midwifery organization is usually over 90%. The influence of these organizations varies: in the Netherlands and Turkey nursing associations are not very influential, whereas in Ireland, Israel, Spain and the United Kingdom professional associations and/or trade unions have significant influence.
Conclusions

In Central and Eastern Europe and the Newly Independent States urgent priorities differ from country to country, but include developing nursing leadership at all levels, reforming nursing education, providing modern learning materials, improving professional image and status, improving nurses' pay and working conditions, clarifying roles and functions, developing professional organizations and interest groups, and developing contact with nurses from other countries. In the Rest of Europe, the priorities for nursing development include legislation, leadership and education. Countries also report a pressing need to improve the status, working conditions and pay of nurses.

An enormous amount of ground still needs to be covered throughout all of Europe to bring nursing practice to a level where it can fulfil its true potential to contribute to health for all. Current priorities differ from country to country, but include to a greater or lesser extent:

- updating nursing legislation
- strengthening nurse leadership, especially at ministry level
- developing nursing education and revising curricula
- revising nursing roles, functions and career structure
- strengthening the management skills of the nursing profession
- strengthening the role of nurses in policy-making at all levels
- developing and/or improving nursing research/quality assurance
- developing and/or improving standards of nursing care, based on research
- increasing networking of nurses in and outside the country
- improving the image and status of nursing, and
- improving salaries and working conditions.

Factors which continue to impede nursing development include gender discrimination; continuing reluctance on the part of many doctors and policy-makers to share power with nurses and respect their views; low pay and poor working conditions; lack of educational opportunities and general lack of resources to encourage development. Nevertheless, nursing practice everywhere in Europe is changing, and there are many indications that the profession is altering its ways of working in response to new demographic patterns, new concerns about costs, and new goals and needs for health care. Great efforts are being made, especially in CCEE and NIS, to explore new
concepts and to implement new approaches to nursing. The need to assess quality and audit nursing interventions is increasingly recognized. Nursing is shifting its focus from mainly task-centred practice to care focused on the health needs of the individual as a whole person, and from hospital-based services to primary health care nursing for both sick and well, with an emphasis on disease prevention and health promotion. Such momentous changes need to be underpinned by appropriate regulatory frameworks, and much attention is being paid to this, though with uneven progress.

Recognition of the need to change nursing practice inevitably brings reform of nursing education. Throughout Europe basic curricula are being reoriented, teaching methods improved, new materials written and educational content strengthened in order to prepare practitioners competent to practise in these new ways. More opportunities are being made available in postbasic and continuing education for nurses to keep up to date and to develop more specialized skills and knowledge. The doors of universities are no longer closed to nurses and increasingly they may not only obtain their basic qualification as a nursing degree, but may also proceed to study and research at master's and doctorate level.

These changes cannot be widespread without effective leadership, and therefore nurses everywhere are attempting to strengthen their position in policy-making and management at all levels from government to the primary health care team. The desire is there but progress is patchy and sometimes retrograde, for a variety of reasons, perhaps above all the traditional male domination of top management. The need for good networks is an important aspect of leadership, and nurses are learning how to create and use networks of all kinds. One crucial means of networking is to develop strong professional organizations, a marked trend, and to link them together in international organizations. More and more journals, too, are being published as a way of exchanging ideas and keeping in touch. It is at present hard to judge whether these huge challenges will negate the efforts of nurses to improve their contribution to health, or whether their commitment to change will be strong and smart enough to win through.
Nursing practice in the South-East Asia Region

Introduction

The South-East Asia Region consists of eleven countries, making up nearly one-quarter of the world's population. (Mongolia became part of the Western Pacific Region by resolution WHA48.1, adopted by the World Health Assembly on 4 May 1995. However, when this paper was written, it was a part of the South-East Asian Region.) Most economies depend on agriculture but countries are increasingly moving toward industrialization. Five of the countries are considered as least developed, i.e. Bangladesh, Bhutan, Maldives, Myanmar and Nepal. In the classification of economies of the World Development Report 1993, these five countries plus India, Indonesia, and Sri Lanka are considered as low income economies. The remaining three countries in the region, Democratic People's Republic of Korea (DPR Korea), Mongolia and Thailand, are considered lower middle income economies. However, this classification of Mongolia may no longer be relevant given the economic setbacks it has experienced in its transition from a central to a market economy system. The region contains almost half of the world's poor; rapid population growth is a major contributing factor. Environmental health hazards include contaminated drinking water, industrial and agricultural wastes, air pollution, noise and pesticide poisoning. During the last decade political uncertainty, military conflicts and natural disasters – floods, earthquakes and drought – have hurt national economies. Nevertheless, several of the countries have had satisfactory economic growth. In all countries development plans stress improved agricultural productivity, creation of new jobs, upgrading of skills, alleviation of poverty and greater participation of both men and women in the development process.

Major health problems include the high incidence of low birthweight infants, poor health of women, especially in Bangladesh, Bhutan, India and Nepal, and respiratory diseases, diseases of the digestive system, malaria, tetanus, diphtheria, tuberculosis and leprosy. There has been a slow decline in mortality and a decrease in low birth weight. Currently cardiovascular diseases, cancer and other noncommunicable diseases are becoming major causes of death in the countries with the highest life expectancies (DPR Korea, Sri Lanka and Thailand).

Primary health care has been adopted by all the countries of the region as the key approach to development of health. However, curative care still predominates. A number of countries are launching efforts to develop decentralization and local planning and encourage the involvement of communities in health development. Substantial progress is being made in
the health education of the public in spite of low literacy levels and few outreach media.

The descriptions of nursing practice in this paper are intended to provide a regional perspective rather than a country by country review. The descriptions primarily reflect the commonalities among nursing in the eight countries classified as low-income countries. Mongolia has been added to the group given the current economic status and situation of nursing in the country. Where differences exist among the countries, these are noted in the review. Since nursing is more advanced in Thailand than in any of the other countries in the Region, statements about nursing practice in Thailand are often included as exceptions to the general situation. Unfortunately, little information is available about the nursing situation in the Democratic People's Republic of Korea, and so this country is generally not represented in this review.

The levels and categories of nursing personnel

There are three main levels of nursing/midwifery personnel in the South-East Asia Region: professional and technical/auxiliary nurses, nurse-midwives, and nursing aides or nursing assistants. Designations of these personnel include nurse, general nurse midwife, technical nurse, health nurse, auxiliary nurse-midwife (ANM), etc. Some nursing personnel may have midwifery training as part of their basic preparation and others have midwifery training at the postbasic level.

The auxiliary midwives, found in Myanmar and Thailand, and the auxiliary nurse midwives (ANMs), which are found in Bhutan, India, Maldives and Nepal, are primarily considered multi-purpose community midwifery personnel. Training of these personnel has been discontinued, and they will not be covered in this paper on nursing personnel. However, in some countries, due to shortages of nurses and difficulties in retaining ANMs in the rural areas, ANMs are working in hospitals in cities and urban areas where they carry out nursing functions. This situation raises questions about the relevance of their training and the appropriateness of their deployment.

Basic fully qualified nurses in the countries of the Region have different levels of general and nursing education. In five countries (Bangladesh, Bhutan, Maldives, Nepal and Sri Lanka), there is only one level of basic nursing education, at the diploma or certificate level. The entry requirement is 10 years of general education followed by three to four years of nursing education. In four of these countries (Bangladesh, Bhutan, Maldives, and Nepal), basic nursing education includes a midwifery
component, and the programme, certificate and/or designation includes midwifery, e.g., Diploma in Nursing and Midwifery, General Nurse Midwife, etc. The exception is Bangladesh, where the midwifery course is one year long following the three-year nursing course, and a separate registration in midwifery is given.

In three countries (India, Indonesia and Myanmar) there are two or more levels of fully qualified nurses depending on their basic preparation. In India and Myanmar, all nurses have completed 12 years of general education; the two types of nursing education are a diploma level course of three years duration and a B.Sc. Nursing course of four years duration. These programmes include some midwifery training as part of the basic nursing preparation. India still gives a separate registration in midwifery despite the fact that the midwifery component in the basic nursing education programme has been considerably reduced over the years and would not seem sufficient now to justify a separate certification of qualification for midwifery practice. In Indonesia, there are three levels of basic nurses. In addition to diploma and baccalaureate prepared nurses, as in India and Myanmar, there is a third level called a health nurse who has three years of nursing education, including some midwifery, following nine years of general education. Health nurses constitute the majority of the nurses in the country, and efforts are being made to upgrade this educational programme to the diploma level.

Only one country, Thailand, has the B.Sc. Nursing degree or its equivalent of four years duration as the basic preparation for the fully qualified or professional nurse. The entry requirement for nursing programmes is 12 years of general education. The programmes are offered by the Faculties of Nursing under the Ministry of University Affairs and the Nursing Colleges under the Ministry of Public Health. The Nursing Colleges cannot award a degree, but the four-year Diploma in Nursing Science course is considered equivalent to the B.Sc. Nursing degree course. Graduates of both programmes enter service at the same grade, and graduates of the Nursing Colleges are eligible to enroll in the master's programmes in the Faculties of Nursing. These courses include a midwifery component, but the degree/diploma and designation do not include midwifery. However, the license of the graduates indicates that they are practitioners in nursing and midwifery.

Some countries have slightly different programmes. In DPR Korea, nursing education is of three years duration with an entry requirement of 11 years of general education; and in Mongolia the nursing education programme is of two years duration with an entry requirement of ten years of education, which is considered higher secondary school level.
Other levels of nursing personnel who have lower qualifications and fewer years of nursing education include the technical nurse in Thailand with two years of training after 12 years of general education, the assistant nurse in Bhutan with two years of nursing education after seventh grade, and the nurse aide in the Maldives with one year of training after ninth grade. Other countries such as Bangladesh and Mongolia have from time to time trained nurse aides or nursing assistants in programmes of six months or less.

Where nurses practise

In general, nurses practise primarily in direct service roles in hospitals and other institutional settings which are located in cities of varying sizes and urban areas. In some countries, nurses work in health centres which are considered part of the primary health care (PHC) network or which are located in rural areas. However, the nurses in these centres are largely confined to the centre itself, usually in the in-patient wards or out-patient departments, where they mainly provide curative services.

In six countries (Bangladesh, India, Myanmar, Nepal, Sri Lanka, and Thailand), there are public health nurses (PHNs) posted in community settings where they are seen as having a community role. This role, however, is primarily as manager, supervisor or trainer, although in a few countries, the PHNs may also be involved in providing promotive and preventive care. Some of these PHNs are required to have postbasic preparation while others are not. In most countries, the number of PHNs is small in comparison to the total nursing workforce. For example, there are only 64 posts for PHNs in Bangladesh, one for each district, while the total number of nursing posts in the country is over 5 000.

Expansion of the roles of these PHNs to include health promotion or direct service in villages or communities is being attempted in some countries but is only at the beginning stages. For example, in Myanmar the newly posted township health nurses are being trained to promote self-care at home and to involve families, communities and NGOs.

The concentration of nurses in hospitals and institutional settings is likely to continue given the acute shortages of nursing personnel in all countries; there are not even sufficient numbers to adequately staff the hospitals. This concentration of acute care is also likely to continue given the vast numbers of community health workers, including ANMs, who are already providing community-based and outreach health services. It would not be seen as cost-effective to replace these workers with qualified nurses at this point.
The exception to this is Thailand. The health centres have been largely staffed by technical nurses rather than professional nurses. However, as health needs and health care demands change, requiring staff with a higher level of skill and decision-making ability, it is likely that the technical nurses in the health centres will eventually be replaced by professional nurses. A project is now underway, funded by the Royal Thai Government, to expand and strengthen professional nursing education programmes.

What nurses do

Since most nurses work in hospitals, they provide mainly curative and rehabilitative care for individuals of all ages, care during labour and delivery and the immediate post-partum period, and long-term care for individuals with chronic or terminal illness. Except in Thailand, the organization of nursing care in hospital wards is generally task-oriented. Nurses' functions in the wards include supervision of nursing and other personnel such as housekeeping staff; considerable managerial activities, such as maintaining inventories of linen, drugs and other supplies and even cleaning reusable equipment; and administrative or clerical activities in support of nursing care. Nearly all the studies on utilization of nursing and midwifery personnel conducted in the last ten years in Bangladesh, India and Nepal showed that less than 50 per cent of nurses' time in the wards was spent in direct nursing care activities. Even this time was spent more on giving medication; taking temperature, pulse and respirations; and assisting in medical procedures; and less on patients' personal hygiene, comfort, safety and health education. Since the hospitals are generally not oriented to provision of comprehensive individualized care, nurses are not likely to provide promotive or preventive care through patient education, discharge planning, etc.

This situation is attributable primarily to the acute shortages of nurses in the wards and the multiple nursing and non-nursing duties they are responsible for. Much of the personal care of patients is provided by family members, nurse aides or other ancillary personnel.

As mentioned earlier, the few community/public health nurses have some involvement in promotive and preventive care, community development, etc., but in most countries their work involves managerial, supervisory and training functions. In Thailand, however, nurses in health centres provide basic medical care, such as treatment of common illnesses. They are also responsible for health promotion and disease prevention in the community.
The level of responsibility and autonomy of nurses

Nurses in general are expected to carry out a great many responsibilities related not only to nursing care but also to managerial and supervisory functions as well as other non-nursing administrative and clerical tasks. However, except in Thailand, most nurses do not have autonomy in their practice. Much of their work involves carrying out doctors' orders for treatment procedures; accompanying doctors on their rounds to maintain the charts; assisting doctors with procedures, etc. The authority to initiate nursing actions independently is limited. There are exceptions to this in intensive care units (ICUs), coronary care units (CCUs) and other specialty units, particularly where nurses have had more training either on the job by the doctors in charge or through advanced formal training programmes, i.e., postbasic or continuing education.

Nurses do not keep nursing care plans, and there is even no provision for nurses to write nurses' notes in the patients' records. Nurses usually keep separate logs, but these are mainly administrative records of treatments and medicines and reports on those patients whose conditions have changed during a shift, rather than comprehensive reports of patients' status, nursing care provided, patient outcomes, etc.

In Thailand, however, the situation is different. Nurses assess the patient's condition and bio-psycho-social needs, diagnose nursing needs, plan and implement nursing care activities, and evaluate care given using the nursing process. If the assessment indicates that a patient requires specific nursing interventions, the nurse will take actions independently. Nurses seek help from physicians and other health personnel when this becomes necessary for meeting the patient's assessed needs. They keep records of their care plans and nursing actions in nurses' notes included in patients' charts. These nurses' notes are also used/reviewed by other health professionals. Nurses are required to be with the medical team when they make patient rounds to provide nursing inputs about patients under their care. Nurses also participate in the medical grand rounds or meetings which are organized to present and discuss interesting patient situations.

What nurses should/could do

Hospital/institutional based nurses should be able to provide holistic care to individuals and families and to integrate PHC in their practice through attention to promotive and preventive care, community-oriented assessments of patients and families, planning for follow-up care on discharge, education of families, patient and family participation in care, etc. The concept of individualized holistic care is now being taught in nursing
education programmes, but nursing practice in the wards remains largely
task-oriented and nurses are subject to competing demands for assistance
from various sources. Nurses' ability to practise holistically is dependent on
an environment conducive to such practice as well as sufficient staff and
other resources.

The same holds for nurses exercising more responsibility and more
autonomy. Now that basic and postbasic nursing educational programmes
have been strengthened, graduates should be able to exercise more
independent decision-making in regard to assessment of patients, planning,
implementation and evaluation of nursing care activities. However, this
would require a change in the perception of and attitudes toward nurses,
i.e., seeing them as professionals rather than as technical or skilled workers,
relating to them as colleagues, etc. This would also require a change in
nurses' self-image and confidence in their own abilities.

In hospitals and other institutional settings, nurses should also be more
involved in and responsible for the organization and management of the
nursing care provided to individuals and families. However, in order for
nurses to take on responsibility for managing direct patient care, their
administrative, clerical and other non-nursing duties would have to be
delegated to other personnel.

In the community, nurses should be more involved with community
health practice, as members of the district health team involved in planning,
managing and evaluating health and nursing care activities; as direct
providers, especially in maternal and child health (MCH), home care,
community programmes for the elderly, etc.; and as technical supervisors,
providing guidance and technical back-stopping for peripheral/auxiliary/
community health workers. PHNs are already carrying out these functions
to some extent; however, their full potential has yet to be realized.

Areas of specialization

The main type of specialization which is widely recognized in the
countries of South-East Asia is community/public health nursing. Midwifery
has also been considered a postbasic specialization but is increasingly being
incorporated in basic nursing education. Other areas in which specialized
training is being requested or is being provided by countries include
operation theatre nursing, accident and emergency nursing, orthopaedic
nursing, etc. With the increase in specialty units and hospitals, especially in
the private sector, other specializations are emerging such as critical care
nursing, neonatal intensive care nursing, oncology nursing, etc.
Formal training in speciality areas is usually provided through short courses of three to six months' duration or through postbasic diploma level courses of 9-12 months and is available in several but not all countries. Postbasic nursing education for obtaining a B.Sc. Nursing and higher degrees is available in Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, and Thailand. Only India and Thailand offer master's and doctoral degree programmes, although Nepal is hoping to start a master's degree course this year. Postbasic education is offered in community health nursing, MCH nursing, psychiatric nursing, medical-surgical or adult nursing and paediatric nursing. Generally, nurses with postbasic training do not have a separate title or designation except for those with public health nursing preparation. These nurses are called public health nurses (PHNs), district public health nurses, public health nursing sisters, etc.

However, with the exception of PHNs, nurses with specialized training are generally not recognized as clinical specialists with an advanced level of nursing practice. Rather, they are seen as staff nurses or ward supervisors for specialty areas. One hospital in Thailand is trying to introduce the concept of the “clinical nurse specialist” who would provide consultation to other nurses and promote research and education in the wards. These specialists would have master's level preparation with several years of service in the wards and some evidence of publications and research to demonstrate their competence.

The responsiveness of nursing practice to changing demography and changing health care needs

Quality nursing care is definitely needed in the hospitals, and this is where the majority of nurses are practising. Nursing care is also needed in community settings and for certain target populations. However, this latter need is still met largely by technical and auxiliary levels of community health workers and midwifery personnel, some of whom have training in nursing. Given the shortage of qualified nurses in the countries of South-East Asia, the situation is not likely to change in the near future.

There is evidence, however, in all countries that the nursing community is trying to respond to changing health care needs. For example, in Thailand training in care of the elderly is being provided and models of care for the elderly are being implemented. In some of the countries which are already facing the need to provide care for people with AIDS, nursing is responding. This is particularly true in Sri Lanka and Thailand. In Myanmar, posts have been created for township health nurses to strengthen the technical supervision of midwifery personnel and to extend the provision of nursing services to communities.
Another indication of responsiveness is the fact that both basic and postbasic nursing education programmes have been reoriented to the community and the PHC approach, which includes attention to demographic transitions and changing health care needs. Efforts have even been made or are being seriously considered to raise the general educational requirement for nursing education to 12th grade as opportunities for general education in countries expand and improve. Also, research in nursing is increasingly being focused on nursing practice in order to identify effective nursing interventions.

However, given the limited authority and autonomy of nursing in most countries, the ability of nursing to independently adapt its scope of practice to meet changing needs is limited. Nursing practice is largely dictated by the health policies and plans of countries and reflects the nature of the health care services in which nursing care is provided. The main issue in the Region is not lack of responsiveness of nursing to changing health needs. The challenge for nursing in most countries is still to provide basic minimum nursing care and to implement mechanisms for quality improvement, standards of care, etc. Again, there have been some attempts to institute change to improve quality, but these are isolated examples rather than widespread movements.

The appropriateness of basic and continuing education

As noted above, basic nursing education programmes have been reoriented and strengthened in relation to national health plans, identified health care needs and the PHC approach. However, given that nurses do not generally practise in communities, questions have been raised in some countries about the relevance of community-oriented nursing curricula which provide learning experiences in community settings. It is felt that greater attention should be given to clinical nursing practice which is more relevant to the institutional settings where the majority of nurses work, or that the application of PHC principles should be stressed throughout the curricula and especially in hospital-based clinical learning experiences.

This, in fact, was one of the findings in an evaluation study of graduates conducted in Thailand. A significant number of graduates felt that knowledge and experiences in nursing practice in communities had little application to their work in hospitals. The study recommended that the nature and extent of experiences related to community aspects of nursing services should be appropriate to and in balance with the graduates' work in hospitals.
A distinction needs to be made between community-based training and community-oriented training: the latter would be applicable in any setting. However, the current community-oriented nursing curricula may emphasise the application of community and PHC concepts and principles in a single course or series of community health nursing courses rather than integrating these throughout the curricula. As a result, students may have difficulty applying or integrating community-oriented learning in other settings.

Unfortunately, continuing education (CE), in the sense of in-service training for nurses after they have completed their basic nursing programme, is limited in most countries. CE is often provided on an ad hoc basis in relation to national programmes such as AIDS, Acute Respiratory Infections, Expanded Programme on Immunization, Diarrhoeal Disease Control, Family Planning, and Maternal and Child Health. While such programmes are designed to meet changing needs, they are usually oriented to the community health workers who actually carry out the programmes. Nurses may participate in such training but mainly for orientation since they are generally not involved in such community level work.

However, there is evidence that, especially in connection with WHO country projects, CE courses related to PHC are being provided for nursing personnel. Attempts have also been made in some countries to involve nursing personnel in multidisciplinary courses such as health systems research.

A few countries have national mechanisms for continuing education of health personnel in general but have difficulty reaching the large numbers in need of upgrading on a regular basis. In some countries, large hospitals or specialty institutions conduct in-service training programmes, but these are oriented to their specific needs.

### Enabling and constraining factors for appropriate quality nursing practice

It is apparent from the preceding discussion that a number of factors affect the provision of appropriate quality nursing practice in the South-East Asia region. A major achievement in the Region has been the steps taken in nearly all countries to revise nursing educational programmes to be community-oriented and to incorporate the PHC approach. A few countries, such as Indonesia, Nepal and Thailand, have been implementing reoriented curricula for five years or more and have moved on to the stage of evaluation and subsequent revision based on the feedback obtained. The reorientation was undertaken in an effort to equip graduates with the knowledge, skills and attitudes they need to competently meet prevailing
health care needs and to adapt their practice to meet changing needs and demands.

However, many educational programmes still suffer from a lack of well prepared teachers and insufficient teaching and learning facilities and resources. This is particularly true of countries which have rapidly increased the number of nursing educational programmes or have drastically increased enrollments in order to meet the increased demand for nursing personnel without expanding the training institutions and resources.

Under these circumstances, the quality of the programmes is compromised although efforts are continually being made to strengthen the educational resources, especially the teaching personnel. A related constraining factor in the implementation of basic nursing curricula, which adversely affects the quality of nursing practice by students/graduates, is the lack of, or inadequate number of professional nursing role models in the clinical/community practice areas used for students' learning experiences. This inadequacy is compounded by the deficiencies in the facilities and resources of the practice settings themselves. These inadequacies seriously undermine the ability of students to practise the new concepts and skills they are being taught in the educational programmes, such as the nursing process, patient-centred approaches to care, etc.

To alleviate this situation, nursing institutions in a few countries have taken steps to develop model or teaching wards in order to provide satisfactory learning environments. An initiative has also been launched by the WHO Regional Office to promote more collaboration between nursing education and nursing services in order to improve the quality of nursing care as well as enhance the relevance of nursing education.

Efforts are also being made through continuing education and inservice training to reorient and upgrade nursing service personnel in existing health care settings in order to improve the quality of care provided. In some countries these courses are conducted with the assistance of the nursing education institutes. However, as noted earlier, these courses or training workshops are often conducted on an ad hoc basis rather than as an integral component of nursing service management. Thus, opportunities for continuing education for most nurses in the region are limited.

Having recognized the need to expand educational opportunities for nurses, three countries (India, Sri Lanka and Thailand) now offer distance education programmes at the postbasic level for the B.Sc. Nursing degree. Other countries are considering using distance education as a means to provide continuing education, especially for nursing and other personnel in rural and remote areas.
Another positive development has been the recognition by many countries of the need for a critical mass of nurses with advanced or postbasic preparation who can assume leadership roles in nursing education and nursing services. This has led to the establishment of or increase in the number of postbasic degree programmes, especially at B.Sc. Nursing level in countries where the diploma is the entry qualification into nursing practice. Other countries which are not able to develop their own degree level courses are using fellowships from WHO or other sources to provide for higher education in nursing.

In nursing services, efforts are also being made in several countries to develop and implement standards of nursing practice as a means to bring about improvements in the quality of nursing care. However, in many countries there is minimal or no involvement of nurses at policy and decision-making levels. As a result, nurses have little control over or even input into decisions affecting nursing practice. Even efforts to develop nursing standards are hampered when nurses have limited managerial authority in health care institutions.

In some countries, efforts are underway to strengthen the top leadership positions or structures for nursing to make possible greater accountability and responsibility for the planning and management of nursing education and services. The development of national action plans in a few countries is also contributing to a clearer direction for the future of nursing practice as well as a more coordinated approach to its development.

A factor which constrains appropriate nursing services management is the fact that nurses promoted to administrative and managerial positions often have had inadequate or no preparation for the administrative, managerial, and supervisory functions they are expected to carry out. Because career structures are primarily based on seniority criteria, there is little encouragement for nurses who have demonstrated leadership qualities or have potential to advance further. The senior nurses in the top leadership and management positions have also not been exposed to the recent advances in nursing science and nursing practice which would enable them to institute or at least support innovations in nursing practice.

With the exception of Thailand, working conditions in the countries of the region are generally poor. Nurses' status and their salaries are low in comparison to other professional groups. Career prospects are limited to the few higher graded nursing posts, whether in nursing education or nursing services, because nurses are generally not considered eligible for non-nursing positions.

A major constraining factor in nurses' deployment in community settings, especially in rural areas, is the lack of adequate housing and
security. This is particularly problematic for young female nurses, especially if they are not married. A few countries have addressed this problem by training a limited number of male nurses specifically to work in rural and other difficult areas. However, this solution has not proved entirely satisfactory because many of the male nurses want to migrate to urban areas where career prospects are better and where school and other facilities are available for their families.

As mentioned earlier, health care facilities are largely understaffed and without adequate essential equipment, supplies, drugs, etc., especially those in outlying areas. These deficiencies greatly hamper nurses' abilities to provide even the basic minimal standard of safe, effective nursing care.

Only four countries (Bangladesh, India, Myanmar and Thailand) have Nursing Councils and Nursing Acts. However, the Nursing Acts primarily prescribe the qualifications of nurses and the criteria for recognition of nursing institutions and, except for Thailand, do not specifically define the role, scope and standards of practice of nursing personnel. Other countries, such as Nepal and Sri Lanka, have been attempting to establish Nursing Councils. Indonesia is planning to institute measures for the accreditation of educational institutions and Thailand is planning for national registering exams to ensure the competence of graduates.

Where there are regulatory mechanisms, efforts have been made to ensure the quality of education and, in the case of Thailand, the quality of services as well. However, these efforts are not without difficulties given the limited resources of the existing Councils (except in Thailand) to enforce the regulations and procedures. In countries without regulatory mechanisms it is difficult to ensure the standardization of educational programmes and implement professional standards of practice. The non-existence or inadequacy of regulatory mechanisms also inhibits the legitimization of the expanded roles and scope of practice of nurses that may be needed in order to respond to increasing and changing health care needs.

In most countries of the Region, except India and Thailand, research in nursing is relatively new. As a result of the recommendations of the WHO Regional Advisory Committee on Health Research in 1989, the Regional Office has been promoting the development of nursing research resources, research training and the conduct of research studies in nursing. National bodies have been established in Indonesia and Thailand which are responsible for the development of research in nursing and, to some extent, the coordination of research activities in the countries.

These initiatives to strengthen research in nursing have emphasized the need for more research in nursing practice in order to enable and support improvements in the quality of nursing care. However, the lack of research
expertise and experience among nursing service personnel and the limited utilization of results of research studies already conducted have been constraining factors. Even in India and Thailand, research in nursing has largely been conducted by nursing students and nurse educators with little dissemination of the research findings outside the educational institutions. Collaboration needs to be strengthened between nurse educators who have the research expertise and nursing service personnel who know the problems that need to be studied, in order to maximize the resources for improving nursing practice.

Conclusion

The countries of the South-East Asia Region have been working to improve nursing education and services so that nursing personnel can make meaningful and effective contributions in support of national strategies for health for all. Major achievements over the past decade have included the expansion and strengthening of nursing educational programmes at basic, postbasic and graduate levels in order to alleviate the persistent shortages of nursing personnel, especially those with advanced preparation. Most countries have revised and reoriented educational programmes in accordance with community health needs and the PHC approach.

Comparable improvements have not come about in nursing services, however, where the main challenge is still the provision of a basic minimum standard of quality nursing care by nurses who are able to be accountable for their practice. Numerous factors related to the health care system, the work environment and the state of development of nursing have hampered the advancement of appropriate, quality nursing practice in relation to health needs and health care demands. The focus of attention needs to shift to nursing practice in order to promote optimal utilization of nursing personnel, taking into account the existing situation in countries and the changes that are likely to occur in the future.
Nursing practice in the Western Pacific Region

Introduction

The Western Pacific Region has 25 countries with a total population of more than 1.5 billion. The region is remarkably heterogeneous: one country has 1.2 billion inhabitants while others are small atolls with only 2000 inhabitants. When examining nursing in the Western Pacific Region, one must be aware of the diverse cultures and situations in the Region. Some countries are experiencing rapid improvements in the health status of people, lifestyles, technology, and economic capabilities, while many areas remain isolated, remote, and almost untouched by modern developments. Countries can be grouped in three clusters by the main causes of death. In the developed countries, cardiovascular diseases, stroke, cancer and accidents are the main causes. In a second group, the gap between these and infectious diseases is narrowing. And in the third group, communicable diseases and malnutrition are the major causes of death. Country situations are complex and each country has unique strengths and problems which affect nursing, yet there are commonalities among these widely differing countries. The priority areas for health in the region are the development of human resources for health, environmental health, eradication and control of communicable diseases, health promotion and strengthening of management.

Modern nursing education provides skills to care effectively for the ill; it also develops attitudes to value health, crucial for both consumers and health care providers. While nurses strive to see that illness is only a temporary state, all health workers, clients, and community members work together through the life span toward optimum health and quality of life. Promotion of health and prevention of disease are needed in both the developed and developing countries of the Region. Nurses in all countries study, learn, teach, and work therapeutically together with teams and communities in a variety of settings. Through daily experience, direct contact with society, and as an integral part of dynamic health service organizations, nursing is developing a “new health consciousness” that is leading to new roles.

Thus, indeed, as one examines nursing as it relates to the dramatically contrasting socioeconomic and political situations in the countries of the Western Pacific Region, the questions “What do nurses do?” and “What could/should nurses do?” are intensely thought-provoking.
The nursing workforce

Many countries in the Region have either or both nurse-midwives and midwives. Cambodia, the Pacific Islands, Philippines, Vanuatu and Viet Nam rely almost completely on them (traditional or trained) to provide the full range of pre-natal, intra-partum and post-partum care outside of urban centres. However, many nurses in rural areas (and some in hospitals) who deliver babies are not qualified nurse-midwives and must rely on whatever obstetrical skills they acquired in their generic nursing education programme.

The Cook Islands, Kiribati, the Republic of Korea, Samoa, Tuvalu and Vanuatu utilize community nurse practitioners – nurses who have had a postbasic course of one year or more to prepare them to provide a higher level of curative and preventive primary health care services in medically underserved areas. Australia has a pilot project to test the use of nurse practitioners in areas with native aboriginal populations. Other countries, such as Fiji, French Polynesia and the Solomon Islands, have expressed an interest in training and using nurse practitioners. The titles given to this category of nursing personnel vary from country to country and include medical assistant, community nurse practitioner, community care managers, etc.

Many countries have nurses with public health training, called public health or community nurses, who have specialized in family health, child care, and implementation of public health programmes. The ways in which these nurses are used vary considerably. In some cases, they are actively involved in providing care at the community level, but in other cases – particularly in the former US trust territory islands – they tend to serve primarily as managers of community health programmes, such as MCH, and have very little patient or community contact.

There is an increasing demand for nurses in clinical speciality areas, particularly in critical care. Japan certifies clinical nurse specialists in 11 areas which include cancer, infection control, critical care and terminal care nursing. The clinical specialists are expected to provide specialized nursing care to clients, to help co-workers improve their care, to provide consultation to members of the health care team, to provide coordination among health and welfare workers, and to conduct research to increase professional knowledge and skill in nursing.
The practice of nursing

Nurses are by far the largest category of health workers and provide the whole range of preventive and curative services at primary, secondary, and tertiary levels. In hospital settings throughout the Region, nurses provide basic bedside care and fill traditional roles, but in all areas, particularly in community settings, the roles and scope of practice are expanding. The functions/roles of nurses are too numerous to list. In fact, the list would be “like a list that God might have prepared before putting the world together”. The expanding roles of nurses reflect the health sector’s efforts to explore ways to achieve universal coverage and improve the quality of health and life by better utilization of resources. Health policy analysts, planners, economists, administrators, and nursing personnel themselves seek cost-effective strategies and improved educational programmes to provide nurses with appropriate skills that will enable them to give the essential services needed today in the communities in which they work.

In a document endorsed by the forty-fifth session of the Regional Committee for the Western Pacific in September 1994, Dr S.T. Han, Regional Director for the Western Pacific Region, pointed out that “there are many closely interrelated factors which influence a person’s health and well-being. Our approach must reflect the recognition that lives are led in complex and ever-evolving circumstances. There is a growing role for the individual, the family, the community, and the nation to participate in health matters. Public policies must also reflect this and must be structured to protect people from harmful elements in the environment.”

He continued by asking: “What is the best way to encourage and enable people to help themselves to avoid disease and disability and to develop lifestyles and environments that support positive health?” Dr Han suggested that “a change is necessary in our way of operating to respond to current developments. We need multisectoral and multidisciplinary approaches that mutually support our search for solving human development issues in sustainable ways.” He suggested that, overall, these issues could be grouped into the following three themes: preparation of life, protection of life, and quality of life in later years.

To respond to the challenges for health according to these themes, nursing needs to find new approaches and roles. To enable nurses to carry out these roles, the following key elements need to be addressed:

(a) government health policies which ensure access for all citizens to essential health care services and which address individual, family and community concerns;
(b) health system reforms which (1) facilitate empowerment of people in health, and (2) identify and provide preventive care for people with high health risks;

(c) clinically competent health teams, in many cases led by nurses at the community level, with attitudes and skills to provide acute patient-centred care and referral services when needed, as well as the full continuum of primary health care to community groups;

(d) recognition of the changing/extended roles of nursing with a legal framework to support the development and use of appropriate skills; and

(e) continued focus on the quality of health services through set standards, appropriate guidelines/protocols and administrative/support systems.

Concerned about more efficient use of health resources, the countries of the Western Pacific Region are addressing these key elements in their own environments. Significant changes are occurring in the roles of nursing. For example, in New Zealand and the Philippines the scope of midwifery practices has been increased by removing legal barriers and increasing reimbursement schemes. Educational programmes for nurses are organized to increase their knowledge and skills in face-to-face counselling, communications, and handling of high-risk situations. Fiji, in a postbasic training programme for midwives throughout the Pacific, together with WHO, tests modules for teachers of midwives on the handling of high-risk maternal situations.

Because mortality and morbidity rates of children and mothers during child bearing continue to be high, a number of countries are continuing efforts to expand the roles of nurses in various programmes such as HIV/AIDS prevention and care, safe motherhood, integrated child care and family planning. Vanuatu recently evaluated the skills of the midwives, nurses and community nurse practitioners who are the sole providers of health care in the islands outside of large metropolitan areas. They identified an acute need to upgrade skills in maternal and child health care/family planning (MCH/FP), especially in the handling of high-risk situations.

As countries make efforts to give staff the skills they actually need rather than relying on traditional hospital training models, nurses are becoming more involved at both regional and country levels in collaborative activities in primary health care and MCH/FP programme areas. In Fiji, Kiribati and Tonga, for example, nurses work collaboratively with health education units to prepare health messages for radio broadcasting about MCH/immunization and other health programmes.
China's health care modernization programme targets change in the roles of nurses nationwide. In a series of strategic planning exercises starting from 1989, China has defined the role of nurses as “direct and indirect care for the sick and injured, as well as health promotion and protection.” The majority of nurses are graduates of secondary nursing schools (elementary school plus two and a half years) whose methods of teaching are based on the roles of nurses thirty or forty years ago. National strategies aim to reduce the shortage of nursing personnel; improve the quality of nursing; improve nursing management; strengthen basic nursing education; and strengthen higher education.

Nursing in Cambodia, the Lao People's Democratic Republic and Viet Nam struggles to redevelop after long periods of political unrest. During these periods, general education was either stopped or poor. Nurses were trained in short first aide courses to meet the acute health needs of the population. Today, with varying degrees of success, these countries are attempting to modernize their health services, and this requires better trained nursing personnel.

China and the Lao People's Democratic Republic, through workshops and the introduction of training materials suitable for nurse teachers in their country, are introducing new teaching methods and strengthening the skills of nurse in the area of prevention of communicable disease.

WHO collaborating centres for nursing development in primary health care in Australia, Japan, the Republic of Korea and Philippines are conducting research on nursing practice and its role in meeting the needs of the ageing population. In addition, methods are being proposed to test the results of direct care for the elderly in the home through local support teams. WPRO supports this effort through making available a “Training Guideline for Health Workers in Quality Care of the Elderly.” Activities to adapt the guidelines to local situations are underway in China, the Philippines, Viet Nam, and the South Pacific Island countries. China, Japan and the Republic of Korea have developed new categories of nursing personnel and/or extended the role of community health workers to provide community nursing services for the elderly.

Historically, in most of the small island countries of the Pacific various categories of nursing personnel have provided the majority of primary health care services to communities. In many island countries, such as Kiribati, nurses (registered nurses and medical assistants) are the only health workers in rural areas and on the remote outer islands. In these situations, nurses are truly multipurpose health workers, providing the full range of primary health care services - preventive and curative. Nurses diagnose and treat patients on a regular basis; dispense medications; manage emergencies as well as chronic conditions; provide all maternal and child health care
including deliveries; provide some dental care; perform minor surgical procedures; keep statistics (in Fiji nurses even do the census); and provide community outreach services.

In most countries, rural health facilities have in-patient beds and nurses admit patients and provide all patient services until the patients are discharged or transported to another health facility. In some countries, such as Vanuatu, nurses in rural hospitals admit patients, share call with physicians and run the wards, providing both traditional bedside nursing care and carrying out the functions traditionally associated with doctors. In the Solomon Islands, even in the capital city of Honiara where there is a national referral hospital staffed with doctors, nurses provide basic outpatient curative services in clinics throughout the area and even in the outpatient clinics located in the hospital itself. Also in Vanuatu, it is nurses who provide outpatient curative services in the main hospital, Port Vila; they also essentially run certain wards.

The level of medical support that nurses have varies tremendously, depending on the number of doctors in the country, the location of the nurse, and the availability of transportation and communication. Sometimes, the main problem is the absolute shortage of doctors. For instance, Tuvalu has only three doctors. One is a recently recruited expatriate, and the two local doctors are in their seventies and serve in administrative posts in the ministry. All three of these doctors are located in the capital city of the main island. Similarly, Vanuatu has only three doctors in government service, two of whom work as medical superintendents of hospitals. The remaining eight doctors in the country are specialists on contract with donor agencies.

In some countries, the shortage of doctors is seriously compounded by the lack of communication and transportation. For example, in Kiribati, where nurses provide virtually all the health care outside of the capital city, nurses are not always able to obtain medical consultation when needed. Some of these islands are very remote, and the HF radios – if, in fact, they are working – may be located far from the health facility. Furthermore, even if the nurse is able to communicate with a physician, timely transport may not be possible due to a variety of constraints, such as rough seas. Nurses working in these situations are very much on their own.

In countries which continue to be politically associated with a developed country such as French Polynesia and the Commonwealth of the Northern Mariana Islands (USA), the health care system tends to be based on the traditional medical model, with limited emphasis on primary health care and a more "traditional" role of the nurse. However, even in these countries, situations are rapidly changing with corresponding changes in the role and practice of nursing.
Two countries which have long associations with the USA, the Marshall Islands and the Federated States of Micronesia, employ primarily male (non-nurse) health assistants on the outer islands. Nurses in these countries are trained in traditional US-oriented programmes (with US entry requirements) and fill primarily traditional roles as bedside nurses in the hospital and as public health nurses (but with very little training, if any, in public health and in very limited roles). Most public health nurses manage grants administered through the US Department of the Interior or the US Public Health Service. These grants are for single purpose programmes, not integrated primary health care services.

In Samoa, the Solomon Islands and Vanuatu, nurses essentially manage the district health services. Nurses in Vanuatu also manage certain clinical programmes and serve as coordinators in programmes for control of malaria, tuberculosis/leprosy, diarrhoeal diseases, etc. Nurses in both the Solomon Islands and Vanuatu are the primary health care coordinators.

In summary, the roles of nurses regionwide are dependent on: (1) historical, economic and geographic factors; (2) the categories and numbers of other types of trained health personnel available; and (3) the capacity of countries to provide the necessary resources to support the implementation of the primary health care/health-for-all strategies of the government.

The nursing practice model often used in Asia gives the family an important role in caring for patients during hospitalization. In many of the developing countries, as well as developed countries with an acute shortage of highly qualified nursing personnel, this model is cost-effective and offers an opportunity to provide the individual and family with knowledge and skills to understand the individual's health problem and to develop a plan for self care.

Regrettably, some countries continue using the inadequate traditional medical health service model, which forces the largest number of nursing personnel into restricted hospital and tertiary care roles. National health policies have an immediate impact on the quality of nursing in all settings, especially at the country/township and district levels. Countries that continue to give priority to high-tech development of curative services at the expense of prevention and protection health programmes have limited resources to develop and maintain the much needed district and community level health infrastructure. Without access to nursing services which support maternal and child health, health promotion, health teaching and basic primary health care services, population groups are at risk for poor health. Therefore, in the Western Pacific Region, efforts are being made to find new mechanisms to set priorities for health resource utilization that will improve the health of all people.
Nursing education

Basic nursing education

Schools of nursing in all countries of the Western Pacific Region are committed to the improvement of health through education and community service. Graduate, undergraduate, and continuing education curricula aim to reflect the unique and changing health needs of countries. Concepts are introduced to encourage academic-clinical integration and to build on the humanistic, caring concepts basic to nursing. Because it is not possible to prepare nurses for all functions they will be asked to do in the future, educational programmes try to create a continued zest for learning and to produce self-confident nurses capable of dealing with diverse and changing roles. The Western Pacific Regional Office provides developmental and consultative services to governments to support general nursing education development and revision of curricula.

In several countries, nursing curricula have been reviewed with the assistance of international experts provided by different agencies, yet because of poor national resource management, the schools remain short of trained faculty, appropriate textbooks, facilities, etc. Thus, nursing education continues to be inadequate in quality. When the national capacity to manage human resource development is weak or the development is not seen as a priority, even the best prepared plans and intentions fail. Countries need to discuss what is “underneath the surface that keeps them behind”. Thus, WPRO encourages strategic planning exercises which look at total systems, the contextual environment and the resources available to maintain and implement nursing education. Nursing education must be affordable, produce effective workers in the context in which they will be employed, and be satisfying.

The basic (generic) nursing studies provide students with a foundation for practice in first-level nursing positions. Most of the least developed countries have three-year certificate level nursing programmes.

In the Philippines, all generic nursing education is at the university level. However, through an evaluation study, they have found that clinical practice models are quite different from what is taught in the classroom. The Association of Deans encourages faculty to work with nurses in the health facilities who serve as clinical instructors in order to help students analyse health problems and use good clinical judgement.

Australia is moving nursing education into the university setting. Singapore has introduced a diploma course at a polytechnic school and Malaysia has started its first degree programme.
Japan is considering a new law which will abolish the assistant nurse system and upgrade the lower level of nursing to a basic nurse who will study in a three-year programme, after 12 years of general education. At the same time, in Japan career opportunities are being increased through the establishment of a Bachelor of Science in Nursing faculty in most prefectures.

The generic non-degree three-year programmes are quite similar in objectives from country to country; however, the quality of teaching and the emphasis placed on particular subjects vary greatly from place to place. Some planners believe that there are enough commonalities in basic nursing to enable one school to prepare nurses for many countries. This was tried in the Northern Pacific island area, but for a variety of reasons, the effectiveness of this strategy was limited. Students from island countries tend not to like to be away from their families for long periods of time and if they do make the adjustment, they may not return to their home country to work. The result has been that these countries suffer from acute shortages of nursing personnel and are therefore making plans to develop their own national nursing schools.

After the Alma Alta Conference, the aim was to build all generic nursing curricula in the Western Pacific Region on the philosophy of primary health care education. However, in spite of many workshops and seminars, there continue to be many problems in changing the actual roles of nurses even after development of primary health care skills. In many countries there are few positions for nurses with primary health care skills. China is an example of this; however, the three-year curricula for the country level health worker (barefoot doctor) is similar to that of a community nurse in other countries.

Primary health care concepts have been strengthened in the three-year nursing education programmes in the South Pacific and these programmes now include community health field experiences. In addition, the programmes in some of the schools (the Cook Islands, Fiji and Tonga, for instance) offer a longer rural experience for students in their final year. Yet most schools are still very weak in preparing nurses in primary care clinical skills, including midwifery. One of the reasons for this is that the tutors themselves do not have the level of clinical skills required to teach these subjects. Only where there are strong postbasic programmes – nurse practitioner programmes, public health programmes and midwifery programmes – are nurses properly prepared for these roles.

In the Pacific Island countries associated with the USA, most nurses are trained in an associate degree programme lasting two and a half years (plus at least one year of prerequisites). A few nurses have gone on to earn a BSN at a four-year institution and a very few have earned master's degrees. In
this regard, a very unfortunate distinction has developed between the so-called "graduate" nurse and the RN. The graduate nurse has graduated from nursing school but has not passed the US Boards while the RN is a graduate who has passed this exam. Very few Micronesian nurses have passed. As these countries have gained independence, new legislation regulating nursing is eliminating this distinction. But the US territories (Guam) and the Commonwealth countries (CNMI and American Samoa) continue to use US mechanisms for licensing and, as a result, have very few indigenous nurses. Many professional nurses must be recruited from overseas. As a result, the Micronesian countries must rely to a large extent on informally trained local practical nurses to provide basic patient care services, including public health nursing services.

Nursing education in the South Pacific countries tends to be based on the model formerly used in Australia and New Zealand. Nurses from these countries attend a three-year course of studies in a national school of nursing. In recent years, preventive primary health care has been integrated into the curricula of these schools, with community clinical experience. The Cook Islands, Fiji, Kiribati, Samoa and Tonga are examples of this model. In these situations, nurse training is a function of the Ministry of Health and most nursing is performed by graduates of these programmes, with practical nurses, where they exist, playing a lesser role.

The Solomon Islands' three-year nurse training programme has been transferred to the Solomon Islands College of Higher Education under the Ministry of Education. Interestingly, in this country, it is the community health workers (formerly called nurse aides) who do much of the hands-on care in the most rural areas. Fully 85% of these health workers are deployed outside the Honiara area and they provide the full range of basic curative and preventive services, delivering babies, diagnosing patients and independently managing their illnesses. Because they are a vital component of the health care system, the government has now developed a standardized one-year training programme for all former nurse aides so that they will be skilled in the tasks they need to perform. Village health workers are also utilized in the Solomon Islands. One concern is that RNs being prepared in a more academic setting might not have the skills needed in curative primary care and obstetrics needed to supervise the nurse aides and help them with their more difficult cases.

Samoa also has an enrolled nurse (practical nurse) programme taught through the School of Nursing. The curriculum for this programme has recently been revised to make it more primary health care oriented, with emphasis on community-based preventive activities.

Fiji trains hospital aides who perform mostly non-clinical tasks such as bedmaking, transporting patients, etc., but who also help the nurses with
some patient care activities, such as feeding patients. The Cook Islands also hire a few nurse aides. A number of people who work as assistive nursing personnel have some nurse training but did not complete the training for a variety of reasons.

Although there has been much progress in reorienting the curricula of many countries to primary health care concepts with the focus on prevention, there is very little PHC curative content in the basic nursing curriculum. As a result, nurses are not prepared to function effectively when they are posted to rural areas. For example, although they may be required to diagnose and treat patients, they may not know which antibiotic to give for which condition. Generally, they follow what they see the doctors do, but this does not necessarily result in good practice. Often the information needed is not incorporated into the curriculum because the tutors - no matter what their academic background - do not have the information themselves and are very uncomfortable trying to present this to students. If treatment guidelines or protocols were developed, these could be used to guide practice and could also serve as the basis for teaching this information.

Increasingly, tutors in the schools are being given the opportunity for advanced study, so more of them have some teaching and/or other post-RN qualifications. This varies from country to country, however, and the majority of the tutors still do not have the necessary skills in teaching methods (particularly clinical instruction and participatory teaching) and many do not have the clinical skills required to teach particular subjects. Further, there is an unfortunate misconception that an advanced degree in itself qualifies a faculty person to teach any advanced course. In one country, nurses prepared at the bachelor's level were earmarked to be faculty in a postbasic nurse practitioner course. The faculty, however, did not have nurse practitioner skills and did not understand the role. The sad result was that most of the students failed the course.

In Cambodia, China, Viet Nam, and some South Pacific countries, faculty are drawn from clinical areas and posted back to teaching in a nursing school within a relatively short period of time after graduation. When these young teachers attempt to introduce modern participatory and clinical practice "hands on" teaching methods, there is resistance from the students, who are used to didactic-authoritarian methods. Rotating senior nurses between the clinical areas and the educational institution has some advantages, but there is also a need for a stable core group of qualified nurse educators to provide leadership and continuity in nursing programmes and to provide guidance for faculty who do not have teaching qualifications.

Another constraining factor related to nursing education is that most tutors do not supervise their students in the clinical area, whether this is in
the hospital or in the community. Nursing school teachers are primarily classroom lecturers who give lectures and make arrangements for students' clinical practice but do not supervise that practice. Furthermore, clinical instruction seems to be the activity least rewarded in the nursing school setting, so there is very little motivation for faculty to be with their students in patient care settings. This has a negative impact on student learning and on the quality of nursing practice in general.

The material resources of nursing schools have seen some improvements over the years. Recently, donors have been involved in building new classrooms and student accommodations in a number of Pacific Island countries, including Fiji, Samoa and the Solomon Islands. WHO has supported the preparation of textbooks and teaching materials in Cambodia, China, Laos and Viet Nam.

**Advanced training for nurses**

Postbasic, graduate and continuing education enable nurses to provide more complex health-related services for the sick and well, in both primary health care and referral settings. These advanced education programmes are a great source of primary care providers. In general, they prepare nurses for specialist/extended roles, but they vary greatly because they are designed to prepare nurses to meet needs in the unique environment in which the graduate will work. These nurses develop skills in health problem assessment, analysis of needs, application of interventions, planning and managing client/community health programmes and evaluation.

Samoa has a very progressive advanced clinical primary health care nursing programme. The course gives nurses expanded skills in the diagnosis and management of common primary health care problems. Graduates are expected to provide comprehensive primary health care in medically underserved areas and manage district health services. Protocols for care drafted in the Cook Islands and Samoa have been adapted for Kiribati and Vanuatu. Students from Cook Islands, Niue, Tokelau and Tuvalu have also attended this course and other Pacific Island countries have expressed interest in sending students.

Across the region, linkages are encouraged between more advanced programmes and sister institutions. For example, nurses in Thailand provide developmental support to Cambodia, China and the Lao People's Democratic Republic through degree and short courses for nurse/midwife teachers and in-country guidance on curriculum development, clinical site models and teaching methods. Japan offers speciality courses in high-tech areas to nurses from China and Viet Nam. The Philippines, with special
skills in the management and organization of nursing education, provide courses for nurses from the Middle East and Pacific Island countries. The Republic of Korea has developed an international health course for nurses, offered in English, which is intended to share expertise in primary health care with nurses from around the Region.

There are bridging courses, especially designed in length and content, for international nursing students in Australia, Guam and New Zealand. The University of Guam has tried to provide relevant content for Micronesian students. However, there are many prerequisites for admission to both the basic RN programme and the RN-to-BSN programme, which Micronesian students find hard to complete. Many Micronesian students find the English composition and basic science courses very difficult, particularly since their high schools were often not strong in these areas. As a result, very few Micronesian students (including the indigenous Chamorros and Micronesians from Guam) have been successful in this programme.

China has 12 new Bachelor of Science in Nursing and two Master's of Science in Nursing programmes. Most of the graduates from these programmes are absorbed immediately by large medical centres. There is a tremendous lack of prepared teachers for secondary schools. To fill this gap, China has established Centres of Nursing Education Excellence to provide postbasic short courses to train teachers in less advanced areas and remote schools.

In the North Pacific, the associate degree programme at the College of the Marshall Islands, which originally followed the US model of two-year programmes, now incorporates maternal and child health, primary health care, and community development skills. The two-year basic programme at the Northern Marianas College, which also follows the US model, is aware of the need to include more primary health care and adjust its programme to meet area needs.

Nurses in the Western Pacific Region are very committed to providing quality care. Study tours, international seminars, long-term fellowships provided by WHO and other donor agencies, and visits arranged by nurses or countries themselves provide a dynamic network for exchange of ideas. In 1994/95, Japanese nurses visited the USA to observe “patient-centred care”. Cambodia's midwives visited the Philippines to observe “family care”. Papua New Guinea nurses studied senior-level management and information system development in Australia. Each year, Fiji sends nurses to Australia for speciality programmes. Malaysian nurses look at health care of the elderly in New Zealand. China's nurses take a management development programme in Hong Kong. The challenge facing the Region in this regard is to maintain the quality of these international exchange programmes in the face of faculty shortages.
Even with all of these programmes, many nurses - particularly those more or less permanently posted in rural areas as well as those posted in hospitals - may not have an opportunity for continuing education during their entire careers. The constraints of cost, distance, and lack of replacements make it very difficult to provide continuing education for the nursing workforce on a regular basis. Trainer-of-trainer courses are one approach, but experience has shown that the knowledge and skills acquired by the trainers do not reliably trickle down to the nurses in the field or at the bedside.

Distance learning courses are now being developed to address these constraints. At present, Fiji offers a one-year course in management for mid-level nurse managers, and the Solomon Islands and Tonga are preparing to provide continuing education using this approach. Print materials and teleconference are the modes currently used. Still, these courses reach only a small proportion of the nurses who need them. This is particularly true of rural nurses. Popularizing the courses and offering them by AM radio is one alternative strategy under consideration.

Since distance education has become popular and accepted, a number of universities in developed countries are marketing these programmes to less developed countries. Most of what is packaged in these courses (most leading to the bachelor's degree) is theoretical knowledge, much of which is useful. However, many areas in primary health care require more hands-on supervised teaching in community settings. Care is needed to ensure that the bachelor's degrees the nurses earn contain substantive useful content and that nurses receive the help they need to apply their knowledge in primary health care and clinical settings.

Research development

Increasingly, the trend is for nursing education and service to collaborate in the conduct of nursing research. For example, family health teams from clinical settings and faculty from schools of nursing in Australia conduct research involving students in action-learning programmes. Recent studies have provided information about understudied, poorly understood health-related behaviours and the stress that occurs during pregnancy. These studies have also looked at the types of nursing and midwifery practice which influence the experience of couples in the birthing and parenting process.

The WHO Collaborating Centres in Nursing/Midwifery Development in Australia, Japan, Philippines, and the Republic of Korea integrate efforts in primary health care, nursing research, practice and education. Students
and faculty have opportunities for free-flowing exchanges of ideas and gain
valuable experience in developing research skills, from the design of studies
to utilization of the findings. The lessons learned by sharing nursing
research findings from country to country are of great significance to the
Region. For example, a monograph with information on nursing research
and development projects gathered from countries of the Region was
prepared by the WHO Collaborating Centre at the University of the
Philippines College of Nursing and this monograph was distributed widely
to nurse leaders in all countries of the Region, as well as globally, with an
evaluation form on the last page requesting readers to share their opinions
of the value of this type of document. Responses came from eleven countries
encouraging WHO to support this type of information exchange as it gave
them new ideas, useful for testing in their own countries.

Enabling and constraining factors in the development of
nursing services

All agree that health would be greatly improved if policy makers
would become bold and adjust traditional systems to more appropriate
models, allocate resources to provide optimal personnel mixes, and support
the operationalization of health services according to well-designed plans.
However, the reality is that change in nursing often occurs in an ad hoc
fashion and skills for management of development are either lacking or
weak. WPRO, concerned about this constraint, has prepared a reference
guideline which contains information on strategic thinking and provides
various processes and tools for more effectively managing the development
of nursing.

Among the major factors constraining access to adequate nursing
services have been the traditional health care reimbursement systems. In the
Western Pacific, a number of countries are looking at health insurance
schemes to make changes in this area. Patients prefer hospitals that provide
adequate nursing care to the traditional system, which requires families to
hire private nurses affordable only by the rich. Changes to expand the scope
of health insurance to cover nursing and other services provided by
community clinics as well as home services are also being designed.

Nursing has a transactional relationship with Health Departments.
Nursing is affected by policy, and in turn nurses affect the implementation
of the Health Department’s programme. There are persistent myths about
nurses being “difficult”, an often unfortunate image because nurses can be
most effective when they are partners in providing health care. Historically,
health systems were top down and authoritarian in their management
approaches. Nurses were told what to do, and information on the actual
situation at the operational level was not heard. However, nurses are clearly the most suited to proposing, refining, and implementing health care policy as it relates to nursing care. To participate effectively, they need the skills to dialogue effectively with policymakers. Old management styles and traditional power-plays, and lack of understanding about how to influence policy decisions often blocked and still do block nursing participation.

Though in the past this was a dilemma throughout the Region, in both developed and developing countries, we are seeing in nursing groups a move from health policy ignorance to more national policy consciousness. Nursing groups have moved from passivism to activism, and they collaborate in community actions for better health care.

In most countries of the Region, the nursing profession contributes the largest number of personnel to the health workforce. Thus, legislation affecting the nursing profession assumes particular significance when evaluating health system performance and in considering changes required to implement “new directions” to achieve health for all. A well-written law on nursing provides guidance to the profession, anticipates and allows for future growth, and empowers nurses to undertake health delivery roles with proper training to address important health needs of a country.

The laws regulating nursing practice vary widely, resulting in nursing practice which ranges from relative autonomy with extended prescribing rights, to great dependence on the medical profession. WHO has been actively working with countries regionwide to review their nursing legislation and has worked with the Micronesian States, which recently became independent, to draft a law on nursing. A number of new laws have been written and passed in other countries as well. Others are in the process of being revised. And still others are badly in need of revision as they date from the pre-colonial or war era. However, from a practical point of view, most nurses do not see how the laws regulating nursing practice affect their day-to-day work. The introduction of these concepts into basic education is very much needed.

Country-level authorities often lack understanding of the economic benefits of quality nursing services partially due to the fact that they lack methods for cost effective analysis of nursing services. Resources are wasted because the development of “nursing and midwifery services” is not strategically planned. Many countries lack a clear policy on national nursing/midwifery service utilization and thus do not provide effective resource allocation to support development/modernization. This results in poor quality performance and ultimately in poor quality health care.

Information systems which enable administrators to make effective decisions about the roles of nurses and the cost of nursing services often do
not exist or, if they do exist, the raw data is not transformed into "information" using an understandable format which reaches people at the decision-making level. As a result, when governments do not have information they often choose to give priority to developing "trendy schemes" rather than upgrading components essential to basic health services. China, Hong Kong, Lao People's Democratic Republic and Papua New Guinea have government programmes to strengthen decision-making related to nursing based on actual national data.

Strengthening of nursing is seen as a high priority by most of the countries in the Region. In several countries, however, basic nursing education remains almost totally neglected and, as a result, the quality of health care is very poor. In Viet Nam, a recent nursing information system developed in pilot provinces enabled the Government to see that the largest number of health workers, who are community health workers, have very limited formal education (3 to 18 months after elementary school). Approximately 3% of nurses have less than seven years of education in total, 41% have 8 to 11 years, and 56% have only 12 years. There are almost no nursing/midwifery teachers with advanced education in teaching methods, management or speciality nursing.

There is emerging recognition of the value to an organization when employees at operational levels are concerned about costs, quality, and outcome issues. The management capabilities of nursing service systems range from extreme dependence on the decision making of others to considerable autonomy and accountability for the level of performance of nurses. Today, countries have programmes to increase the responsibilities and capacities of nurse managers, making them accountable for handling resources. For example, in Samoa, health post managers are asked to keep an inventory of all supplies and equipment and are asked to prepare annual estimated budgets. According to the Minister of Health, this increased responsibility has, in fact, greatly reduced wastage.

Papua New Guinea has applied economic concepts to long-term development planning for nursing services. However, the process has been constrained by unrest in the country. Weak central management structure inhibits nursing leaders from providing much needed educational and administrative support to provincial and district level staff.

It is certainly true in the Pacific that one of the constraints for appropriate quality primary health care nursing practice is the weak management of the health services in general and nursing services in particular. Many nurse leaders are not effective managers. Many have had no management training and run the nursing services in a top-down management style based on seniority and a variety of personal factors. As a result, the younger, better trained nurses are unable to fully utilize their
skills and quickly become demotivated. Even in countries where there are strong nurse leaders and managers, nurses tend to be isolated from the rest of the ministry, included only when strictly nursing matters are discussed. Because they are not included in broad planning activities and in major policy decision-making, they become narrow in their thinking and have little understanding of the whole picture. Therefore, when they are consulted, they may have little to offer. This vicious cycle has a negative effect on primary health care service delivery as well as on nursing development. Participation on multidisciplinary study tours, workshops and meetings could be helpful in addressing this. A few countries have begun to include nurses on senior management committees in the health ministries, where these exist. However, this is very dependent on the individual Secretaries of Health.

One issue of concern is that some countries of the Pacific are moving to a management model in which there is no chief nurse or the equivalent (and no chief medical officer). Nursing is integrated into the other directorships based on function, e.g., preventive services. There is much to be said for this health management model. The problem is that the nursing services in these countries are so weak that they tend to lose whatever voice and power they have if there is no identified advocate. Further, if there is no focal point for nursing in these countries, it is very difficult for donors and technical agencies to work with the nursing cadre.

One of the results of weak management and lack of understanding of primary health care is that the clinical and public health services tend to exist as two separate systems. Most nurses identify clinical services as “hospital services” and public health services as primary health care. Primary health care is seen as preventive care as opposed to curative care. Thus, the integrated approach to primary health care services simply does not exist in most countries of the Western Pacific Region. This situation seems to be exacerbated (and very difficult to address) when there is no nursing focal point.

The working conditions of nurses remain a major issue affecting the quality and availability of service. Because of low wages, authoritarian management styles and lack of opportunities for career mobility, nurses either seek other options or become demotivated and resistant to change. Nurses from Malasia, Philippines and the small South Pacific Islands have for years migrated to countries like Australia, New Zealand, USA and the Middle East for better opportunities. This is now taking new forms. For instance, in Fiji, nurses are now looking for employment opportunities in other Pacific Islands where the wages are higher, e.g., the former US trust territories (the Marshall Islands, Palau), Nauru, or the Commonwealth (US) of the Northern Mariana Islands. In addition, nurses remaining in Fiji are
looking to other sectors for employment such as the airlines and the Department of Social Welfare.

An article in *Nursing New Zealand*, January 1995, states that “there is an extreme shortage of experienced nurses throughout the country who left the health sector after the 1993 health sector reform for other types of employment due to lack of career opportunities causing great wastage to health”.

Finally, it is difficult for nurses posted in rural areas not to feel that they have been forgotten, especially in Cambodia, China, the Lao People's Democratic Republic, Philippines, Viet Nam and isolated Pacific Island areas. The shortages of drugs, equipment and supplies in many countries; the lack of transport in most countries; and the deteriorating health facilities in many rural areas make work difficult and discouraging. This cannot help but affect their practice.

A major problem at the regional level is maintaining effective liaison and cooperation with nursing services and functioning at country level. National nursing leaders and officials are without mechanisms to communicate nursing/midwifery development needs/situations to WHO. Without resources allocated to a comprehensive set of regional activities for the development of nursing/midwifery services, the components of nursing practice, education, research and management are split into ad hoc, non-focused, short-impact projects. The Western Pacific Regional office works to strengthen coordination among programmes to ensure an integrated approach to nursing/midwifery activities in countries.
Summary and conclusions

These papers from the six regions of the World Health Organization give a brief view of the nature of nursing practice in the world today. Clearly, nursing practice is everywhere influenced by political, economic and cultural realities, and these realities differ not only from region to region but also from country to country. For example, rich countries have many more resources for health care – and for nursing care – than poor countries. The Region of the Americas is characterized by great economic inequities and consequent inequities in health care: in Latin America and the Caribbean, nearly half the population live in poverty and many have no access even to basic health care, while the rich countries of the north, Canada and the United States, have the most sophisticated health care in the world. In the African Region, which has 29 of the world’s 47 least developed countries, over half the population lack safe water and two thirds are without proper sanitation. Most women still go through childbirth without trained assistance. In the richest countries of the Western Pacific Region, health care and nursing practice are highly developed, but in the poorest countries there are areas where clinics have no clean water and nurses lack basic training. In recent years natural disasters, ethnic conflicts and civil wars have devastated health care systems in many countries, and countries in conflict have diverted funds from national health to defence and ammunition. In some countries of the world, nursing personnel have not been paid for more than a year and schools of nursing are in serious disrepair.

The context for nursing practice in the six WHO regions includes not only socioeconomic and political realities, but the changing nature of health care systems. Many countries are involved in health care reform, which often means more privately financed health care, raising questions about the role of the public sector and the provision of primary care and preventive services. Inevitably these become also questions about the role of nurses.

What nurses do

Nearly everywhere nurses make up the largest proportion of the health care workforce. They are the most widely distributed group and they have the most diverse roles, functions and responsibilities. Nurses provide health and nursing care to individuals, families, groups, and communities. Their care includes health promotion and disease prevention as well as the treatment of common diseases, acute care, rehabilitation once an illness has passed the acute phase, and long-term care of persons with chronic, degenerative or terminal illnesses. What individual nurses do, however, varies widely from country to country and even within countries, depending
not only on the context described above, but on the availability of nurses, the availability of physicians and the nurse-physician ratio. In some rural areas nurses are the only health workers and they provide the full range of primary health care. Nurses may not only provide care but essentially manage all the district health services, coordinating a variety of programmes to control malaria, tuberculosis, leprosy, diarrhoeal diseases, etc. Many countries have a strong tradition of midwifery and midwives may act with considerable independence, not only in making deliveries but in preventive care and health education.

In most of the world, however, the great majority of nurses work in hospitals, primarily in urban centres, giving curative and rehabilitative care. In some areas they have a great deal of autonomy, assessing patients' conditions, diagnosing nursing needs, initiating nursing actions independently when needed and participating with physicians in rounds and meetings to present and discuss patient situations. In other places, they have few if any autonomous functions, working under the direction of physicians, carrying out doctors' orders for treatment procedures or assisting doctors. In other words, they are essentially medical assistants. Their work is organized by tasks and they are not expected or permitted to make decisions about the care of patients. In other hospitals nurses' responsibilities may include not only direct patient care but maintaining inventories of linens, drugs and other supplies, supervising housekeeping staff, even cleaning reusable equipment and carrying out clerical work. Some studies have found that in many hospitals less than half of nurses' time is spent in direct nursing care. In countries with acute nursing shortages, nurses may act only in managerial and supervisory capacities, leaving most direct care of ill patients in the hospital to families and in the community to auxiliary, often untrained, workers or to families.

Factors affecting the scope and quality of nursing practice

The great differences seen in the scope of nursing practice today are related to numerous constraining and enabling factors. Constraining factors include the multiple, confusing levels of nursing personnel in many countries, the lack of advanced preparation of nurses, especially those in managerial positions, and the absence in many countries of standards for nursing practice. Other constraining factors are outside the control of nursing. As noted above, the context for nursing differs from country to country, as do the resources for nursing and nursing education. However, there are some common influences on nursing practice worldwide. The first of these is that most nurses are women and therefore the position of nurses in society and the value given to nurses' work are aligned with the position of women in the society. In every country nurses have traditionally been
subordinate to physicians. In many countries nursing is still seen as a low-status job, not a career, and wages and working conditions are poor. In some countries of Central and Eastern Europe, for example, the social status of nurses was until recently approximately equivalent to that of unskilled manual workers – though in other countries, nurses are held in high regard and the profession enjoys wide public support.

The pay for nurses also constrains practice. In a third of the world’s countries nurses’ salaries are lower than those of other occupations requiring a similar level of education, and in some of the least developed countries nurses’ salaries are actually decreasing. In many developing countries the significant shortage of nurses in rural areas is a direct result of poor working conditions and low pay. Also, in some countries it is difficult for nurses posted in rural areas not to feel that they have been forgotten. The shortage of drugs, equipment and supplies in many areas; the lack of transport; and the deteriorating health facilities in many rural areas make work difficult and discouraging.

**What nurses could do**

As the World Development Report 1993 (World Bank, 1993) notes, nurses could provide most of the primary health care services considered essential for the health of populations. Non-physician primary care providers such as nurses and midwives have been shown to be cost effective. Indeed, studies have found that appropriately prepared nurses can provide as much as 80% of the health care and up to 90% of the paediatric care that is currently delivered by physicians, at equal or better quality and at less cost. Nurses could also be cost-effective providers for the world’s growing population of elderly.

Nurses could also assume greater responsibility for the organization and management of health care. In hospitals they could take more leadership in assessing patients and in planning, implementing and evaluating care, organizing and leading the work of others. Further, given their understanding of the importance of health promotion and disease prevention, they could take a lead in refocusing health care away from hospital care toward community and home care, and manage health care personnel to support primary health care.

**Conclusions**

There is clear evidence that nurses throughout the world are improving their skills, upgrading both basic and advanced education for nurses and enlarging the scope of practice to respond to changing health care needs. In
all six regions of the World Health Organization, there have been major advances in the last decade. In particular, nurses everywhere have been reforming nursing education to prepare practitioners to practise in new ways, to keep up to date, and to develop more specialised skills and knowledge. The doors of universities are no longer closed to nurses, as they once were in many areas, and nurses are increasingly studying not only at the baccalaureate level but at the master's and doctoral level. Nurses are also attempting to strengthen their leadership and to gain more authority in policy-making and management at all levels from the primary health care team to the central government.

However, given the limited authority and autonomy of nurses in many countries, the ability of nursing to independently adapt and expand practice remains limited. Nursing practice is dictated by the health policies and plans of countries and by the resources available for health care. In many areas there are acute shortages of nurses, particularly well educated nurses, and the main challenge is still to provide basic nursing care.

These six papers on nursing practice throughout the world provide considerable evidence of the current problems as well as the great promise of nursing and nurses. As these papers make abundantly clear, everywhere there are urgent priorities for nursing. They include developing more nursing leaders at all levels; continuing to reform and upgrade nursing education; improving the pay, working conditions and professional status of nurses; developing legislation and standards for nursing practice; strengthening the role of nurses in policy making and management; and increasing the ability and commitment of nurses to facilitate family and community participation in health care.

The Expert Committee on Nursing Practice which met in 1995 used these six papers as a basis for its deliberations, and the conclusions and recommendations of the Committee point the way to ensuring the delivery of comprehensive nursing care to populations in different cultural and political contexts in countries at different stages of socioeconomic development.

In particular, the Expert Committee recommended that Member States should assess the need for nursing services at all levels of the health care system and in all settings, assess current human and financial resources to identify strengths and weaknesses in addressing these needs, and develop national policies and plans for nursing/midwifery development to enable nursing personnel to provide comprehensive care.

The committee noted that strategies for developing nursing and midwifery should enable adequate numbers of nurses to be recruited and retained, especially in underserved areas, provide resources to create the positions needed, and ensure adequate and equitable pay and working
conditions. The committee also pointed to the need to establish a regulatory framework for nursing practice and education, and to develop systems to monitor the quality of nursing care in all settings. Finally, the committee recommended promotion of nurses to leadership positions at all levels of the health care system, strengthening their capacity to develop comprehensive nursing care.

Nursing practice today is at different stages of development in different countries. Solutions to problems have to suit the needs of each country and must be arrived at through the collaboration of nurses, nurse educators, nursing managers, other health care workers, and representatives of the communities with whom nurses work. Yet in all countries, strategies to carry out the recommendations of the Expert Committee will go far toward overcoming the factors constraining nursing practice and enabling nurses around the world to achieve their potential and assure health for all.
References and acknowledgements


The papers listed below were prepared for the Expert Committee on Nursing Practice, Geneva, 3-10 July 1995, and were used as a basis for this document. The regional papers are referred to in the text by the acronym of the WHO regional office concerned. The authors of these papers are gratefully acknowledged.


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