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THE NEED FOR NATIONAL PLANNING FOR NURSING AND MIDWIFERY IN THE EMR

CONTENTS

1. INTRODUCTION

Nursing services are the backbone of any health system. Nursing personnel constitute the largest segment of health human resources in most countries of the world. Nursing services are delivered in hospitals, homes, schools, health centres, factories and other settings which offer preventive, promotive, curative, rehabilitative and restorative care. Furthermore, nursing personnel work at all levels of health service delivery, primary, secondary and tertiary and can also be involved in provision of direct care to individuals, families and communities at large, in developing health policies and strategies as well as programme development and implementation. It is within this frame of reference that the current paper is presented.

2. SITUATION ANALYSIS IN THE EASTERN MEDITERRANEAN REGION

The last few decades have witnessed impressive initiatives from governments of Member States in this Region aimed at developing nursing and midwifery services; schools of nursing were established to provide the required workforce, mass media campaigns were launched to attract young females to join this career, incentives schemes for nursing personnel were instituted to reduce attrition among employees, and training opportunities were provided for preparation of nurse educators and managers. Despite these efforts 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 operation and the implementation of national health strategies.

2.1 Shortage of nursing personnel

Table 1 reflects the magnitude of the shortage of nursing personnel in all Member States. This chronic problem is the result of increased demand for nursing services on the one hand and an inadequate supply of appropriately qualified nurses on the other. Increased demand for nursing services is the outcome of expanding health systems infrastructure, increased population, the introduction of medical technology in service delivery, and greater awareness of the public to the importance of health care. All these factors have led to an increased demand for preventive and promotive health services in addition to curative care.

In some countries the migration of qualified nursing and midwifery personnel to the Gulf countries and/or other Western countries such as the USA and France has depleted the supply of nursing personnel. Other factors resulting in this inadequate supply appear to be one or more of the following: insufficient numbers of candidates applying to nursing schools, high attrition among students during the course of study and high drop out among nurses working in the various institutions, particularly hospitals. In the past, these three factors contributed equally to the inadequate supply but, more recently, recruitment has

Table 1. Number of nurses (total of all kinds) per 10 000 population and ratio of nurses to physicians, for countries of the Eastern Mediterranean 1970, 1980-82, 1988-92

Member States	Nurses per 10 000 population			Ratio nurses/physicians		
	1970	1980-82	1988-92	1970	1980-82	1988-92
Afghanistan	0.6	1.1	1.2	1.2	1.6	0.9
Bahrain*	26.4	30.2	27.4	6.4	3.3	2.5
Cyprus	19.7	40.1	43.3	2.5	3.1	2.1
Djibouti	27.9	8.8	12.0	6.3	7.3	6.0
Egypt	10.8	16.5	19.6	2.1	1.3	1.0
Iran, Islamic Republic of	3.9	9.2	7.4	1.3	2.4	2.2
Iraq	3.5	6.1	7.6	1.1	1.1	1.2
Jordan	13.2	7.5	8.7	3.6	0.7	0.5
Kuwait*	45.9	54.7	43.2	4.9	3.5	3.1
Lebanon	9.5	13.9	11.2	1.4	0.9	1.3
Libyan Arab Jamahiriya*	15.3	31.3	41.3	4.0	2.1	2.8
Morocco	--	10.7	9.2	--	2.9	3.4
Oman*	2.9	8.5	31.5	2.4	2.1	2.7
Pakistan	1.5	1.8	2.8	0.6	0.5	0.6
Qatar*	25.8	35.4	43.5	3.6	3.2	2.4
Saudi Arabia*	2.7	7.2	32.0	2.7	1.9	2.1
Somalia	3.4	5.2	2.8	6.8	8.7	4.7
Sudan	6.5	7.3	7.0	10.8	6.6	7.0
Syrian Arab Republic	3.7	8.9	10.4	1.4	2.0	1.1
Tunisia	14.1	11.7	23.9	8.3	4.2	4.4
United Arab Emirates*	10.5	40.0	35.6	1.0	2.5	2.2
Republic of Yemen		4.4	5.4	--	--	2.5
France**			44.0			
Germany**			40.4			
Netherlands**			81.6			
United Kingdom**			49.7			

Source: Health Situation and Assessment Unit, WHO/EMRO, 1994; based on data received from countries.

-- = No available data in the Regional Office
* = Large expatriate workforce
** = Only for qualified nursing personnel.

been less of a problem in several countries of the Region, such as, Bahrain, Egypt, Jordan, Syrian Arab Republic and Tunisia, where there has been a surplus of applicants to nursing schools. It is commonly understood that any shortage of nursing personnel is due to too few trained nurses for the available posts. However, in a few countries of this Region the shortage is due to too few nursing posts provided for in the approved budget of governments. This situation has led to either a reduction in the number of basic nursing programmes by Ministries of Health or to limits placed on the number of candidates entering nursing schools.

The shortage of nursing personnel is the fundamental cause of low standards of nursing care experienced in many countries. As the demand for nursing care outpaces the ability of the countries to produce or provide additional nurses, the work load on existing personnel increases, standards of care fall and morale among nurses declines leading to high attrition in the workforce. This descending spiral lowers the image of nursing and adds to the cycle of shortage.

The pressing need for governments to provide care for the sick has led 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 difficulties. Low quality of services and increased demand for supervisory posts to guide and control unqualified personnel are the result 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.

To adequately understand and analyse the nursing shortage and deployment problem and to prepare comprehensive solutions for it, accurate and reliable information is needed. Sufficient information and data must be gathered to assess the size and nature of the problem and guide the development of appropriate policies and strategies. However, reliable information on the number of nurses and midwives of different levels of skills who are either available for employment or who are employed in the countries of the Region is lacking. While gross numbers may be known, there are few details that are required to undertake more than broad target-setting.

2.2 Deployment of nursing personnel

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.

2.3 Basic nursing and midwifery education

All countries in the EMR have basic nursing schools and 16 countries have midwifery training programmes. These programmes are administered and affiliated mainly with Ministries of Health, Ministries of Education, universities, military services and private organizations. There are variations in the type of both nursing and midwifery education among the different Member States and sometimes, within the same country, two or three types of basic nursing courses may exist. Very few countries have only one type of training programme. A multiplicity of programmes leads to multiplicity of standards and as a result affects the delivery of nursing services with a negative impact on the quality of care. Entrance requirements for preparation of a nurse range between nine and twelve years of schooling. In some countries there may be two to three programmes each with a different set of entrance and graduation requirements. In Egypt, there are three types of education programmes to prepare future nurses. The secondary technical nursing programme offers a three-year course following nine years of schooling. The technical institutes' nursing sections have programmes of two years' duration after completion of secondary education. The University nursing education programme requires completion of secondary education and its studies extend over four years, to be followed by a one-year internship. Lebanon also has three types of nursing education programmes, and the medical centre of American University of Beirut recently introduced a fourth programme. Bahrain has two programmes both requiring twelve years of education. The first, the associate degree, is for three-and-a-half years and the second, a B.Sc. degree course, is for four years. Pakistan has two programmes; the entrance requirement for both is completion of intermediate education. The duration of the lady health visitor course is two years while the hospital nursing programme covers three years of general nursing and one year of midwifery.

The requirement of nine years of schooling, the predominant requirement for many programmes in a number of countries in the EMR, is inadequate for the preparation of the nurses of the future. 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 and, since the students cannot cope with the course requirements, a high drop-out rate is common. Furthermore, students would only be 15-17 years old at graduation, i.e. adolescent youths, too emotionally immature to cope with the responsibilities of caring for the sick in hospitals or dealing with the health problems of families in the community. The young graduate, confronted with complex and stressful situations for which she/he is not adequately equipped or supported to cope, will frequently choose to leave the profession. It is unfortunate that an entrance requirement in many nursing schools is that a student should not exceed a certain age and should be single, because this excludes more mature candidates from enrolling in nursing education and frequently limits the number of potential candidates to nursing schools.

Nursing curricula require two to four years of study and most are developed on a Western medical model, mainly, English, French and more recently American. As such they do not address the appropriate socio-cultural and religious values or the main health needs of the population and the requirements of the health system in countries of the Region. Their orientation tends to stress curative and individual health care. Thus, graduates of many nursing programmes are not prepared to participate in, or support, the national health strategy of Health for All through primary health care. In recent years with international assistance as well as bilateral support, curricula which are more relevant, community-oriented and problem-based, have been adopted by a number of countries in the Region. Implementation, however, has encountered problems arising from the affiliation of the nursing schools to the hospitals and the need of the hospitals for the services of the students to overcome the shortage of the nursing workforce. Also, teaching staff are not fully oriented or prepared to undertake training in the community. Finally, the dominance of the medical profession in nursing schools has also contributed to resistance to change in the curriculum.

Availability of educational resources, both human and material, ranges over a wide spectrum. Few institutions have adequate qualified, well prepared teachers and up-to-date teaching/learning materials. The majority of nursing schools lack basic minimum requirements for appropriate training. Field practice areas in community settings are lacking and there are few role models to guide and inspire students during their training. Teaching/learning materials, particularly those which are culturally relevant and in the national language, are scarce in schools of nursing in most Member States. A few countries, such as Egypt, Qatar, Syrian Arab Republic and Tunisia have developed literature, but although the materials meet the immediate needs, they do not attain the standards of current scientific publications in the various nursing specialities which are available in the international market. For this reason the Regional Nursing Advisory Panel at its second meeting, held in June 1993, strongly recommended the development, translation and adaptation of nursing textbooks and reference material in national languages in selected subjects within basic nursing education programmes. The lack of resources compromises the quality of the training and competency of the graduates.

In summary, nursing education in the Region should be transformed and standards set to ensure the graduation of competent nurses who deliver comprehensive nursing care and contribute effectively to the various health services of the countries in the EMR. This process of transformation requires careful planning to achieve the desired goals and outcomes.

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 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,

Table 2. Distribution and percentage of WHO fellowships and awards by country during 1 January 1989 to 31 December 1993

Country of Origin	1989		1990		1991		1992		1993	
	N	%	N	%	N	%	N	%	N	%
Afghanistan	2	3.6	4	5.1	2	1.9	2	5.0	0	0.0
Bahrain	0	0.0	3	27.3	0	0.0	0	0.0	3	33.3
Cyprus	9	42.9	10	32.3	2	14.3	1	12.5	6	35.3
Djibouti	1	25.0	0	0.0	1	12.5	3	27.3	1	11.1
Egypt	1	1.0	3	3.8	14	12.3	13	13.4	10	8.3
Iran, Islamic Republic of	13	26.5	4	10.0	6	9.4	1	1.7	4	5.7
Iraq	2	5.1	0	0.0	0	0.0	0	0.0	0	0.0
Jordan	2	4.9	1	5.9	1	3.8	0	0.0	1	3.8
Kuwait	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Lebanon	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0
Libyan Arab Jamahiriya	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Morocco	5	16.7	5	20.0	4	9.1	4	15.4	1	2.6
Occupied territories	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Oman	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pakistan	0	0.0	0	0.0	1	1.1	0	0.0	3	5.9
Qatar	0	0.0	0	0.0	0	0.0	0	0.0	1	33.3
Saudi Arabia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Somalia	1	10.0	4	44.4	0	0.0	0	0.0	0	0.0
Sudan	10	20.4	4	10.8	2	4.0	0	0.0	0	0.0
Syrian Arab Republic	3	13.6	1	4.3	0	0.0	2	3.4	2	5.7
Tunisia	0	0.0	2	5.9	4	8.2	0	0.0	0	0.0
United Arab Emirates	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
UN Relief & Works Agency for Palestine Refugees	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Yemen, Republic of	16	18.8	21	32.8	5	8.5	1	2.9	2	5.4
Total	49	10.0	62	11.35	43	6.11	27	4.90	34	6.4

a scarcity of midwifery training programmes, and an inadequate supply of qualified midwives. If maternal mortality in the EMR countries, which was addressed at the Thirty-fifth session of the Eastern Mediterranean Regional Committee in 1988, is to be eliminated or reduced and the recommendation of adding "more M in MCH" is to be implemented, then expansion of nurse midwifery programmes, in terms of number of additional programmes and candidates accepted, must be given serious consideration. Ministries of Health will find that investing in midwifery education will be a cost-effective strategy for implementing the safe-motherhood initiative. A US study published recently demonstrated conclusively that certified nurse midwives provide equivalent or better services for their patients than physicians. There were fewer induced deliveries, less use of forceps and fewer episiotomies among women attended by midwives. Babies were healthier and the hospital stay was shorter. More than twice as many mothers attended by midwives breast-fed their babies [1].

2.4 Education for nursing specialization

Because of the complexity of health services at all levels of care, qualified nursing personnel with advanced knowledge and specialized skills are required. Management of cancer patients, intensive care nursing, diabetic patient education, accident and emergency care, infection control, occupational and mental health nursing, to name only a few, are speciality nursing fields which are needed in most countries of the Region. Yet training in many of these skills is not available for production of the required number of specialized nurses. At the same time, opportunities for overseas training through fellowships are limited and costly. **Table 2** provides detailed information on the number of nurses who received WHO Fellowships awards during the period 1989-1993. While there may be various socio-cultural reasons such as family responsibilities, or academic reasons such as not meeting the language requirement, which limit travelling of the female nurse, serious consideration should be given to providing opportunities for specialized nursing training either within countries or abroad.

2.5 Continuing education

Systems of continuing education for nursing personnel to update their professional knowledge and improve the quality of nursing services are lacking in a number of Member States of the EMR. During the first Gulf Nursing Conference held in Abu Dhabi, United Arab Emirates in 1993 one of the participants indicated that this was her first participation in a nursing conference since her employment fifteen years ago. This is not unique. Unfortunately, it is the norm in most countries rather than the exception. If quality of care is to be improved and standards of health service delivery to be maintained, then continuing education activities must be an integral part of the health system infrastructure for staff development and retention. A continuing education programme should address practice-related topics as well as professional and employment aspects that would help in their career mobility, such as foreign language courses, managerial capacities training and leadership building.

2.6 Nursing and midwifery practice

Nursing services are delivered in Member States of the EMR by a variety of nursing personnel and auxiliaries with various levels of education and competence. It is thus no surprise that the quality of nursing services ranges from excellent to poor. While competence plays a major role in determining the quality of practice, several other factors also contribute. These could be managerial, legal and/or institutional. 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 are a few examples of situations which lead to deterioration of the quality of nursing care. Interpersonal relationships among management and nursing personnel and communication styles 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 in schools and the community at large. 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 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 individuals counselling, etc., are carried out on a limited scale. In hospitals, the organization of nursing services frequently follows distribution of tasks such as medication administration, sterilization of equipment, dressing and wound care, and patient investigation, etc., among the available nursing personnel. 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. Alternative approaches to management of nursing services such as patient care management, primary nursing care and team approach patterns for unit staffing must be considered. Such approaches allow for appropriate observations and patient assessment, identification of total needs, undertaking appropriate interventions to address the patient problem and evaluating the outcome of the nursing actions, such as utilizing the nursing process to deliver comprehensive nursing care following a systematic approach.

The focus of nursing and delivery of nursing services must shift from being dictated to, by the medical establishment, or hospital management requirements, to the needs of the patient and his family. Such a shift requires establishment of standards of nursing care and nursing protocols that will emphasize the nursing process. It requires a reorientation of all personnel working in hospitals and appropriate in-service education and an adequate and appropriate system of nursing management and supervision.

In special care units such as intensive care, and those 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 services is high and the contribution of nursing staff to patient welfare is evident. However, in areas where the nursing personnel have not been well prepared, they function as general staff nurses. 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.

In non-hospital settings such as schools, industry and health centres, nursing services are delivered in the clinic of these institutions and are again curative in nature. Nurses attend to the sick and injured and are seldom involved in formal and informal health education activities. Maintaining a healthy environment, promoting healthy behaviour and empowering clients to be health advocates are examples of services which are usually not rendered in these settings.

In view of the shortage of nursing personnel, one would expect that, where available, they would be used solely for direct patient care and family support. In a number of studies in several countries of the Region, it was found that nurses spend a sizeable percentage of their time in non-nursing activities. In Bahrain, a 1986 study revealed that 77.7% of total observations made of nursing personnel were of nursing activities while the remaining observations were of personal clerical, indirect or training activities [2]. A similar study carried out in Egypt, in Ain Shams University Hospital reported that "regarding the estimation of time spent in performing direct and indirect nursing activities, the present study revealed that nurses consumed more than 2/3 of their time in indirect care activities in the units studied throughout the three different tours. These results were consistent with several studies done in Egypt" [3]. In a study at the maternity hospital in Kuwait, the researcher found that the activities carried out by various categories of nursing personnel in all selected units in the morning shift showed that more than one-half of all personnel's time (59.7%) was consumed by patient-centred activities [4]. In Sudan the total patient-centred activities were (38.6%) [5]. Nurses are often assigned in hospitals, as well as in health centres, to non-nursing jobs in laboratories, the X-ray department, pharmacy and administration, a situation which depletes the nursing workforce and affects the quality of services.

The management of the nursing service at the institutional, regional and national level is another matter which deserves consideration. Managers of nursing services are appointed to these posts on the basis of years of service and with no educational preparation in nursing service management. Usually, they are appointed in the institution in which they have been practicing, their management ability is limited and they tend to perpetuate existing systems with which they are familiar. This situation limits the possibilities of introducing any change in nursing practice and consequently in the improvement of nursing services. For this reason EMRO embarked on a programme of strengthening managerial capabilities of nurse managers to

improve the quality of nursing care by holding a regional workshop on nursing management, supporting national training activities for various levels of nurse managers and developing a training manual to be used for in-country training activities in nursing services management.

2.7 Organizational structure for nursing departments in ministries of health in the EMR

With the broad scope of nursing services in each country, the number of nursing personnel employed and the magnitude of the problems confronting the delivery of nursing services, each Ministry of Health needs a unit or department covering national, provincial and regional levels entrusted with the planning, implementation and evaluation of nursing services. A review of the structures for nursing development in the Ministries of Health revealed the following:

10 countries have a unit, department or post for an adviser responsible for nursing services on a national level;

4 countries have nursing representation at the national level within the departments, units and sections of manpower, training, primary health care or maternal and child health.

8 countries have no nursing representation in the ministries of health at the national level.

Clearly there is scope for improvement in most countries. Even those that have designated units at the national level must ensure that the number of professional posts is adequate and that they are filled by capable staff. (In the Department of Health in the UK, the Office of the Chief Nursing Officer has around 30 professional nurses).

In addition to being adequately staffed, each position should have a clear job description and guidance must be provided on the type of work to be undertaken for planning, implementation, and evaluation of nursing services. Responsibility without authority creates a situation that is frustrating, leads to a high turnover rate in these posts, and creates unwillingness of independent capable, qualified nurse leaders to take such jobs. As nursing services represent a substantive and integral part of many different programmes such as MCH, EPI, curative medical care and primary health care, it is essential that nursing input in the planning and policy formulation stages of these programmes be considered. Often chief nursing officers are called upon only during the implementation phase of the programme and when there are problems confronting implementation, such as when there is a shortage of nursing personnel in certain districts.

3. MAJOR ISSUES AFFECTING NURSING AND MIDWIFERY DEVELOPMENT IN THE EMR

The preceding review of the nursing and midwifery situation in Member States of the Eastern Mediterranean Region reveals pressing issues to be addressed by governments both within and outside the health sector if problems affecting the delivery of comprehensive quality nursing services are to be solved.

3.1 Status and image of nursing as a profession

The low status of nursing in society and within the health field has a negative impact on the recruitment and retention of capable youth in this profession. The low status of nursing may stem from a stereotyped image of the nurse as uneducated, of low intelligence, from a low socio-economic class, doing menial work in the health establishment. Furthermore, nurses are frequently portrayed as a doctor's helpmate with no control over the health service rendered. Attitudes of some members of the medical profession towards nursing personnel also do not instill pride in the work being done or show respect for the individual nurse. Lack of power, prestige or a role in decision-making of nursing personnel in the health system have contributed to the low self esteem of nurses which in turn limits their ability to act as advocates for the profession.

Nursing is predominantly a women's profession. In many EMR Member States, especially in rural and periurban areas the status of women leaves much to be desired. "Although programmes have been made to revise the status of women by legislative means to ensure gender neutrality, measures are lacking with respect to effective implementation and enforcement of such laws. A large gap persists in many countries between legal declaration on the rights of women and the full realization of these rights in daily life, owing to cultural traditions inherent in a patriarchial society, weakness in law enforcement, cultural and national discriminatory practices, and the lack of awareness by most women of their full legal rights" [6]. This low status of women compounds the low status of nurses and nursing. It should be noted that many Member States are encouraging young men to join the nursing profession, a viable strategy to address issues confronting nursing as a career for women.

In the health system nursing personnel are given only nursing jobs and they move only within the nursing hierarchy which is always headed by non-nursing professionals. Senior management and policy-making positions are not open to nursing personnel. Further education of nursing personnel to prepare them for leadership positions in the health system is essential.

Lack of visibility of the contribution of nursing to health care and welfare of the people has promoted a lack of understanding by the public of the nature of nursing and of the scope of nursing as a profession. Nursing personnel have an excellent opportunity to demonstrate and explain to the public, politicians and community

leaders the nature of nursing while they provide care - they must capitalize on this situation to improve the status and image of nursing.

The limited educational requirement for entrance into nursing educational programmes together with the limited number of years of professional education have given nurses lower grades in civil service schemes. This fosters low status of nurses and prevents them from pursuing higher education, a prerequisite for senior management positions.

In recent years governments have taken initiatives to improve the status and image of nursing in Member States. University education has been established to prepare well qualified nursing personnel with leadership capabilities. Mass media campaigns were launched to increase public awareness of the nature of nursing and the value of nursing services to the health of the nation. Nursing schools in some countries have started a scheme of "open house" in which the schools are open to high school students and their families to familiarize them with the nature and scope of nursing education. In one country of this Region, a qualified nurse has been appointed director of training in the Ministry of Health. If more such initiatives were undertaken by governments they could have an impact on changing the status and image of nursing in the Region. Any change in people's perception is a long-term process that involves deep-rooted culturally bound beliefs and systematic plans must be adopted by the governments to continuously address this crucial issue.

3.2 Changing scope of nursing practice

The practice of nursing in most Member States 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. Frequently nurses and midwives are unjustifiably excluded from many promotive, preventive and therapeutic tasks. If nursing services are to offer a viable support to the health system at all levels, primary, secondary and tertiary, and have an impact on national health strategy and the achievement of health for all, a different attitude should be adopted by health policy makers and planners in collaboration with nursing leaders. The World Bank's Development Report of 1993, Investing in Health [7], emphasized that the health gain per dollar spent varies enormously across the range of interventions currently financed by government. Redirecting resources from high-cost interventions to those that cost little could automatically reduce the burden of disease without increasing expenditures. A limited package of public health measures and essential clinical intervention is a top priority. The report also points out that a minimum health package could be delivered at the district health system level (district hospitals, health centres, clinics and households) and most services in the minimum package can be delivered by nurses and midwives.

If this proposal were considered by Member States of the EMR a revolution would be required to revamp the current scope of practice of nurses and midwives. Health assessment, case finding, health education, management of minor illnesses and injuries, antenatal monitoring, post-natal follow up, cancer screening, provision of family planning services, conducting home deliveries, hypertension and diabetes education and monitoring, community organization and developmental work, individual and family counselling, and promoting healthy environment are a few examples of the many and varied activities that can be assumed by nursing and midwifery personnel. All the above-mentioned activities are already being carried out by nurse practitioners and midwives in industrialized developed countries.

In the coming century, the majority of health services--curative, preventive, promotive and rehabilitative--will be delivered at the district and community level, while specialized hospitals and medical centres will provide tertiary and critical care. This will require specialized nursing services.

Specialized nursing services will be provided for individuals and groups of patients with complex physical, psychological and social problems. The nature of these problems will determine the type of specialized nursing required. Nursing personnel working in specialized nursing units will develop their level of expertise to meet the need for knowledge in the health and biomedical fields. Among specialized nursing services will be cardiovascular nursing, cancer nursing, renal dialysis, intensive care, critical care, infection control, rehabilitation, patient education, and nursing care of the aged, to name only a few.

Home health care will become a reality and nursing services in this area will need to be developed. Nursing services should have two components. Within the first component, they should aim at the provision of personal care and management of the sick and disabled who have been discharged from the hospitals or whose families have elected to care for them in their social environment, that is, curative in nature. Within the second component, their role will also be promotive, preventive and restorative. Nursing activities should concentrate more on the second component. The importance of home visits has long been an integral part of public health services in many countries. In a study of the impact of home visits by public health nurses on the outcome of very low-birth weight babies of high-risk mothers, it was found that there was a reduction in hospital costs and medical care [8]. While morbidity can be diagnosed in the clinic its environmental and psycho-social origin can usually be found where people live and work. With the recent increase in morbidity due to diseases such as tuberculosis and malaria, along with the need for controlling the spread of Acquired Immunodeficiency Syndrome (AIDS) and other Sexually Transmitted Diseases (STD), and the fight against schistosomiasis and other diseases prevalent in the Region, the need for home visiting as an integral part of community nursing becomes apparent.

To adopt a programme of home health care as an integral part of health service delivery requires appropriate planning and development. Policies and protocols must be developed to guide the nature of the service, the scope of practice of nursing personnel, organization of work, payment, etc. An appropriate infrastructure is needed to improve communication between the public and the health service, to ease case/family workload, to assist in the supervision of the nurses rendering care and to provide a similar support service and to back up systems for referral of serious cases when required. Many of these components are currently available for the delivery of primary health care although a reorientation and adaptation are required to encompass home care.

3.3 Specialized training

As the scope of nursing services expands and changes to meet the pressing needs of the people and of the health system, new skills and knowledge are required for efficient and effective practice of nursing personnel. Hence, programmes in various nursing speciality areas lasting from six months to two years training, must be developed. Such programmes require planning for an increase in both the quality and numbers of personnel. Their development will require both extensive material and human resources. Like other specialized training programmes, nursing training programmes are very expensive because the number of students who are admitted is usually limited. Hence, it might not be cost effective for every country to develop its own specialized programmes. It is worth considering that regional training programmes be developed at this stage of professional nursing development.

In developing speciality programmes, emphasis should be given to developing clinical nursing expertise founded on broad, basic, medical and behavioural sciences. Such programmes should not follow the medical model but should reflect the nature of nursing practice and nursing service requirements. In planning such a programme, innovative approaches should be considered and an adequate amount of flexibility should be incorporated. To attract candidates to such programmes, policies on financial support of study and appropriate rewards after graduation should be considered.

3.4 Nursing leadership

Traditionally, nursing and midwifery have been "driven" by the medical profession. As a result nursing and midwifery leadership did not evolve. Most of the members of the medical profession are men and nursing/midwifery personnel are women, and given the status of women in many Member States it is no surprise that this leads to medical dominance over the nursing profession. Age is another factor that has affected leadership development: the nursing workforce in most countries of the EMR is predominantly young because the entrance requirement to the nursing school is between 14 and 17 years of age and years of service are limited by high attrition. Inadequate basic education preparation, due to the narrow scope of most nursing education programmes, does not provide nursing students with the

knowledge and general education that could serve as a foundation for leadership capabilities. Finally, the health system hierarchy is not conducive to building nursing and midwifery leadership.

If changes are to take place within the nursing service delivery system, the development of a cadre of potential leaders is a top priority. What is needed are capable nurses and midwives who are assertive, critical thinkers, with commitment and an interest in serving the people, who are creative, have vision and who can empower nursing and midwifery personnel as well as those who are working in the health and health related sectors.

To develop leadership capabilities, the participants of the Intercountry meeting on Nursing in EMR countries held in the Regional Office in September 1987 supported the WHO document on "Leadership in Nursing for Health for All: A Challenge and Strategy for Action", and fully endorsed the recommendations for action by countries. These recommendations are still valid and need concerted efforts for their implementation. They focus on:

- the need to identify potential nurse and midwifery leaders who could contribute to national strategies for PHC, and to initiate appropriate educational activities and learning opportunities to mobilize a group of such leaders at each level of a national health system;

- encouragement and support of the development of links between such leaders, educational institutions, service organizations and non-governmental organizations to form a resource and to support networking at all levels of the health system;

- inclusion of nurses as members of governmental bodies concerned with planning, implementation and evaluation of health services and health personnel development programmes, and as members of delegations to relevant international conferences and assemblies;

- establishing, or increasing the appropriate number of nursing posts in government service, particularly at senior levels of national health systems;

- facilitating and encouraging identification of potential leaders among young nurses, to develop their attributes and abilities and to enable them to acquire a broader understanding of health development.

4. REGIONAL STRATEGIC PLAN OF ACTION

The Regional Advisory Panel on Nursing for the Eastern Mediterranean Region, during its second meeting in June 1993, developed a strategic plan for nursing development following the review of the quality of nursing in Member States.

In addition to a futuristic statement on the capabilities required of professional nurses, the strategic plan defined the following seven goals, with specific activities to meet each goal:

1. to define the roles and responsibilities of nurses with involvement of other health team members and the community;

2. to ensure that the education system for nursing is flexible and responsive to health care needs and to the sociocultural context of the delivery of nursing care services;

3. to strengthen knowledge, develop flexible attitudes for the team approach, ensure high levels of skills and place all within a perspective for the future;

4. to strengthen management and leadership capabilities of nurses;

5. to encourage the use of health systems research to identify areas for improving nursing practice;

6. to effectively utilize available resources (human, material and financial) including the initiation of mechanisms to ensure appropriate deployment, distribution and retention of nurses;

7. to increase the participation of nurse leaders in the formulation and/or reformation of policy and any required legislative framework.

Among the activities proposed to achieve these goals are to:

- clarify levels and categories of nurses within a regional framework;
- develop a system of nurse education development in collaboration with service deliveries in a team approach;
- strengthen in-service training programmes particularly for key nursing leaders to help them lead the change towards the future;
- establish post-basic management programmes;
- encourage collaborative health systems research projects to address gaps in health services delivery relevant to potential nursing/midwifery inputs;
- accelerate the development of management information systems including targeting nursing data collection to enable better planning and management;
- develop strategies to improve the perception of nursing through education of other health team members and the media; and
- encourage the use of task forces on nursing to provide advice during policy development.

5. REQUIREMENTS FOR NATIONAL PLANNING FOR NURSING AND MIDWIFERY SERVICES DEVELOPMENT

Planning, according to Hassouna, "is a system process which enables the organization to optimally use its available resources to

achieve a collectively approved set of objectives. Traditionally, planning activities were divided among management levels with policies, strategies and medium- and long-range planning as the responsibility of top managers and short-range planning and implementation to lower managers. In strategic planning, this division of responsibility is no longer adhered to and all levels of managers are involved in the planning process as a team. The two major functions of strategic planning are to increase the intervention among managers so that plans throughout the organization are consistent with its long-range objectives, and to increase the flexibility of the organization so that it can respond to environmental change" [9].

In most Member States of the EMR, planning for nursing and midwifery services at all levels, particularly at national levels has been given lip service. Most planning at national level has focused on quantitative requirements for nursing and midwifery personnel. National health strategies and national health plans seldom refer to the quality of the nursing service being delivered and what must be achieved in developing these services. If current defects in the delivery of nursing and midwifery services are to be addressed it is important to adopt a systematic planning process for the production of national, regional and institutional, strategic, action-oriented plans. To institutionalize such a process at any level, a number of requirements must be fulfilled.

1. Political will and commitment to address chronic and complex problems affecting the delivery of midwifery and nursing services is necessary. This creates a climate conducive to effective and efficient action, and mobilizes the human and material resources needed for effective planning, implementation and evaluation of plans. Finally, it encourages the development of those entrusted with the planning process within nursing, midwifery and the health sector at large.

2. A viable structure, unit, section or department within the organization of the Ministry of Health. This should have an adequate number of highly qualified and experienced nurses and midwives and the required budget and administrative support for appropriate functioning.

3. A shared clear perception of what nursing and midwifery services should encompass at all levels of health care. Such a perception would address the present situation and project into the future, the nature and scope of nursing and midwifery practice within a context of change--political, economic, social, technological and epidemiological--in which such service will be offered.

4. A core group of nursing and midwifery leaders with vision, commitment, and who are prepared to lead the process of change with its inherent risks. Although leadership capabilities exist in the current nursing and midwifery workforce, training in modern principles and concepts of nursing and health planning and management is required. Such training should be an integral part of the continuing education system for nursing and midwifery personnel.

5. An adequate information system, including not only gross numerical numbers of the work force, but also data produced by health system research on crucial problems that have hitherto hindered the delivery of nursing and midwifery services.

6. Undertake selected studies for assessment of the nursing and midwifery workforce. This includes use of modern methods and approaches focusing on workload, skills mix and patient classification. Such studies are carried out in different hospital units, primary health care centres and other health centres, to determine the number of nurses and midwives needed and at what level of skill. These methodologies should replace the traditional approaches of nurse/population ratio and nurse/physician ratio in determining workforce requirements.

6. CONCLUSION AND RECOMMENDATIONS

The full potential of nursing and midwifery services and personnel is still not fully utilized to implement national health strategies and achieve health for all in many Member States of EMR. If properly developed this service could have a direct impact on health system delivery. Nursing and midwifery personnel, if mobilized, could 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 persistent problems and issues affecting the delivery of this service.

On the basis of the information in this document, the following general and specific recommendations are submitted for discussion and consideration by the Regional Committee.

1. To encourage the establishment of a nursing and midwifery administrative unit, section, or department, in all Ministries of Health and strengthening of those that already exist. The objective of these units is to play an active role in setting policies for nursing and midwifery development, in planning for the delivery of quality nursing and midwifery services and in the management of the service and personnel involved.

2. To undertake the development of a national strategic plan for nursing and midwifery service development, which would have specific goals and activities, would address the problems affecting the delivery of quality nursing and midwifery services and would form an integral part of the overall national health plan.

3. Leadership and management capabilities should be developed among nursing and midwifery personnel at all levels of the health care system to assure mobilization of the nursing workforce to achieve the required changes in nursing and midwifery service delivery. This could be carried out through the establishment of management development programmes, use of multi-disciplinary and team building approaches among various health care providers,

encouraging the use of a task force on nursing to provide advice during policy development and facilitation of nurse leaders' involvement in health systems-oriented discussion and debates.

4. Establish standards for nursing and midwifery services practice as a first step to introducing a system of quality assurance to strengthen the contribution of nursing and midwifery to the health care of the people.

5. Assess the quality of nursing education programmes and undertake necessary measures such as upgrading entrance requirements for schools of nursing, development of innovative curricula which are culturally relevant and addressing the health needs of the countries, strengthening the teaching staff capabilities and improving the teaching/learning resources to assure production of good, competent nursing and midwifery personnel.

6. Encourage the development of continuing education and training programmes in various fields of nursing specialization so that nursing personnel will be able to provide the skilled services required to deal with problems of the individual, family and community within a complex health system.

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REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

EM/RC41/11
October 1994

Forty-first Session

original: Arabic

Agenda item 13

THE NEED FOR NATIONAL PLANNING FOR NURSING AND MIDWIFERY IN THE EASTERN MEDITERRANEAN REGION

Summary of Recommendations

It is recommended that Member States:

1. Establish and strengthen the nursing units in ministries of health to be able to undertake a leading role in the development of nursing and midwifery services.

2. Give high priority to the development of national strategy plans aiming at improving the quality of nursing and midwifery services and meeting the health needs.

3. Develop minimum standards for basic, post-basic and continuing education in nursing and midwifery that are compatable with the complexities of the health services delivery system and the scope of practice required of the nursing and midwifery personnel.

4. Promote training in nursing services management at national, regional, and institutional levels of the health systems.

5. Review and update existing health legislation related to, and enact required regulatory mechanisms for, nursing and midwifery practice.

6. Create public awareness about the scope of nursing and midwifery practice, through formal and informal approaches, utilizing the local education system, the mass media and social marketing.

7. Support the development of leadership capabilities among nursing and midwifery personnel at all levels of the health care system to achieve the required changes in nursing services delivery.

WHO is requested to:

1. Continue to provide the necessary support to Member States for planning, education, practice, and management of nursing and midwifery.

2. Provide the necessary support for implementation of the Regional Plan for Nursing Development.

3. Promote and support the use of health systems research as a viable mechanism for identifying problems related to nursing and midwifery practice.

4. Provide the necessary support to establish regional nursing training centres to offer educational programmes in nursing specialties.

5. Submit a progress report to the Regional Committee on this matter at its Forth-fourth Session in 1997.

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

EM/RC41/11
October 1994

Forty-first Session

Agenda item 13

THE NEED FOR NATIONAL PLANNING FOR NURSING AND MIDWIFERY IN THE EMR

Summary for the Report

Dr E. Abou Youssef, Regional Adviser, Nursing, introduced the document.

Nursing and midwifery services are one of the main pillars of the health system of any country. Member States in the Eastern Mediterranean Region are confronted with various difficulties in meeting the demands of these services, both from qualitative and quantitative perspectives.

Many factors contribute to the inadequacy of nursing and midwifery services. Since these factors and situations differ from one country to another, a single solution alone is not possible. It is, therefore, of utmost importance that a systematic approach be adopted by officials concerned in ministries of health. The development of a national strategy plan for nursing and midwifery services, addressing priority problems, is extremely important if these services were to contribute to national health strategies and the achievement of health for all through primary health care approach.

The presentation focused on an analysis of the situation of nursing and midwifery services in Member States, identified the main issues that are confronting the development of nursing and midwifery and provided an overall view of the regional plan for nursing and midwifery development which advocates systematic planning as the key to addressing persistent problems and issues affecting the delivery of these services. Dr Abou Youssef identified, for the purpose, the requirements of the nursing planning process.