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Nursing and Midwifery Workforce Management

An Annotated Bibliography



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FOREWORD



The nursing and midwifery workforce is a valuable resource for national health development, especially in scaling up health system responses to achieve the Millennium Development Goals. The nursing and midwifery workforce in the South-East Asia Region needs to be well managed so that we will have motivated and competent nurses and midwives, who provide quality care, when and where needed.

This annotated bibliography, developed by the Advisory Group on Management of Nursing and Midwifery Workforce, provides information that will be useful in strengthening the nursing and midwifery workforce in the Region. The range of ideas and experiences covered should prove effective in addressing various issues confronting nursing and midwifery workforce in countries of the Region.

WHO is deeply committed to help Member States achieve a well-managed nursing and midwifery workforce contributing to equitable and accessible quality health services for optimal health of our people. I firmly believe that our joint efforts can, and will, make a major difference to the quality and effectiveness of health care in the Region.

A handwritten signature in black ink, appearing to read 'Uton Mughtar Rafel', with a horizontal line underneath.

Dr UTON MUCHTAR RAFEL
Regional Director





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Deep appreciation is due to many WHO Staff from Evidence and Information for Policy; Sustainable Development and Healthy Environments; Communicable Diseases; and Family and Community Health Departments of the Regional Office as well as from Country Offices and Headquarters who have made valuable contribution in its development.



INTRODUCTION

This annotated bibliography is a companion document to the *Conceptual Framework for Management of Nursing and Midwifery Workforce* and the *Guidelines for Management of Nursing and Midwifery Workforce*.

It provides information from the literature relevant to strengthening nursing and midwifery management, and references for access to full articles. Where possible, Internet references are provided, given that hard copies are expensive to get and their access is time-consuming.

The annotated bibliography is not intended to provide a complete and comprehensive overview of the literature for each element of the conceptual model for management of nursing and midwifery workforce. Rather, it is intended to provide a range of ideas and experiences that may be useful to countries in the South-East Asia Region (SEAR), and which may stimulate innovative thinking to find new solutions and approaches to develop the nursing and midwifery workforce.

OBJECTIVES

The specific objectives of the annotated bibliography are to:

1. Identify factors influencing the five key elements of the conceptual framework, both positive and negative, which may impact on the management of the nursing and midwifery workforce.
2. Focus on countries in the SEAR, while recognizing that the published literature specifically related to SEAR is sparse, and identify other literature considered potentially useful to SEAR.

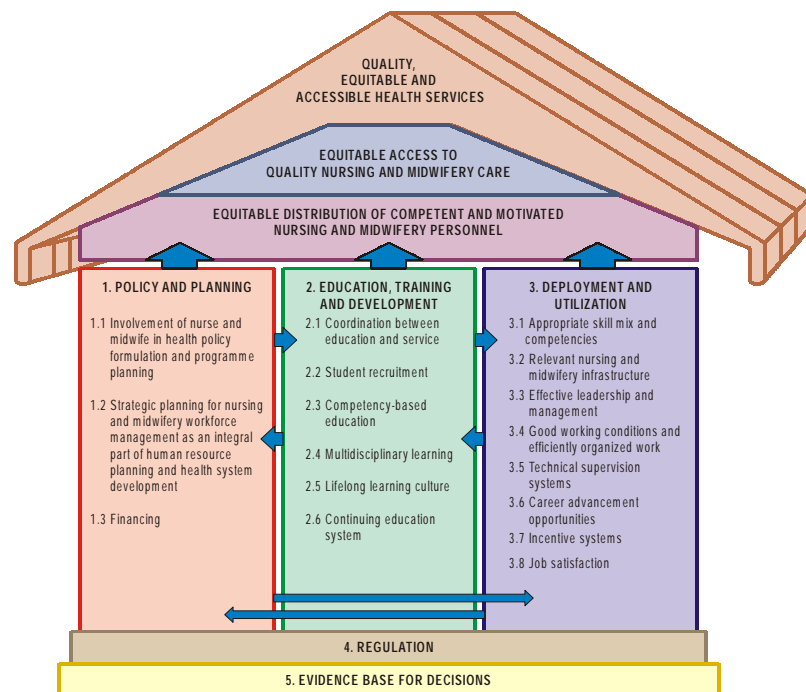


ORGANIZATION

The annotated bibliography is organized under the five key elements of the *Conceptual Framework for the Management of the Nursing and Midwifery Workforce*:

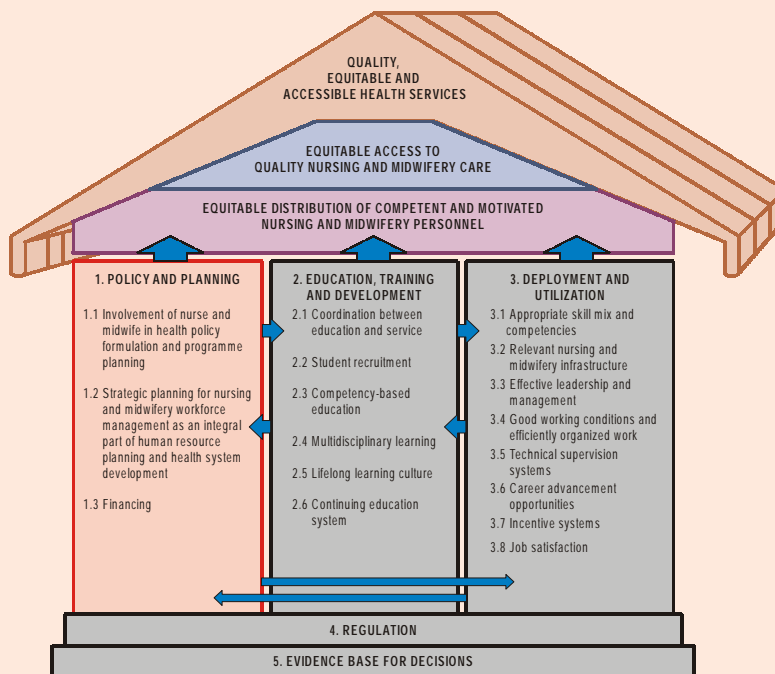
1. Policy and planning
2. Education, training and development
3. Deployment and utilization
4. Regulation
5. Evidence base for decisions.

The schematic presentation of this conceptual framework is provided below for reference.



For ease of description and use, the elements of the conceptual framework are described under the headings of (1) Policy and Planning; (2) Education, Training and Development; (3) Deployment and Utilization; (4) Regulation; and (5) Evidence Base for Decisions.





1. POLICY AND PLANNING

- 1.1 Biscoe G, Lewis B. Strategic and business planning. In: Clinton M, Schiewe D (eds). *Management in the Australian health care industry*. 2nd ed. Melbourne: Addison Wesley Longman, 1998.

(Additional information from gbiscoe@bigpond.com)

The Biscoe/Lewis chapter is a 'how to' for strategic and business planning, using the model developed by Lewis and used by Biscoe to develop the China Ten-Year Strategic Plan for Nursing and Midwifery Development, the first SEAR Strategic Plan for Nursing and Midwifery Development (1995), the WHO Eastern Mediterranean Strategic Plan for Nursing and Midwifery Development, the Sri Lanka Strategic Plan for Nursing and Midwifery Development, the Nepal Strategic Plan for Nursing and Midwifery Development, the strategic plan of the WHO Global Advisory Group on Nursing and Midwifery, etc.

- 1.2 Buchan J, Parkin T, Sochalski J. *International nurse mobility: trends and policy implications*. Geneva: World Health Organization, 2003. Document No. WHO/EIP/OSD/2003.3.

<http://whqlibdoc.who.int/hq/2003/WHO_EIP_OSD003.3.pdf.>

This 2003 report was funded by WHO, the International Council of Nurses, and the Royal College of Nursing. It examines trends in nurse recruitment and migration to five destination countries (Australia, Ireland, Norway, the United Kingdom, and the United States of America) and assesses information from four source countries (the Caribbean, Ghana, the Philippines, and the Republic of South Africa).

The report notes that data is often anecdotal and accurate data is difficult to obtain. In general, nurse workforce shortages in a destination country relates to a combination of possible historical factors, including poor nurse workforce planning, unattractive pay, other poor working conditions, poor career options, and early retirements from the nursing workforce, resulting in failure to attract, recruit, or retain sufficient numbers of nurses.

Reasons for nurses migrating from source countries appear also to be from a combination of factors, including poor pay and working conditions at home relative to perceptions of those in the destination countries. In both destination and source countries the authors conclude, with some supporting evidence base, that nurse migration is symptomatic of system problems in attraction, recruitment, and retention of nurses, with inadequate policy responses by governments.



Different languages between destination and source countries are cited both as a concern and a limiting factor to migration in some instances.

The report confirms that international nurse recruitment is resulting from a global shortage of nurses, but that ‘the underlying problems can only be solved by local-level and country-level improvements in the status of nursing and in the planning and management of the nursing workforce’. Home-based solutions may be more cost effective than international recruitment, including active recruitment of new people into nursing, active recruitment of nurses no longer active in the workforce back to nursing, and that these need to be supported by flexible working conditions, improved working conditions, and part-time career opportunities.

Improved data collection and analysis is needed to identify root causes of the reasons for nursing shortages at the country-level in both source and destination countries so that targeted solutions can be developed.

The report concludes that there are three policy options available to countries. These are: (i) support improvements in pay, working conditions and nurse prestige in countries to provide a quality of life such that nurses want to stay in their own country; (ii) encourage and facilitate country-to-country managed or regulated flow of nurses; (iii) institute an arrangement where compensation is provided by the destination country to the source country, either direct financial compensation or perhaps well-trained nurses funded through aid programmes. The authors believe that constraining mobility is unethical, and that free trade blocs will not assist in long-term solutions.

1.3 Chrislip DD, Larson CE. *Collaborative leadership: how citizens and civic leaders can make a difference*. New Jersey: Jossey-Bass, 1994.

Drawing on their extensive research—which includes six in-depth case studies and 46 additional studies of successful community collaborations—the authors provide insight and answers to the major challenges facing communities today. They describe how to design, initiate, and sustain a constructive, collaborative process; and they show that the leaders who are most effective in addressing public issues are those who have the credibility to bring together the right people to create visions and solve problems.



1.4 Council of Deans Head Quarters. *Council of Deans Strategic Plan 2002–2006*. London: UK University Faculties for Nursing, Midwifery and Health Visiting, 2002. [cited June 2003].

<<http://www.councilofdeans.org.uk/docs/CouncilStrategicPlan2002-2006.pdf>>

This is an example of a strategic plan developed to give national leadership to the promotion and enhancement of nursing, midwifery, health education, and research. The plan emphasizes collaboration with other key stakeholders in health and education. Within the plan there is emphasis on working across the multiprofessional spectrum to enhance evidence-based practice and education; to inform the relevant policy development and priority setting agenda within the departments of health, and higher education funding bodies through lobbying and representation on relevant committees, professional and statutory bodies; to contribute to learned academic and policy debate at national and international levels; to ensure that members are informed of policy developments; and to facilitate a forum for the exchange of good practice by widening the representative role of the Council to encompass the allied health professions.

Factors that will assist and constrain the implementation of the plan are noted (e.g. funding changes, quality assurance issues).

1.5 Gebbie KM, Wakefield M, Kerfoot K. Nursing and health policy. *Journal of Nursing Scholarship* 2000; 32(3): 307–315.

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12462827&dopt=Abstract&itool=iconabstr>

This is a qualitative study by the Columbia University School of Nursing of 27 nurses active in health policy at the national, state, local or organizational level. The purpose of the study was to describe the ways nurses are, and are not, effective in the development of health policy in the United States today, and to provide useful information for those interested in making nursing a more vital part of the policy arena. The findings are relevant to SEAR. The strengths and weaknesses of currently available information for policy work are highlighted. There are two relevant key conclusions: (i) Once nurses are engaged in policy development they seek opportunities to continue policy development work; (ii) Nursing/midwifery research or information is rarely used in national health policy development. The authors suggest that a stronger relationship and connections are needed between nurses/midwives in policy positions and nurse/midwife researchers.



1.6 Global Network of WHO Collaborating Centres for Nursing and Midwifery Development. *Strategic plan for 2002–2004*. Virginia, 2002. [cited June 2003].

<[http://cnhs.gmu.edu/whocc/NetworkInfoExchange/StratPlanFeb02\(ChicagoRev\).doc](http://cnhs.gmu.edu/whocc/NetworkInfoExchange/StratPlanFeb02(ChicagoRev).doc)>

This strategic plan was developed to achieve clarity on future directions and key result areas, and actions on the way to get there. The Network's core business is to conduct advocacy and evidence-based policy activities within the framework of WHA and regional resolutions and the WHO Programmes of Work. Among the stated Operating Principles are that (i) management of the Network will utilize participation of its member Centres in strategic and collaborative arrangements necessary to complete its work and produce outcomes; (ii) there will be long-range strategic planning for each of four years; and (iii) strategic plans will be evaluated every two years in conjunction with each biennial meeting. Strategic goals are, and will be, formed and adjusted taking into account accomplishments to date and emerging priorities.

1.7 Glouberman S. *Towards a new perspective on health policy*. Health Network of the Canadian Policy Research Networks, 2001. [cited June 2003].

<http://www.cprn.org/Release/Back/btnp_e.htm> (executive summary)
 <http://www.cprn.org/docs/health/tnp_e.pdf> (full text of report)
 <http://www.cprn.org/docs/health/tnc_e.pdf> (Towards a new concept of health: three discussion papers—
 (i) Glouberman S (2000) 'Social inequality—Aristotle's insight';
 (ii) Kisilevsky S, Groff P, Nicholson C (2000) 'The health gradient challenge: a new approach to health inequalities';
 (iii) Glouberman S (2000) 'A dynamic concept of health')

This paper presents the finding of a three-year research project on the development and implementation of health policy. The research project involved more than 3500 people and considered the fundamental questions: What is health? What is a health system? What is health policy?

The paper concludes that the quality of the interaction between the individual and his or her social context is a key contributor to health, and that measures of the health status of a population are good indicators of its socioeconomic well-being. The report stresses the importance of placing reform of the health care system within a broader socioeconomic context.



1.8 Hayes M, Glouberman S. *Population health, sustainable development and policy future*. Ontario: Canadian Policy Research Networks, 1999. CPRN Discussion Paper No. H01. [cited June 2003].

<http://www.cprn.org/docs/health/phsd_e.pdf>

This is a useful discussion paper that defines the health policy context generically applicable to most countries. The overlap and relationships between the social dimensions of sustainable development and the socioeconomic influences on health are examined.

It suggests that since health research is now demonstrating the importance of the impact of social circumstances on health, policies to support sustainable health development could include early childhood education, support for pregnant women, reducing economic disparity to improve health and government/employer collaboration and to increase employees' control over their work.

1.9 International Council of Nurses. *Guidelines on shaping effective policy*. Geneva, 2002. [cited June 2003].

<http://www.icn.ch/Guidelines_shaping.pdf>

This is a useful and practical nursing-specific document developed within the framework of a WHO publication on the policy process, which emphasizes that improved health of populations requires governments to change or improve existing policies (*The policy process in health policy and systems development: an agenda for research*. WHO, 1995). The International Council of Nurses' guidelines define simply and clearly the four major components of health policy development: (i) the policy process (formulation, implementation, and evaluation/feedback); (ii) the policy reform (health priorities, organizational or health system arrangements, financing, regulation); (iii) the policy environment, and (iv) policy-makers.

Practical examples for nursing input are given for each component. Different countries require different approaches, and the rationalist and incrementalist approaches to policy development are differentiated. Guidelines are provided on how nurses can be effective in influencing, and contributing to, policy, as individuals and through their professional associations. The former might include keeping abreast of specific and broader issues in health and development, and the latter might include publishing and discussing clear position papers on specific health policies.



Methods to prepare nurses for effective input to policy development include incorporating leadership and policy development in basic and post-basic nursing programmes and in continuing education; identifying and developing young nurses with potential for leadership; including organization development and culture in leadership programmes and promoting the development of positive cultures in organizations; preparing nurse educators in new teaching methods; and promoting a positive image of the contribution of nursing.

1.10 International Council of Nurses. *ICN on international trade agreements*. Geneva, 2002. [cited June 2003].

<http://www.icn.ch/matters_trade.htm>

This policy statement has implications for national policy development in SEAR countries. An explanation is given that international trade agreements are rules between nations that seek to reduce trade barriers and promote the mobility of capital, goods, service and personnel. The services trade is expected to continue to expand faster than trade in goods. Health is one industry targeted for future agreement. Pros and cons of international trade agreements are cited. Implications for nursing are given as:

- (i) Cross-border supply (where the supplier of health in one country makes the service available to the population in another country, e.g. telehealth);
- (ii) Consumption abroad (where patients travel from one country to another for treatment);
- (iii) Commercial presence or 'establishment trade' (the provision of for-profit health services by foreign-owned health care providers or health transnational corporations); and
- (iv) Provision of health services by foreign people (e.g. migration of doctors and nurses/midwives).

Eight key areas of interest to nurses are presented:

- (i) Equitable access to health and social services;
- (ii) Health insurance portability and/or access;
- (iii) Equitable distribution of pharmaceuticals and medical equipment;
- (iv) Sound professional (as opposed to trade motivated) regulation of nursing and education practice;
- (v) Impact of health sector reform generated by trade or economic interests (e.g. substitution of professional staff with lesser qualified person);



- (vi) Health sector pay and conditions that support the provision of quality services and the attraction and retention of competent personnel;
- (vii) Viable human resource development policies and incentives, including attractive career structures and international accreditation of qualifications; and
- (viii) Nurses access to decision-making bodies nationally and internationally.

1.11 McKay L. *Report of the international symposium on Canadian health policy, Toronto, Ontario, 8–10 May 2000*. Health Network: Canadian Policy Research Networks. [cited May 2003].

<http://www.cprn.org/docs/health/ris_e.pdf>

This is a summary of an international health policy symposium that addressed the relevance and usefulness of developing health policy, based on the concept of the quality of interaction between an individual and his or her social context as a major contributor to health. The proceedings of the symposium were divided into four subject areas corresponding to four stages in the development of health policy: public health, the health care system, health promotion, and inequalities in health. The thesis argued that all the four elements are essential for inclusion in health policy development.

1.12 Ministry of Health, Government of Indonesia. *National Strategic Plan on Making Pregnancy Safer (MPS)—Indonesia 2001*. Jakarta: Ministry of Health, 2001.

This document provides a good description of strategies in action and processes to develop a national strategic plan focused on a specific health issue. The Indonesian Ministry of Health (MOH) emphasizes improving the health and welfare of mothers in response to unacceptably high maternal mortality in Indonesia. The target set was a decrease in the maternal mortality ratio (MMR) from 450 per 100,000 live births in 1995 to 225 per 100,000 live births by the year 2000, and to 125 by the year 2010, as part of the Safe Motherhood Initiative (SMI). In 1997, MMR was 334 per 100,000 live births. Contributing factors were the inadequate and poor service quality provided by health personnel, which contributes to more than 20,000 maternal deaths annually. The major challenges to reducing MMR are presented. In October 2000, the President of Indonesia and the Director-General of WHO launched the Making Pregnancy Safer initiative. Following its launch, a national Making Pregnancy Safer Working



Group was formulated, which included national and international partners. To support the national working group, a technical team was established to meet every week to discuss the existing issues, strategies and activities with the aim of creating a policy that provides quality and affordable maternal health services.

The national goals, strategies and activities to be implemented around Making Pregnancy Safer are outlined. A draft document on the national Making Pregnancy Safer strategic plan and plan of action was to be completed by August 2001 and disseminated among national and international partners for input. In collaboration with WHO, the MOH met regularly with GOI/NGO/donor agency coordination meetings focusing on the strategies of Making Pregnancy Safer. The donor meetings provided a forum for discussion, advocacy and partnerships towards implementing the initiative countrywide.

1.13 Office of the Chief Nursing Officer, Department of Health.
NSW health. New South Wales, Australia. [cited June 2003].

<<http://www.health.nsw.gov.au/nursing/branch.html>>

<<http://www.health.nsw.gov.au/nursing/publications.html>>

A good overview is provided (either in hard copy on request, or through the websites above) of the role of a Chief Nursing Officer and staff in (i) providing policy advice to government; and (ii) monitoring policy implementation. Also available is a regular newsletter, *CNO Update*, on current nursing and midwifery policies and other policy documents, which may have useful generic applicability to SEAR countries. Examples of nursing/midwifery policies potentially useful to SEAR countries include safe medication practice, patient safety, and nurses and midwives as independent practitioners. Other policy publications include:

- *NSW framework for maternity services* (2000)
- *NSW recruitment and retention of nurses' progress report* (2001)
- *A Project Report to the Nurses Registration Board of NSW on the 'Development of Guidelines for Registered and Enrolled Nurses Regarding the Boundaries of Professional Practice'* (1999).



1.14 Queensland Nurses Union. *Issues of concern to Queensland nurses*. Brisbane, Australia, 1999. [cited June 2003].

<<http://www.qnu.org.au/issuesof.htm>>

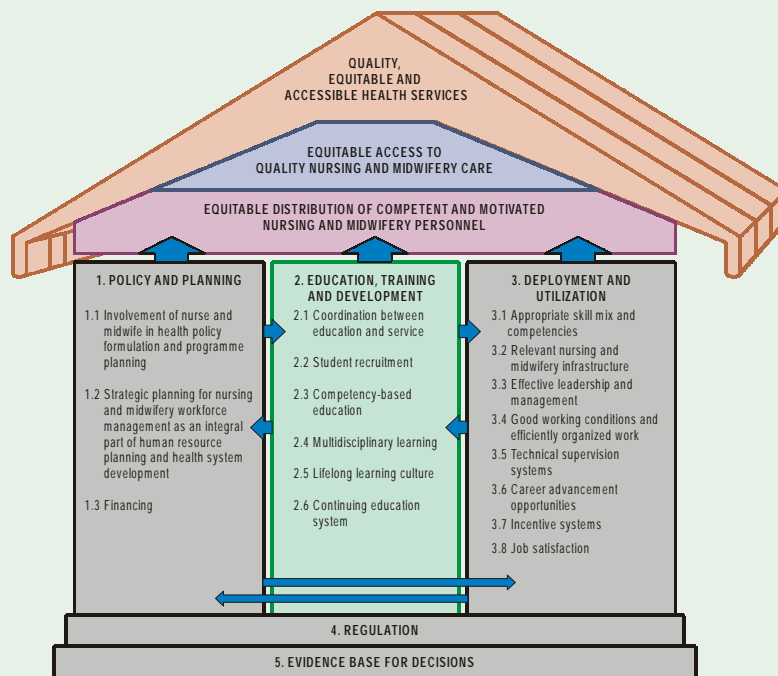
This is a submission to government in Australia but it reflects common global themes and principles that emerged during the 1999 WHO global intercountry analysis to report progress against WHA 49.1. It is also a good illustration of the rapid rise in developed countries of strong nursing/midwifery union movements and the influence they now have on government policy development. The submission contains recommended policy changes including: (i) increases in health funding; (ii) new approaches to negotiating wage and salary improvements for nurses and midwives; (iii) improved education for nurses and midwives; (iv) strengthened human resource management; (v) improved career structures as a means of attracting nurses/midwives to the professions, and retaining them as motivated workers that feel valued; (vi) a variety of health and safety improvements in the workplace; and (vii) employment equity for nurses/midwives with other health professionals.

1.15 World Health Organization. *Informal consultation process to develop the strategic directions and plan of action for strengthening nursing and midwifery*. Geneva: WHO, 2001.

<www.who.int>

This was a global consultation to assist in the global development of the Nursing and Midwifery Strategic Directions and Plan of Action for implementing WHA Resolution 54.12. Key common issues confronting nursing and midwifery services globally are cited as: (i) restricted roles for nursing and midwifery providers; (ii) limited use of innovative service models; (iii) gaps between evidence and practice; (iv) insufficient mechanisms to ensure the quality of nursing and midwifery services; (v) human resource shortages; (vi) migration of nurses and midwives and other health professionals; (vii) gaps between education and training, and competences required in practice; (viii) workforce issues, including poor working conditions; (ix) stewardship/governance issues including lack of appropriate legislation and governance infrastructure; (x) insufficient mechanisms for ensuring that the contribution of nursing and midwifery services to health targets is fully considered in policy-making processes; (xi) financing issues including lack of money to extend nursing and midwifery service coverage; limited incentives for cost-effective and innovative models of care; lack of or limited reimbursement for services provided by nurses and midwives.





2. EDUCATION, TRAINING AND DEVELOPMENT

2.1 American College of Nurse-Midwives. *Continuing Competency Assessment (CCA) Programme*. Washington, DC. [cited June 2003].

<<http://www.midwife.org/edu/cca.cfm>>

Processes and procedures are described for midwives who wish to take this distance learning programme. The aim is to keep midwives up to date with developments in their field and improve their competence.

2.2 American College of Nurse-Midwives. Department of Global Outreach. Washington, DC. [cited June 2003].

<<http://www.midwife.org/dgo/index.cfm>>

The purpose of this Department is to provide technical assistance to develop skills of midwives in developing nations. Projects briefly described include: (i) *Life Saving Skills Training Programme* that aims to improve the knowledge and skills of midwives and other maternity care providers in Ghana, Indonesia, Uganda, Nigeria, and Viet Nam; (ii) *Healthy Mother/Healthy Newborn Programme* being implemented for midwives in Cambodia and Viet Nam; and (iii) *Community Partnerships for Safe Motherhood Programme* being implemented in India to prepare home birth attendants, pregnant women and their families in obstetric first aid. The site also has a list of related publications.

2.3 Barnard J. The World Wide Web and higher education: the promise of virtual universities and online libraries. *Educational Technology* 1997; 37(3): 30–35.

Over 30 million adults now use the Web, with a shift from affluent-only users to more representative users. This is creating a paradigm shift in education. The author argues that distance education courses from more universities are needed, not only to reach working adults but also to try to control rising costs and to provide flexible course offerings through new media. Creation of online universities are driven by market forces and technological innovation and tightening government budgets. This has resulted in a shift away from planning and funding based on the number of students to the actual competence of students and the creation of high performance standards. This has also resulted in a need for better instructional design since teachers do not have face-to-face communication.



2.4 Brown B. *Web-based training*. Ohio: Educational Resources Information Center, 2000. ERIC Digest No. 218. [cited June 2003].

<<http://ericacve.org/docgen.asp?tbl=digests&ID=103>>

Education and training via the World Wide Web are growing rapidly. Reduced training costs, worldwide accessibility, and improved technological capabilities have made electronic instructional delivery to adult learners a viable alternative to classroom instruction in many developed countries. As technology becomes more widely available in developing countries and countries in transition, the accessibility of web-based training will become more widespread. The efficacy of Web-based training (WBT), including issues of market demand, learner participation, training options, and programme design needs to be analysed for each country. Outcomes can be improved through implementation of appropriate instructional design principles.

2.5 Brown BL. *Applying constructivism in vocational and career education*. Ohio: Educational Resources Information Center, 1998. ERIC Information Series No. 378. [cited June 2003].

<http://ericacve.org/mp_brown_01.asp>

This paper explains how people construct knowledge through their interpretive interactions and experiences in the social environment. Constructivist perspectives are a growing influence among educators seeking to help students connect learning with life experiences, which makes constructivism highly relevant to vocational and career educators. The author provides examples of applications in career and vocational education; practical curriculum, instructional, and assessment strategies; and annotated lists of print, media, and web resources. The compilation is intended to guide practitioners in using constructivist principles.

2.6 Burkitt I, Husband C, Mackenzie K, Torn A, Crow R. *Clinical judgement and nurse education: nursing identities and communities of practice*. London: English National Board for Nursing, Midwifery and Health Visiting (ENB), 2000. [cited June 2003].

<<http://www.nmc-uk.org/cms/content/Publications/rh44.pdf>>

This research study evaluates cognitive (knowledge) and affective (skill) processes developed in the education of nurses. The researchers found that the learning of nurses was not purely an intellectual process, but also a



practical one where effective nursing practice is ‘constructed’ through associating and working within a ‘community of practice’.

Recommendations include: (i) clinical staff understanding their collective role in the student nurse/midwife’s education experience; (ii) nurse/midwife educators also spending some time in practice; and (iii) ensuring that nurse/midwife student placements are long enough for them to become integrated into the full working routine of a community of practice.

2.7 Daniel SJS. Why universities need technology strategies. *Change* 1997 July–Aug; 11–17.

This article applies to nursing/midwifery schools, with common global themes of costs, access and flexibility. The traditional models will not be able to educate everyone and will cost too much. The Open University model is used as an example of an effective, quality, low-cost university that is a technology-based learning system. The author states that a coherent, unified plan for using technology is needed rather than allowing individual faculty and departments to be autonomous. The author argues that the university (or the nursing/midwifery school) must respond better to student needs, offer distance education, and be less driven by the needs of the professors than by the needs of the students.

2.8 Dean JM, Mountford B. Innovation in the assessment of nursing theory and its evaluation: a team approach. *Journal of Advanced Nursing* 1998; 28(2): 409–418.

This is a five-phase evaluation programme of changes to nurse education in the United Kingdom (devolution of assessment, moves to higher education, revision of the aims) and to local concerns (fairness to students, validity and reliability of written assessments, helping staff with less experience of assessment, and student learning). A team approach to marking and moderating was developed and piloted in Southampton. The evaluation methodology is described as well as the largely positive outcomes. A team approach is recommended as appropriate to both pre- and post-registration nurse education.



2.9 Fenwick T (ed). *New directions for adult and continuing education: sociocultural perspectives on learning through work*. Number 92. San Francisco: Jossey-Bass, 2002.

This book is an introduction to current themes among academic researchers who are interested in sociocultural understandings of work-based learning and working knowledge: how people learn in and through everyday activities that they think of as work. The authors explore how learning is embedded in the social relationships, cultural dynamics, and politics of work, and they recommend different ways for educators to be part of the process. Models of learning in work, based on situated learning theories, are presented. Issues of culture and difference, gender barriers, and the influence of powerful organizational forces on workplace learning are examined critically. The focus is more on presenting important new theoretical ideas about learning in work than on recommending strategies for practice.

2.10 Gaffney KF. Encouraging collaborative learning among culturally diverse students. *Nurse Educator* 2000; 25(5): 219.

<http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=101435>

The article describes a teaching and learning environment set up to teach a course with students from 13 countries of origin. The programme invited students to comment on particular customs and traditions in their ethnic group, with topics including veiling, coin rubbing, and evil eye, and students were required to do an assignment arising out of the programme. Some students still had difficulty in overcoming sensibilities, and avoided clinical contact with people who were different from them.

2.11 Hart A, Lockey R, Henwood F, Pankhurst F, Hall V, Sommerville F. *Evaluation of the effectiveness of midwifery education in preparing midwives to meet the needs of women from disadvantaged groups*. London: English National Board for Nursing, Midwifery and Health Visiting (ENB), 2001. [cited June 2003].

<<http://www.nmc-uk.org/cms/content/Publications/rh46.pdf>>

The study includes a useful literature review, a national survey of pre- and post-registration midwifery education, and case site exploration in three areas of the United Kingdom to investigate the effectiveness of midwifery education in preparing midwives to care for clients likely to experience



inequalities in health and/or access to services. The study finds that while inequality issues are emphasized within the philosophy of midwifery curricula, the emphasis rarely flows through completely to curricula aims, learning outcome statements, education delivery and assessment. The authors call for a new education model to develop what they call ‘inequalities imagination’ in the vein of sociologist Wright Mills’ (1959) ‘sociological imagination’, introducing concepts such as culturally competent care, cultural safety, anti-discriminatory, and anti-oppressive practice.

2.12 Imel S. Technological proficiency as a key to job security. *ERIC Trends and Issues Alert No. 6*. Washington, DC, 1999.

<<http://ericacve.org/docs/tia00074.pdf>>

Although not all current jobs require basic computer skills, technological advances in society have created new jobs and changed the ways in which many ‘old’ jobs are performed. Workers who are proficient in technology have a greater current and potential advantage as technology is introduced into the workplace, and the need for technologically proficient workers will only continue to grow.

2.13 Long A, Kneafsey Y, Berry J, Howard R. *Exploring the role and contribution of the nurse in the multi-professional rehabilitation team*. London: English National Board for Nursing, Midwifery and Health Visiting (ENB), 2001. [cited June 2003].

<<http://www.nmc-uk.org/cms/content/Publications/rh45.pdf>>

This two-year study was commissioned by the ENB, an organization which promotes the importance of quality education for quality care. The study investigated the way in which nurses in multi-agency teams in rehabilitation identified the ‘total’ physical, emotional and social care needs of the client and their career, nurses’ actual and desired role in this regard, and how well nurses believed their nurse education had prepared them for this role. The research identified six core roles for the nurse in this context: (i) assessment, (ii) coordination and communication, (iii) technical and physical care, (iv) therapy integration and continuance, (v) emotional support, and (vi) involving the family. Results indicated that only 36% of respondents felt, in hindsight, that their pre-registration education had adequately prepared them for their role in rehabilitation, and more than 50% had financial and other difficulties in attending training courses relevant to their work. The authors conclude that changes in both pre- and



post-registration is needed to adequately prepare nurses for rehabilitation practice, and that the findings are also relevant to other health and social service providers.

Recommendations are published in the ENB's *An evaluation of the effectiveness of midwifery education in preparing midwives to meet the needs of women from disadvantaged groups* and include using the findings for curriculum redesign and planning to include: (i) knowledge of disadvantaged women's lives; (ii) strengthening midwife attitudes and communication to disadvantaged women; (iii) improving methods of educational delivery and assessment; and (iv) determining who delivers education related to inequalities.

Other recommendations are in the ENB's *Policy implications of research exploring the role and contribution of the nurse in the multi-professional and multi-agency rehabilitation team* and include that the researchers believe the findings have wider application to other branches of nursing and to professional education in other health and social care disciplines; integration of rehabilitation within the curriculum means it is at risk of becoming 'invisible'; and that a common inter-professional language should be developed for the patient's/client's benefit.

2.14 Lorenzon M. *Bibliography of print resources on library instruction*. Michigan State University, 2002. [cited June 2003].

<<http://www.msu.edu/user/lorenze1/>>

This is the author's collection of print resources available from libraries and provides a good source of well-researched material (over 300 reference sources) for nurse and midwife educators. The references are divided into ten categories, which include assessment and criticism of library learning, active learning, methods and theory (both scholarly and 'how to teach'), international linkages, issues in higher education, nursing/midwifery-specific books and articles, how to use technology to access libraries, including on-line resources information, and resources for teaching about how to access and use health libraries.



2.15 Martin P, Klotz L. Implementing a nursing program via live interactive video: lessons learned. *Nurse Educator* 2001; 26(4): 187.

<http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=100520>

An overview of a college of nursing's implementation of a nursing programme via live interactive television for students living some distances from the main campus. The article includes the experience of initiating the programme, the process of ensuring faculty and students adapted to the challenges of the medium, and a summary of the first five years of operation of the programme. The main benefit of the programme was flexibility, but the study found there were frustrations and difficulties associated with the programme. The authors conclude, however, that the benefits outweighed the costs.

2.16 McCall MW. *High flyers: developing the next generation of leaders*. Cambridge, MA: Harvard Business School Press, 1997, 336 pp.

This guide presents a useful strategic framework for identifying and developing future leaders in organizations. McCall asserts that the real leaders of the future are those employees who have the ability to learn from their experiences and remain open to continuous learning. The author explains how management can create an environment that supports and nurtures talent development and that senior leaders and managers have a responsibility to identify, mentor and develop younger people with talent and potential. The author also places responsibility on individuals to take charge of their own continuous learning and development.

2.17 Ramsey P, Blowers S, Merriman C, Glenn LL, Terry L. The Nurse Center: a peer mentor-tutor project for disadvantaged nursing students in Appalachia. *Nurse Educator* 2000; 25(6): 277.

<http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=101243>

The article describes and discusses the first year of a project initiated at an Appalachian regional university to improve participants' academic achievement, increase retention, and improve pass rates of disadvantaged students by using peer mentor-tutors. Problems included noncompliance of peer mentors (which was improved through counselling), and the failure



of some mentors to complete the necessary documentation (their stipends were withheld until it was done). Peer mentoring was successful in improving academic achievement of disadvantaged students. The programme has now been extended to postgraduate students.

2.18 The Indian Health Service, National Council of Nursing.

Maintaining appropriately trained staff: a National Council for Nursing position paper. Maryland, 2000. [cited June 2003].

<<http://www2.ihs.gov/Ncon/documents/trngprovider.doc>>

<<http://www2.ihs.gov/Ncon/documents/training.pdf>>

Recommendations are aimed at ensuring the availability of appropriately and adequately trained staff and have potential usefulness for SEAR countries. Recommendations include: (i) establishing national benchmarks for basic grade personnel qualification; (ii) developing standard orientation programmes for all new staff; (iii) establishing regional ‘competency centres’, perhaps in partnership with local education institutions, that could provide ongoing competency testing for employees and remedial training if necessary.

On-the-job training issues include: (i) including training as part of any contract for new equipment; (ii) networking between multidisciplinary professional staff using meetings, newsletters and technology such as e-mail and teleconferencing where available. Continuing education suggestions include developing partnership between education and practice settings to provide continuing education programmes especially tailored to the needs of each practice setting. Suggestions for further formal education include supporting alternative means of education including distance education.

2.19 University of Newcastle, Faculty of Health, School of Nursing and Midwifery. *Strategic Plan 2000–2007.* New South Wales, 2002. [cited June 2003].

<<http://www.newcastle.edu.au/school/nurs-midwif/strategic-plan.html>>

This is a practical example of the many strategic plans now developed for schools of nursing/midwifery across the world. It provides clear areas to achieve between 2000 and 2007, and the values that will underpin the school’s activities. The vision of the School of Nursing and Midwifery is that it aspires to be a leader in practice-oriented education and research, and through partnerships, work for the betterment of health care at the



regional, national and international level. Its mission is to produce competent, consumer-focused and confident graduates through education and research endeavours.

The School's values are academic and research excellence; consumer-focused practices; a commitment to life-long learning; a commitment to competence in decision-making and clinical judgements; accountability and responsibility in practice; nurses as autonomous moral agents; safe and effective practice based on evidence; empathy, compassion and ethical behaviour; strength in leadership; practice based on principles of social justice; collaborative practices; active partnerships with students, community and professionals; faculty and clinicians who are interested in and committed to their work; pride in a credible nursing profession; and an ability to adapt to contemporary health practices.

The goals of the School are to: (i) contribute to the University's role as a leading research and research training institution engaged in the discovery, integration, teaching and application of knowledge; (ii) provide a first class student-centred educational experience for all students; (iii) further develop diversity of pathways to higher education through articulation arrangements with an increasing array of government, industry and private partners; (iv) internationalize our identity through our student body, staff, academic offerings and services; (v) build a supportive and productive environment for our students and staff; (vi) build strong and enduring relationships with our graduate body.

Key objectives are provided. Some of these include: (i) to develop flexible and innovative subjects with an emphasis on both generic and professional knowledge and skills; (ii) to review the mode of course delivery to increase flexibility, to satisfy consumer needs and to promote efficient use of resources; (iii) to increase postgraduate coursework enrolments by 10% and international student enrolments by 10% of 1999 figures; (iv) to attract, through competitive scholarships, quality students regionally, nationally and internationally; (v) to consolidate strategic alliances with relevant organizations; and (vi) to provide specific educational packages to meet differentiated needs of particular employers and professional groups.



2.20 US Departments of Commerce, US Departments of Education, and US Departments of Labor, the National Institute for Literacy, and Small Business Administration. *21st century skills for 21st century jobs*. Washington, DC, 1999.

<http://www.ilr.cornell.edu/library/e_archive/gov_reports/21stjobs/21stjobs.pdf>

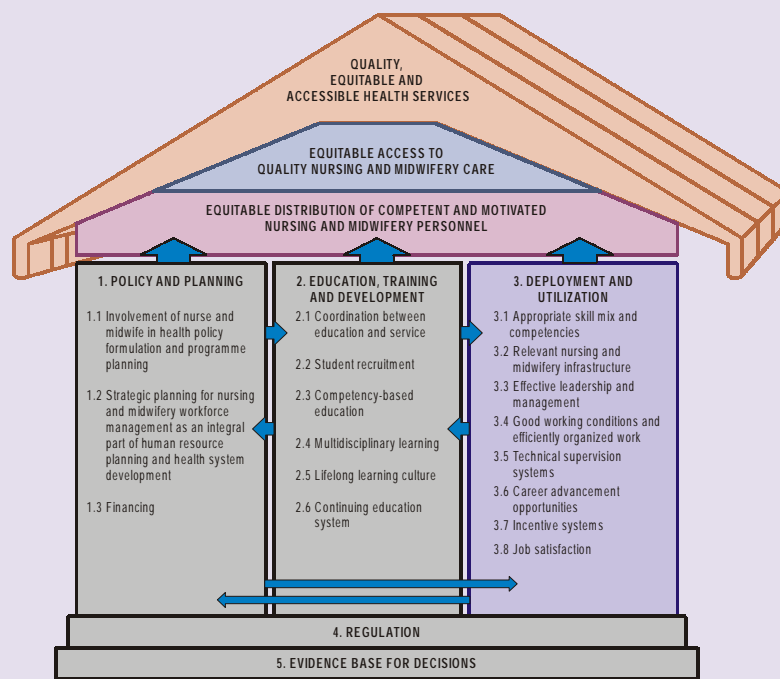
This report was issued in conjunction with a satellite summit hosted by Vice President Al Gore. Its subject was the new challenges for employers and workers that are created by global competition, the Internet, and the widespread use of technology. While it is possible to compete in this new global economy by creating low-wage, low-skilled jobs, the report states that the United States of America has chosen to take full advantage of its labour force and to create high-performance workplaces. The report states that in the workplace of the twenty-first century, the nation's workers will need to be better educated to fill new jobs and more flexible to respond to the changing knowledge and skill requirements of their existing jobs. Life-long skills development must become one of the central pillars of the new economy.

2.21 World Health Organization. *Collaboration between nursing services and education for improving the quality of nursing care and education: report of an Inter-country Consultation, Yangon, Myanmar, 14–17 October 1996*. New Delhi: WHO Regional Office for South-East Asia, 1997. Document No. SEA/NURS/413.

<http://whqlibdoc.who.int/searo/1994-99/SEA_NURS_413.pdf>

This report provides results of a study of experiences in collaboration between nursing services and education in countries in the SEAR and proposes models for strengthened collaboration.





3. DEPLOYMENT AND UTILIZATION

3.1 Association of Hong Kong Nursing Staff. *Nursing grade reform*. Hong Kong Hospital Authority, 2000. [cited June 2003].

<http://www.nurse.org.hk/e1_4_7.htm>

These papers include a discussion paper on nursing grade reform within the Hong Kong hospital system, including a background to the reform process, and a proposed framework. An appendix to the discussion document covers proposals for judging nursing competency, including personal, functional, organizational, and people and team competencies.

The other papers include the comments of the Association of Hong Kong Nursing Staff on the consultation paper, and reservations voiced by the members of the association. These included uncertainty about job security and limits on promotion prospects after reform, and concerns at an increased ratio of health care assistants to registered nurses that would affect the quality of health care.

3.2 Bennis W, Manus B. *Leaders: strategies for taking change*. 2nd revised ed. New York: Harper Business, 1997, 235 pp.

Leadership, according to the authors, is about judgement and character, and can be best handled by integrated human beings. This book concentrates on four themes shared by leaders: (i) *vision*—leaders with intensity and commitment whose attention is focused on the goal and the agenda express a magnetism that attracts followers; (ii) *communication*—the tool for sharing meaning; (iii) *trust*—whereby the leader's position offers security to followers; (iv) *deployment of self through positive self-regard*. Leaders are shown as setting direction, managing change concurrently with the provision of high-quality service, and attracting new resources.

3.3 Brement C, Currie G, Procter S. Exploring the relationship between HR and middle managers. *Human Resource Management Journal* 2001; 11(3): 53–69.

This study focuses on middle-level line managers and their involvement in the management of human resources in a National Health Service (NHS) hospital trust in the United Kingdom. Using a framework drawn from the strategic management literature (Floyd and Wooldridge, 1992, 1994, 1997), it examines their involvement in realizing strategic change in the



HR area and the organizational conditions that frame this. The study suggests that, in their relationship with the HR function, middle managers may enjoy significant involvement in bringing about strategic change—beyond merely implementing the strategy determined by the HR function; the relationship is one of partnership. To facilitate this, middle managers should be allowed to cross functional boundaries within the organization, there should be significant investment in their development, HR strategy should consist of broad themes rather than tight prescription and the HR function should operate alongside middle-level line managers.

3.4 Brown B. *Part-time work and other flexible options*. ERIC Digest No. 192. Washington, DC, 1998.

<<http://ericacve.org/docs/ptoptions.htm>>

This paper examines flexible work options, including part-time work, and the impact on worker satisfaction, performance, and productivity for those people who want flexible work options. Part-time work, job-sharing, and other flexible work option models are now used widely in many health systems, particularly where women (nurses, midwives, doctors, others) seek to balance reproduction and careers.

3.5 Brown B. *Changing career patterns*. ERIC Digest No. 219. Washington, DC, 2000. [cited June 2003].

<<http://ericacve.org/docs/dig219.pdf>>

This paper is included because nurses and midwives in developed countries are leaving nursing and midwifery for different careers, compounding the acute global nursing/midwifery shortage. The author presents the fact that many workers from all sectors are pursuing varied career paths that reflect sequential career changes. This set of ongoing changes in career plans, direction, and employers portrays the lifetime progression of work as a composite of experiences. The paper explores how changing technologies and global competitiveness have led to redefinition of interests, abilities, and work options that influence career development.

3.6 Brown BL. Conflict management. *ERIC Trends and Issues Alert*. Washington, DC, 1998. [cited June 2003].

<<http://ericacve.org/docs/conflict.htm>>

The dynamics of a diverse workforce are being increasingly understood.



These dynamics are becoming increasingly complex because of organizational changes. The complex communication required is highlighting both overt and covert interpersonal conflicts among workers, which impact on the quality of services provided. This paper proposes new types of training and employee development programmes to help workers acquire skills in conflict management.

3.7 Frick DM, Spears LC. *On becoming a servant leader: the private writings of Robert K. Greenleaf*. San Francisco: Jossey-Bass, 1996, 394 pp.

According to former AT&T chief Robert K. Greenleaf, organizational leaders get fulfilment by serving employees, customers, and the community. This has interesting relevance to managing the nursing and midwifery workforce. This collection of Greenleaf's writings examines the practice of leadership and its relationship with power, management, and organizations.

3.8 Gillow K. *Organizing the nursing work force: a review of the literature*. Working Paper 93-1. Nursing Effectiveness Utilization and Outcomes Research Unit, Faculty of Nursing, University of Toronto, 2002.

<<http://www.fhs.mcmaster.ca/nru/publications/workingpapers/93-1.htm>>
(Available from gbiscoe@bigpond.com on request)

This paper looks at maximizing the productive time of nurses/midwives. Views from the literature are presented which indicate that nurses spend slightly less than one-third of their time engaged in direct patient care activities (Capuano and Kinneman, 1989; Hendrickson, Doddato, and Kovner, 1990), where other patient-related activities could be performed competently by other categories of personnel that are less expensive to train and have lower salaries (e.g. housekeepers, ward clerks, transporters/orderlies, etc.). The ratio of support personnel to professional being substantially lower in the hospital industry than in other industries is noted (Hendrickson et al., 1990).

Suggested alternative models to increase productivity and reduce costs include:

- (i) Reassignment of non-clinical tasks (e.g. returning non-clinical tasks to their original departments, which frees nurses for direct patient care



and results in cost savings; integrating other support departments within nursing, which may facilitate quality, cost-effective care; and creating new types of diversified support employees, which may facilitate quality, efficient, cost-effective care);

- (ii) Delegation of clinical tasks to nonprofessional support employees (e.g. Registered Nurse [RN]/Non-Nurse partnerships, in which an RN delegates patient care activities to a non-nurse partner based on the readiness of the partner to perform them, and unpartnered clinical support workers, who are not paired with any one RN, but are supervised by a group of RNs in the performance of direct patient care activities not requiring the knowledge and expertise of an RN or health care assistant, and where these employees are also prepared to help with other support tasks).

The author notes that the cost–benefits of such models have not been fully explored, and that delegation of direct patient care activities to unlicensed personnel is controversial. However, some procedures have no real relationship to patient recovery (e.g. changing bed linen) and could be performed competently by less highly trained employees.

The author notes that nurses/midwives in direct contact with patients appear much more likely to deal with total patient needs than are a lesser proportion of nurses/midwives acting to give care through clinical support workers (Halloran, 1983). The paper concludes with saying that industrial engineers suggest 16% as a reasonable figure for nonproductive time on the job; nurses/midwives appear to spend only 11–12% of their time engaged in nonproductive activities; and nonprofessional caregivers spend over 24% of their time engaged in nonproductive activities. There is no evidence provided to support these assertions.

3.9 Helgesen S. *The female advantage: women's ways of leadership*. New York: Doubleday, 1995.

There is increasing realization that nurse/midwife leaders need to develop greater capability in leadership and management. There is also a significant shift in developed countries with nurses and midwives being appointed to senior executive positions such as CEOs of hospitals, and secretaries and director-generals of ministries of health. As the majority of nurses/midwives are women, their rise to senior management has not been without difficulty, possibly based on their different approaches to management than men. In a companion study to Mintzberg's 1973 study



of five executives' days, minute-by-minute, this book examines the professional careers and personal lives of four women managers (two of them entrepreneurs). Helgesen summarizes eight differences between men/women leadership styles: (i) Women worked at a steady pace, but took small breaks; men did not take breaks. (ii) Women did not view unscheduled tasks and encounters as interruptions (women saw this as caring, being involved, helping). (iii) Women made time for activities not directly related to their work (women did not suffer from feeling of intellectual isolation as did men). (iv) Women preferred live encounters, but scheduled time to deal with mail (men left mail to secretary). (v) Women maintained complex network of relationships with people outside their organization. (vi) Women focused on ecology of leadership (long-range planning, seeing whole relationships and interactivity of relationships). (vii) Women did not just identify themselves with job (as did men) but saw their own identities as complex and multifaceted. (viii) Women scheduled in time for sharing information. In general, the women leaders were existential leaders. (Existential leaders are able to reconcile a concern for bottom-line results with a concern for people, who focus on both ends and means, are good at both planning and communication, and are reality-based, able to comprehend all of the important aspects of existence.) (p. 31)

3.10 McNamara CP. Organizational excellence. *Business and Economic Review* 1997; 43(4). [cited June 2003].

<http://research.moore.sc.edu/Publications/B&EReview/BE43_4/mcnamara.htm>

This article provides the prevalent view that, in order to be successful, organizations must establish a flexible but clear strategic direction with a team-based organizational concept and supporting processes and systems in place. They must also show a relentless commitment to the intangibles of leadership style, human resource planning, organizational values, and excellence. According to the author, this organizational excellence demands a new leadership style, with successful organizations creating a special culture with a unique blend of values, beliefs, tools, and language. The culture to aim for, which is dependent on the leaders in the organization, is one where staff and managers feel involved and excited, and where the demarcations and boundaries between professional groups, so prevalent in the health sector generally and hospitals in particular, disappear.



3.11 Mellor S, Mathieu JE, et al. Employees' nonwork obligations and organizational commitments: a new way to look at the relationships. *Human Resource Management* 2001; 40(2): 171-184.

Complex interactions were found between employees' marital status, number of children, and having relatives nearby as related to the continuance dimension, but not the affective dimension, of commitment to people's place of work. The conclusion is that organizations need to develop family-friendly employment conditions. This has particular implications for shift work and rostering practices for nurses and midwives.

3.12 PolyOptimum. California. [cited June 2003].

<www.PolyOptimum.com>

This website is an example of software support for monitoring, managing and reporting on health labour resources, and costs. Originally designed for management of the nursing and midwifery workforce, it can be used throughout the health system. PolyOptimum provides reports on labour hours and costs, including graphical reporting on key performance targets for optimum staffing levels against patient demand. It increases management accountability, pinpoints inefficiencies in rostering and staff management practices, and identifies the causes of inefficiencies. PolyOptimum electronically calculates and displays rosters, optimizing them against patient demand and staff requests. It also has computer simulations of rosters, shift lengths, and staffing plans; allows nurse/midwife managers or other health managers to prospectively analyse rosters for costs and appropriateness against patient demand and budget availability. PolyOptimum can be quickly and easily implemented.

3.13 Scott MP. Being centered, setting limits, and having fun. *Association Management* 1997; 49(3): 55-57. [cited June 2003].

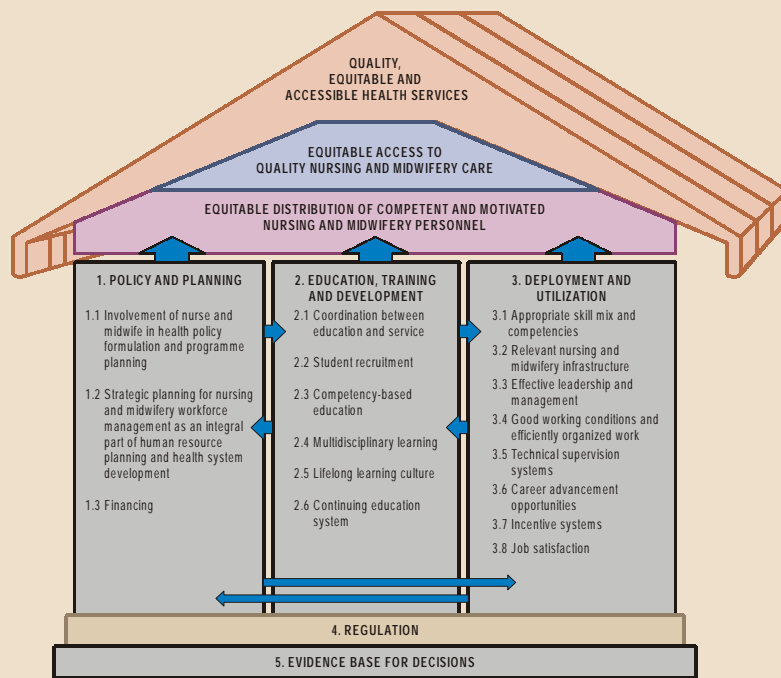
<http://www.archives.gov/research_room/alic/staff_resources/organizational_change_bibliography/organizational_culture.html>

It is possible for individuals to manage change and develop a greater sense of career focus in the midst of change and reform by examining three principles: (i) *the principle of centredness*, which means that as a centred person you have a strong mission or purpose in life, values to help you in your decision-making efforts, and a vision to steer your future;



(ii) *the principle of limits*, which means that you cannot do everything, but must focus on what is important versus what is urgent, creating a greater sense of balance to the physical, mental, social, and spiritual aspects of your life; and (iii) *the principle of fun*, which means keeping life in its proper perspective by having fun.





4. REGULATION

4.1 Caiden GE. What really is public maladministration? *Indian Journal of Public Administration* 1991; 37(1): 1–16.

Administrative failures and maladministration are elements that underpin the need for regulation. The concept of maladministration is administrative action (or inaction) based on or influenced by improper considerations or conduct, and is multidisciplinary in nature.

Basing on research conducted in different countries on administrative failures and maladministration, Caiden attempts to construct a view of public maladministration that draws sustenance basically from the bureaucratic process with its impact on administrative behaviour and organization. To evolve a proper theoretical framework, he presents an interesting and comprehensive typology of over 175 bureaupathologies. Drawing support from research findings, Caiden endorses the view that these bureaupathologies reflect not the failings of individuals in public administration organizations but the systematic and organizational deficiencies caused by bureaucratic inertia and complacency.

The article reflects the gamut of maladministration as referred to in scholarly writings and research conclusions. Caiden quotes an ombudsman definition of maladministration as ‘administrative action (or inaction) based on or influenced by improper considerations or conduct’. Most people could describe maladministration by examples (illegality, corruption, ineptitude, neglect, perversity, turpitude, arbitrariness, undue delay, discourtesy, unfairness, bias, ignorance, incompetence, unnecessary secrecy, misconduct and high-handedness).

4.2 International Council of Nurses (ICN). *Regulation Network Bulletin* 1999 December; Issue No. 3. [cited June 2003].

<http://www.icn.ch/regnetbul3_99.htm>

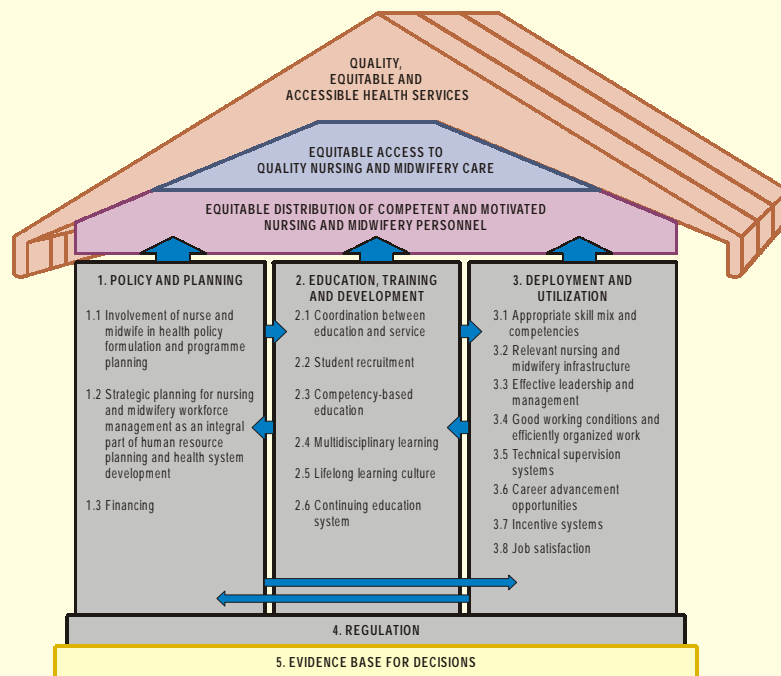
The position of ICN is that there is a global need to have common understanding of competency due to emerging technology, trade agreements, and migration and international mobility, and that a multidisciplinary framework is needed for shared multidisciplinary competencies.



4.3 World Health Organization. *Standards for midwifery practice for safe motherhood*. Delhi: WHO Regional Office for South-East Asia, 1999. Regional Publication, SEARO, No. 38.

The standards are widely considered as prototypes that can be adapted and implemented in countries for midwifery education and practice. Models include general midwifery practice, postpartum care, life-saving midwifery care for selected obstetrical emergencies and complications. The standards were field-tested in four countries before publication.





5. EVIDENCE BASE FOR DECISIONS

5.1 Badou JA. A nation of health researchers. *IDRC Reports* 1994; 22(1). [cited June 2003].

<<http://www.idrc.ca/books/reports/V221/nation.html>>

An interview with Eusebe Alihonou, head of Benin University's Health Research Sciences Faculty, about the Essential National Health Research (ENHR) programme in the early 1990s in Benin to explore the most effective way to promote research in developing countries. Five key principles were identified: (i) the need for all research to be geared for solving development problems or meeting the needs of the population; (ii) the importance of involving the community at every stage of the research process; (iii) the research to be undertaken by multidisciplinary teams, with results disseminated to communities, decision-makers and researchers; (iv) research structures to be decentralized; and (v) research costs to kept, as far as possible, to a minimum by mobilizing local as well as external resources.

5.2 Holloway I, Wheeler S. *Qualitative research in nursing*. 2nd ed. Oxford: Blackwell Publishing, 2002.

This new edition builds and develops the key information nurses and midwives need to understand and undertake qualitative research. There are helpful descriptions and guides on action research, narrative analysis and data analysis, and chapters on legal and ethical issues.

5.3 International Council of Nurses. *Nursing research: a tool for action*. Geneva. [cited June 2003].

<http://www.icn.ch/matters_research.htm>

One of a series of Nursing Matters fact sheets produced by the International Council of Nurses (ICN) and available on the Council's website. The paper defines nursing research and stresses its importance in answering questions about health care interventions and finding better ways of promoting health, preventing illness and providing care and rehabilitation. It lists the priority areas for nursing research as health and illness, and delivery of care services.

It also recommends strategies for encouraging and supporting nursing research, including helping national nurses associations, establishing a network of nurse researchers, and promoting opportunities for nurses to publish internationally.



5.4 Madjar I, Taylor B, Lawler J. The role of qualitative research in evidence based practice. *Collegian* 2002; 9(4): 7–9.

This article presents the views of three eminent nurse/midwife leaders on evidence-based nurse/midwifery practice. The first opinion, by Professor Irena Madjar, Professor of Nursing, University of Newcastle, Australia, states, in part, that evidence should not be limited to findings of experimental research and meta-analysis, nor that it ‘...should be assumed that wise and judicious application of quantitative evidence will just happen without clear understanding of the human context in which patients and health professionals interact’. Professor Bev Taylor, Foundation Chair of Nursing, Southern Cross University, says that the humanity of nursing, ‘...found in interpersonal relationships between nurses and patients’, is challenging to quantify but is a critical component of evidence-based nursing/midwifery practice. Qualitative research is important to strengthen evidence-based practice. Professor Jocalyn Lawler, Dean, Faculty of Nursing, the University of Sydney, says that insufficient questions have been asked about evidence-based practice, these include the rules of evidence and ‘...how these may or may not work in different disciplines, particularly nursing where the research traditions have evolved differently (to medicine)’. There are a restricted range of nursing practices that comply with the medical model of evidence-based research, for example, the randomized controlled trial.

5.5 Pan American Health Organization, Division of Health and Human Development. *Strategies for utilization of scientific information in decision-making for health equity*. Washington, DC, 2001.

<<http://www.paho.org/English/HDP/hdr/MEX-final.pdf>>

The final paper from a workshop held in Mexico in June 2001 to draw up recommendations for the development of PAHO’s Virtual Health Library (VHL) project, and to set up a collaborative review group on health equity to promote the development of evidence-based policies in this area. The report stresses that there is no single recipe for evidence-based policies, and these must by definition vary from country to country, depending on the context. Nevertheless, the workshop did come up with some recommendations. These included developing ‘observatories’ for health equality along the lines of one set up in Bolivia; diversifying the sources and data and promoting transparency; ensuring quality control of research in health equity; and using the media to ‘market’ the idea of health equity.



5.6 Shaver J. *Evidence based nursing and midwifery research: issues and future directions*. 2000. [cited June 2003].

<<http://www.conference2000.ch/pdf/shaverprecis.pdf>>

A precise of a paper presented at the International Conference on Health Research for Development held in Bangkok (10–13 October 2000). It stresses the move away from the focus on diagnosis of disease to one that assesses the factor contributing to health, noting that this is an approach that fits well with nursing ideology and has the potential to bring nursing science more to the forefront. It discusses the elements needed to build a nursing research agenda.

5.7 Vonderheid SC, Persaud V, Stein-Parburg J, Ghebrehiwet T, Hanuchararnkul S, Boontong T, Phuphaibul R. *Challenges, strategies and priority areas for nursing and midwifery research: report of the pre-conference on nursing and midwifery research*. 2000. [cited June 2003].

<<http://www.nursingsociety.org/programs/Bangkok.rtf>>

This planning paper for the International Conference on Health Research for Development (Bangkok, Thailand, 2000) addresses the nursing and midwifery research needed for an evidence base for nursing and midwifery development. The emphasis is on having a well-defined agenda for global health research with identified priorities and strategies. There are key challenges and strategies presented that reflect core issues of global concern to nurses and midwives:

Equity—more research required on (i) the health care needs of populations, (ii) the factors contributing to inequities, (iii) health education and promotion, and (iv) educational programmes for nurses and midwives to ensure that they are competent to deal with vulnerable populations.

Ethics—better understanding of ethical codes of (i) conduct among researchers, practitioners and educators, and (ii) strengthened advocacy of nurses and midwives on behalf of patients, families and communities.

Capacity building—creation of a critical mass of researchers through educational programmes in research methodology and project management for current and developing researchers, and mentoring relationships between expert and novice researchers.



Research environment—the paper calls for (i) the development and utilization of a national plan to identify priority areas for research, especially for nursing and midwifery research and (ii) strengthened collaborative research between nurses/midwives and other multidisciplinary key stakeholders including from other health disciplines, the community and policy-makers.

Governance—establishment of national institutions for nursing and midwifery research to provide research funding, set priorities, facilitate networking and collaborative projects, disseminate findings, inform policy-makers and develop a research database.

Policy and financing—greater advocacy by, and involvement of, nurses and midwives in health policy development and decision-making, including nurses/midwives influencing the allocation and use of research funds at all levels. Increased international collaboration between developed and developing countries is seen as another way to reduce funding inequities.

Knowledge production—the use of information systems and databases is proposed as a way of identifying gaps in knowledge and other issues in this area, and intervention studies to examine the effectiveness and cost of nursing and midwifery care.

Knowledge management and utilization—mechanisms to translate research findings into more than one language is one strategy suggested to overcome inequities in access to the knowledge base between developed and developing nations; other strategies include greater dissemination of information between countries, including publishing in international journals, promoting research results to clinicians, educators, policy-makers and the public, and using other outlets such as presentations at academic conferences and community forums as well as print publications.

The paper also briefly reports on a working party discussion on health research priority areas identified for nursing and midwifery in Thailand. Topics covered include health and illness, the health system in the wake of health reforms, education, and ethics.



