

SEARO Technical Publication No. 25

Nursing and Midwifery Workforce Management

Conceptual Framework



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FOREWORD



The nursing and midwifery workforce can offer a valuable resource to national health development, especially in scaling up health system responses for achieving the Millennium Development Goals. However, their potential contribution is not always realized. Despite various efforts at regional and country levels, there are persistent shortages and maldistribution of nursing and midwifery personnel, as well as an inappropriate mix of professional skills in many countries of the Region. This has a negative impact in the delivery of equitable, accessible and appropriate health care to all sections of the community.

Therefore, the issues confronting the nursing and midwifery workforce in our Region including low pay, low status, poor working conditions, lack of sufficient sanctioned posts, etc. need to be addressed critically and strategically, so that the services of our nurses and midwives are utilized optimally. To provide guidance to countries on how to effectively address these issues, a multidisciplinary Regional Advisory Group was established in 2001.

This concept document, developed by the Advisory Group, highlights ways to manage the nursing and midwifery workforce in countries of the Region. It provides a strategic context for countries to analyse the existing situation of their workforce and enable them to identify and address priority areas requiring special attention.

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 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', written in a cursive style.

Dr UTON MUCHTAR RAFEL
Regional Director





PREFACE

Most countries of the Region still experience a shortage of appropriately skilled nursing and midwifery personnel. In many settings the problems are compounded by maldistribution of existing personnel and an inappropriate skill mix. This inevitably impacts on the ability of a country to provide equitable and accessible quality health services. The situation prevails, despite various efforts at national and regional levels in the past few decades to strengthen the nursing and midwifery services in support of national Health for All goals. This has hampered the contribution of the nursing and midwifery services to national health development and the health of the population in the South-East Asia Region.

The issues confronting the nursing and midwifery workforce need to be addressed to strengthen the health services in the Region. Nurses and midwives alone cannot address these issues effectively; participation of other major stakeholders in health services is crucial. The WHO South-East Asia Region therefore established a multidisciplinary Advisory Group on Management of Nursing and Midwifery Workforce to provide advice and guidance to countries on how to effectively address these issues. The list of members of the Advisory Group is provided in Annex 1.

The Advisory Group, in its deliberation, developed this concept document to provide the framework to guide countries for effective management of their nursing and midwifery workforce as well as a strategic context for in-depth country analysis. This conceptual document for Nursing and Midwifery Workforce Management has three companion documents: *Guidelines*; *Analysis of Country Assessments*; and *Annotated Bibliography*. The combined purpose of these four documents is to assist countries of the South-East Asia Region in analysing their current situation, identifying priority areas for action, and developing and implementing strategic interventions to strengthen the management of the nursing and midwifery workforce to enhance their contribution to quality health services that are equitable and accessible.



ACKNOWLEDGEMENTS

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Acknowledgement is also gratefully made to the International Council of Nurses and International Confederation of Midwives for their valuable comments that helped to further refine the conceptual framework.

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 contributions throughout the process.



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A. INTRODUCTION

A well-managed nursing and midwifery workforce is a means to an end, it is not an end in itself. The purpose of a well-managed nursing and midwifery workforce is competent and motivated nursing and midwifery personnel who provide quality care, contributing to the provision of quality health services that are equitable and accessible.

Since 1994, studies in other Regions have found that a well-managed nursing and midwifery workforce contributes to reduced hospital morbidity and mortality,¹ reduced costs, and strengthening of effective health services. Where the converse is true, community dissatisfaction increases, and eventually ‘health care’ becomes a political and media issue, and public perceptions become increasingly difficult to manage and change.²

Without a well-managed nursing and midwifery workforce, the sum of all other strategies will not achieve quality health services that are equitable and accessible. The current global nursing shortage provides evidence of this. The shortage is seen as a major threat to the future of the world’s health care systems.^{3,4}

All countries in SEAR face considerable challenges in achieving quality health services that are equitable and accessible—financially, geographically and culturally accessible. Infrastructure costs are high and increasing, including costs driven by technological change, at a time when resources available to the health sector are reducing, and community expectations are increasing. Community expectations include wanting the health workforce to have responsive attitudes and behaviours, and appropriate skills and competencies. A double burden of diseases is prevalent in the Region. Poverty is an added complexity, with its impact on ill health, social issues, and equity and accessibility.^{5,6}

Too often, the health workforce has difficulty in keeping pace with new health knowledge and skills, and with strengthening its attitudes and behaviours. Morale and motivation are too often low or inconsistent. Effective health service leadership and management skills, including in nursing and midwifery, are in short supply.

A well-managed nursing and midwifery workforce is a major contributing factor to cost containment, quality improvement, community satisfaction, and competent and motivated nursing and midwifery personnel,⁷ and is a strategic government investment of the highest importance.



B. WORLD HEALTH ORGANIZATION AND MEMBER STATES

Nursing and midwifery have been on the WHO agenda for more than 40 years. The 2001 World Health Assembly (WHA) Resolution 54.12: Strengthening Nursing and Midwifery recognized the essential role of nurses and midwives in reducing mortality, morbidity and disability, and in promoting healthy lifestyles.

The 2001 WHA resolved that further action is needed to maximize the contribution of the nursing and midwifery workforce to quality health services that are equitable and accessible. WHA Resolution 54.12 urges governments:

- to involve nurses and midwives in health policy development, planning and implementation at all levels;
- to establish comprehensive human resource development programmes that support the recruitment and retention of a skilled and motivated nursing and midwifery workforce;
- to develop and implement policies and programmes that ensure healthy workplaces and quality work environments for nurses and midwives; and
- to develop and enhance the evidence base for nursing and midwifery.⁸

Item 7 of the resolution requested the Director-General to ‘rapidly prepare a plan of action for strengthening nursing and midwifery and to provide for the external evaluation at the conclusion thereof’ and to report back to the 56th WHA in 2003 on the progress in implementing the plan of action.

WHO HQ initiated a consultation process among a wide range of partners and key stakeholders to shape the strategic direction and develop a plan of action for nursing and midwifery.⁹ The establishment of the SEAR Advisory Group on Management of the Nursing and Midwifery Workforce supports the strategic direction, and complements and informs the global plan of action.

C. WHO IS A NURSE OR A MIDWIFE IN THE SOUTH-EAST ASIA REGION?

‘Nursing and midwifery personnel’ is a collective term for a wide variety of health workers in SEAR. It includes professionals, technicians and auxiliary health workers, as well as nursing aides and nursing assistants. Titles



include Nurse, General Nurse-Midwife, Technical Nurse, Health Nurse, Assistant Nurse, Nurse Aide, Auxiliary Nurse-Midwife (ANM), Midwife, Public Health Midwife, Auxiliary Midwife, etc. A list of the full range of ‘nursing and midwifery personnel’ in SEAR is provided in Annex 2.

The wide range of categories in SEAR provides a rich source of data for intercountry and regional analysis of the most cost-effective nursing/ midwifery categories and competencies to strengthen national health services.

In general, global experience is that a flexible and well-managed nursing and midwifery workforce has fewer rather than more categories of ‘nursing, midwifery and “other” personnel’. They are well educated, and can be deployed and utilized flexibly and effectively in a variety of settings. In general, motivation is higher, there is a greater breadth and depth of clinical competence, standards of care are higher, and their basic training provides a solid foundation for a culture of lifelong learning based on professional standards and ethics. Thailand is a good example of this approach.¹⁰

D. THE CONCEPTUAL FRAMEWORK

The aim of the conceptual framework is to assist countries to develop strategies that assure a strong and effective nursing and midwifery workforce. These strategies should help in recruiting the right numbers of nursing and midwifery personnel with the right knowledge, skills and attitudes at the right location.

A well-managed nursing and midwifery workforce is defined as ‘having competent and motivated nursing and midwifery personnel who contribute to equitable and accessible quality health services by providing quality nursing and midwifery care when and where needed’.

A well-managed nursing and midwifery workforce requires:

- effective and efficient nursing and midwifery workforce policy and planning;
- effective and efficient education, training, and development of nursing and midwifery personnel; and
- effective and efficient deployment and utilization of nursing and midwifery personnel.

The goal is a suite of effective and integrated strategies that result in a well-managed nursing and midwifery workforce. To deliver/meet this goal

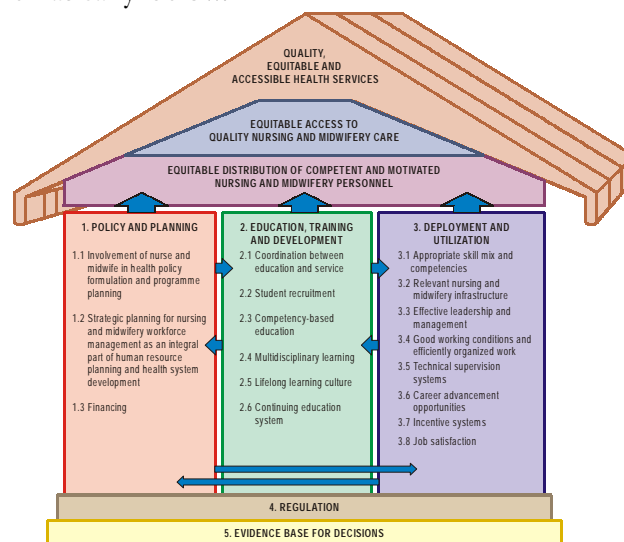


requires an evidence base for decisions to ensure a strong foundation as well as necessary regulation and legislation.

Strengthening the nursing and midwifery workforce is more than simply improving education and training, pay, working conditions, and performance and career development. Strengthening the nursing and midwifery workforce is multidimensional. It involves interdependency between an individual and the organizational culture, policies and structures, and enables strategic capacity for linkages between a myriad of issues such as information, ethics, awareness, motivation and behaviour.¹¹

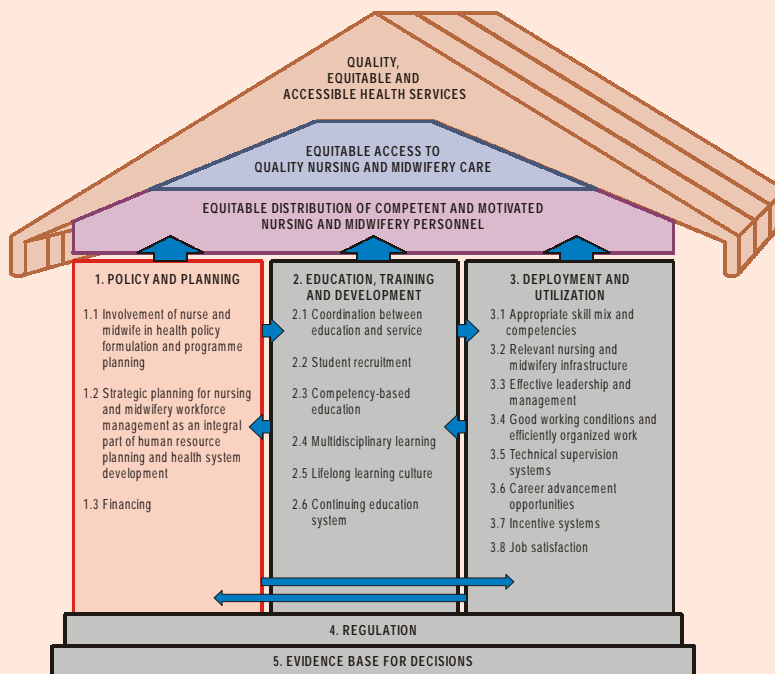
This sounds simple, but the challenges are ‘system’ challenges. A case history of one SEAR country (Annex 3) illustrates the complexity of the health system within which system change in nursing and midwifery is required. System change requires multidisciplinary consultation to develop strategies. The strategies must target system change, be robust, be developed for the mid- and long-term, sustained, monitored, well managed, and integrated with a national strategic approach to health system development.

Simplistic, single-issue approaches have a weak impact at best and, at worst, fail to stop a decline in the quality of a country’s nursing and midwifery workforce,¹² and thereby the achievement of quality health services that are equitable and accessible. The conceptual framework is presented schematically below.



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 Involvement of nurse and midwife in health policy formulation and programme planning

In addition to Resolution WHA 54.12, a few WHA Resolutions for strengthening the nursing and midwifery workforce were also adopted in the 1980s and 1990s. They also recommended greater involvement of nurses and midwives in policy formulation. The reasons are three-fold.

First, nearly every health policy and programme affects nurses and midwives in some way, given that the nursing and midwifery workforce forms a substantial part of the health system's workforce. Nurses and midwives, who are in close and continuous contact with patients, families and communities, often have insightful and different views compared to other categories of health workers. Their contribution assists policy and programme changes to better meet need.

Second, nurses and midwives are also directly affected by most changes in health policy, whether it is health financing policy and patient revenue capture, or decisions to commence new services, or advances in infection control.

Third, involving nurses and midwives helps accelerate the development of the nursing/midwifery profession, including its capacity to work collegially and constructively at all levels of the health system to achieve strengthened health services.

Increasingly, nurses and midwives in SEAR and elsewhere want to be involved at the policy and programme-planning level, but do not always have the required knowledge and skills, and/or senior officials do not think it necessary to consult them. In the culture of nursing and midwifery, lack of involvement and consultation on policy and planning impacts on motivation, job satisfaction, and feelings of being valued team members. Over time, this creates deeply embedded attitudes and behaviours that manifest in a variety of ways, from union unrest to general disillusionment.¹³

To ensure effective nursing/midwifery involvement in policy development, the importance of facilitating, mentoring and encouraging appropriate policy development skills and knowledge cannot be overemphasized. It is difficult for others in the health system to develop appropriate policies for strengthening the nursing and midwifery workforce, if the nurses and midwives are unfamiliar with providing critical thinking on the potential effectiveness of the policies.



This is a lesson learned in countries that are currently facing difficulties in attracting, recruiting, and retaining nurses and midwives, and/or that have increasing difficulty in maintaining standards of nursing/midwifery care. They are realizing that meaningful involvement of nurses in policy and planning is an important strategy to ensure a strong nursing and midwifery workforce that has the capacity to positively contribute to the strengthening of the health services, and to the policies that underpin the services.

Where the nursing/midwifery workforce remains weak, or is in decline, it is a major restraining force on general health service improvement. Nursing/midwifery workloads and thus supply requirements generally increase as health services strengthen. However, the number of nurses/midwives, their education, competencies, incentives and job satisfaction do not always keep pace.

In the majority of developed countries, for example, education and competencies are high. But because of poor incentives and job satisfaction, many nurse/midwives are leaving the profession, a fewer number are attracted to the profession, or many nurses/midwives continue in the profession with low motivation.^{14,15} There is every reason to assume that this phenomenon will continue to spread globally, unless policies and plans are effective and strategically targeted.

Countries in SEAR that are making, or have made, considerable progress towards a well-managed nursing and midwifery workforce are characterized by effective leadership at policy and programme-planning level.¹⁶ These effective leaders hold chief nursing officer or similar



positions, or lead nursing/midwifery councils, or nurse/midwife associations, or nurse/midwife faculties. These countries follow the principle that service should inform policy, and policy should inform service.

In some SEAR countries, however, nurse/midwives are appointed to senior Ministry of Health positions and, in some cases, fail to live up to expectations. Their policy and programme-planning input is perceived as ineffective, and so neither valued nor listened to particularly. The perception of nurses/midwives of not being valued becomes the reality.¹⁷

Given that the transition from nurse/midwife operational management expertise to policy and planning expertise is not always successfully achieved, appointments of nurses/midwives to key leadership positions should be made on merit and with great care for the person's potential to be effective. Development opportunities should be provided where needed, including active mentoring by senior and more experienced Ministry officials, and through formal development education programmes.

The situation in other countries varies. Government chief nurse appointments are increasing in Europe, particularly in Central and Eastern Europe, and the Newly Independent States, decreasing in francophone Africa and are traditionally strong in Anglophone Africa. In Iceland, Canada, the US, the UK, Aruba, Australia, New Zealand, Thailand, Korea and Norway, nurses/midwives have been either elected or appointed to Parliament. Stronger national nursing associations are emerging in many countries, and they are demanding a greater voice in health policy and programme planning.

To prepare nurses and midwives for effective input to policy and programme planning, and for effective implementation, some exposure should be given during basic education. If nurses and midwives do not understand the bigger picture, and a country's strategic direction for health, they are missing a key foundation for ongoing learning and wider positive contribution to the health system (*see* section 2: Education, Training and Development).

Policy competence in members of the nurse/midwife regulatory councils is also important, as is policy competence in senior members of nurse/midwife professional associations. This creates a cadre of competent people whom governments can involve in consultation and policy development, as well as programme planning and implementation.

In most developed countries, nurses and midwives now hold general



management and policy development positions at every level in the health ministries. There are also specific nursing and midwifery positions in policy and programme planning. This enables nurses and midwives to provide valuable input to strengthening the nursing/midwifery workforce, as well as strengthening health services generally. Examples of involvement in policy development include: new services for care of the elderly, community-based services, hospital infrastructure planning, standards of care, multidisciplinary workforce planning, strategies and policies to underpin ethics (e.g. codes of ethics for the health workforce), and equity (e.g. user costs for health services).

In most SEAR countries, the number of nurses and midwives competent in policy and programme planning is small, and their age profile high. Strategies to develop a group of potential ('next-generation') leaders competent in policy and planning is an essential government investment.

1.2 Strategic planning for nursing and midwifery workforce management as an integral part of human resource planning and health system development

A strategic plan for nursing and midwifery development is needed to provide a clear direction for the development of the nursing and midwifery workforce, and identify the key result areas to achieve. The plan provides a structured approach to activities and plans of action, and is intersectoral as appropriate (e.g. where nursing/midwifery services and education are under different jurisdictions or ministries).

As a follow up to the Resolutions WHA 45.5 (1992) and WHA 49.1 (1996) that urged Member States to formulate and implement a national strategic plan, most countries in the Region developed national strategic plans for nursing and midwifery development (Bangladesh and Thailand in 1994, Indonesia and the Maldives in 1997, Myanmar in 1999, and Sri Lanka and Nepal in 2001).

The strategic plans have been a major mechanism for nursing and midwifery development in a few countries of the Region. For example, following the formulation of its strategic plan in late 1999, the Maldives successfully established the Directorate of Nursing Services to lead and facilitate nursing development in the country, and the Nursing Council in early 2000 to regulate the quality of education and practice of nurses in order to safeguard the public.



Countries in other Regions have also found national strategic planning to be an important strategy to guide progress. In 1989, China, for example, began developing their 1991–1996 national strategic plan for nursing and midwifery development. Evaluation in 1999 showed dramatic transformation of the nursing and midwifery services over more than 2000 of China's health facilities.

The success of implementation depends partly on the *process* used in developing national strategic plans. The process must be multidisciplinary, involve the most senior officials as well as nurse/midwife leaders, and be targeted towards achieving more effective contribution of nursing/midwifery to national health goals. The mid- and long-term strategies for strengthening the nursing and midwifery workforce must be integrated with government directions, policies and planning, if they are to be meaningful.

There are other benefits of a multidisciplinary approach that strategically assist in strengthening the nursing and midwifery services. These include new multidisciplinary contacts and relationships, mutual learning exchanges, and a better climate created for collaborative change management. For strategic plans to be meaningful and have an impact on nursing and midwifery development, sufficient time and resources must be invested in ensuring the implementation of the plan. Appropriate mechanisms must be in place to drive, monitor and evaluate the implementation. Successful implementation of the strategic plans is dependent on providing the necessary leadership and management by high-level multidisciplinary steering committees, together with the active involvement of stakeholders at every level. The plans must be translated into meaningful activities at the local and national level and be supported by appropriate capacity building to facilitate involvement and participation.

An essential part of a national strategic plan for nursing and midwifery development is human resource planning. This should include

- integrating workforce planning with planning for service delivery;
- planning for an integrated workforce, i.e. multidisciplinary teams;
- integrating the process of planning—across disciplines, regions and sectors.

Planning is not sufficient to prevent shortages but it highlights where and when shortages are likely to occur and what can be done. Most SEAR countries have a shortage of nursing and midwifery personnel. In some SEAR countries there are more doctors than nurses and midwives. Why is



the ratio of nurses:doctors important?

The answer, at the bottom line, is ‘costs’ and ‘appropriate care’ or ‘quality’. Doctors are more expensive to train and educate than nurses, and doctors generate more costs through their role of prescribing treatment. In times of oversupply of doctors, doctors take on tasks that nurses could do (downward substitution) and there is more overservicing. In times of undersupply of doctors, nurses and midwives take on ‘higher’-level tasks (upward substitution) with either no change, or some improvement in quality, at reduced cost. Overservicing of doctors is more random and less prevalent.

‘Appropriate nursing and midwifery care’ refers to the fact that the competencies of nurses and midwives are different from those of doctors, and that those who are doctors, or have some other skill, cannot usually meet patient needs for nursing/midwifery care, within appropriate cost and quality parameters.

Achieving quality health services that are equitable and accessible implies that the least expensive category of health workers that can maintain and enhance quality is the category that should provide care and/or treatment. Critics of substitution cite examples of countries such as Canada, where less expensive, less well-trained auxiliary nurses have been substituted for registered nurses in some facilities, sometimes, many think, inappropriately. As a result, the Canadian Government has now committed to a three-year 8 million Canadian dollars’ strategy to strengthen nursing/midwifery quality of care.¹⁸

The substitution equation is

$$\text{costs} + \text{quality} = \text{substitution decisions}$$

not ‘costs’ alone. It is false economy to focus on direct costs only, as indirect costs rise substantially where quality is neglected.¹⁹ Where the quality of the nursing and midwifery workforce decreases, indirect costs rise (through increases in clinical error and morbidity and mortality)²⁰ as do patient and community dissatisfaction.²¹

A national doctor:nurse ratio is regarded as a very general, macro-planning tool only, because of the number of influencing variables

- within each health facility
- geographically
- related to variations in burden of disease, illness and wellness patterns,



and level of, and access to, available services.

The *World Development Report*²² advocates that nurses and midwives could deliver most of the minimum essential public health and clinical services, with doctors providing clinical supervision and direct care of complex issues and complications. It suggests, as a rule of thumb, that the ratio of nurses:doctors should exceed 2:1, as a minimum, to deliver public health care and essential interventions, with 4:1 or higher considered more satisfactory.

The suggested doctor:nurse ratios assume

- maximum efficiency in utilization and deployment of nurses, midwives and doctors;
- that they have good competencies, knowledge and skills, and provide quality care; and
- that health infrastructure, including equipment, is appropriate to the level of services.

Since the *Report*, some developed and developing countries (e.g. Australia and Fiji) have introduced higher-level nurses and midwives, who practise more independently as nurse or midwife ‘practitioners’, including in rural and remote areas.²³ In Myanmar, there are new roles for nurses/midwives working at the community level in rural areas. The role of the nurse and midwife is changing through a combination of practical need, costs and quality effectiveness analysis, government policy and political will, and advocacy.

Other examples of substitution include Thailand’s nurse anaesthetist role, used extensively in operating theatres. In the former USSR countries, a new Family Health Nurse role has been developed, and is being implemented.²⁴ In the USA, in rural New England, where small towns of 2000–4000 people are the norm, doctors employ nurse practitioners to provide care to all patients except those with the most complex problems. Anecdotal evidence states that doctors’ job satisfaction is increased as it allows them to focus on more complex clinical care, and nurse practitioners’ job satisfaction is also high, the standard of their care is high (and is regularly quality assured by the doctors), and patient satisfaction is high.

Nursing and midwifery workforce planning requires, therefore, quantitative and qualitative approaches, at the national level, *and* strategies at the local level to reform health facilities and achieve maximum efficiency



and quality. Because of the interdependent nature of the many variables that influence nursing/midwifery workforce planning, such planning cannot be usefully done in isolation but must be an integral part of a strategic approach to human resources for health (HRH) planning.

Where countries have not, for a variety of reasons, been able to develop strategically focused HRH planning and, within this, nursing/midwifery workforce planning, they are facing severe challenges (e.g. Sri Lanka).

1.3 Financing

To be effective, health systems require the right number of nurses, with the right competencies, working in the right areas. Even where this is not being achieved, and even where nurses and midwives have low salaries, the total costs to the health care budget are usually substantial.

The health workforce is seen as a cost to the health system, and cost containment is a requirement in all health systems. Increasing the number of nurses and midwives increases costs. The health budget usually cannot expand to fit increased costs. The result is no increase in nurses and midwives where there are perceptions of need. Improving the quantity and quality of nurses and midwives, beyond re-ordering existing resources to improve the efficiency and effectiveness of work patterns and clinical practice, will cost money.

This simple scenario is fairly typical in most SEAR countries. There is a lot that can be done to improve the efficiency of work patterns and quality within the fixed costs of a health facility. These interventions should be made as a first step before additional nurse/midwife numbers are considered.

A more strategic way to look at the cost of the nursing and midwifery workforce is in the same way as one looks at any financial investment. If nursing and midwifery are inputs to the health system's effectiveness, how can that input be more strategically targeted to achieve a greater return on investment? If this means some additional financial input at the front end, how can the return on that additional investment be calculated?

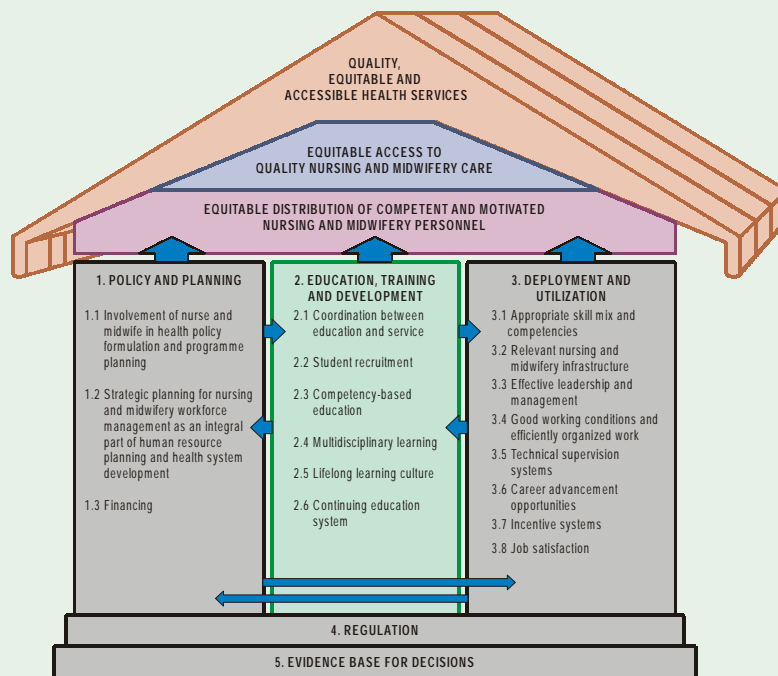
To secure appropriate investment in nursing and midwifery services, knowledge of health system financing and costing of services as well as substantial skill in mobilizing and maximizing resources is required.



However, there are a large number of strategies for reducing costs. These are all based on the aim of achieving the the right number of nurses, with the right skills and competencies, working in the right place and at the right time. They include quality and efficiency improvements at health-facility level; quality and efficiency measures, and their monitoring and evaluation; development and implementation of best-practice nurse/midwife:patient ratios related to patient dependency criteria; cost-modelling capacity based on ‘what if’ scenarios (for example, what if professional nurse numbers were increased and auxiliary nurse numbers decreased, or the reverse; what if cleaning staff were increased and nurse/midwives were free to provide nursing care, what would be the cost implications, e.g. decreased length of stay in hospitals; what if other workforce substitution was implemented, what would be the cost implications, including of increases or decreases in quality); more efficient and effective rosters; appropriate resource allocation.

Not investing in improved management of the nursing and midwifery workforce is being falsely economical, as the indirect and hidden costs are high where the nursing and midwifery services are weak. The dilemma is that increasing the return on investment requires first finding more money up-front to invest.





2. EDUCATION, TRAINING AND DEVELOPMENT

2.1 Coordination between nursing and midwifery education and service sectors



Coordination between education and practice, with service needs driving education, is critical to achieve quality health services that are equitable and accessible. Mechanisms to strengthen coordination between education and service are needed to achieve nursing and midwifery education that is relevant to service needs and requirements.

The approach to education and service for nursing and midwifery is different from, for example, medicine. In medicine, educators are more likely to also be practitioners and/or researchers. Nurse/midwife educators are more usually exclusively focused on education, and nurse/midwife practitioners more usually exclusively focused on clinical service delivery.

This creates gaps between what nursing/midwifery educators teach, and what is *required* for effective health services and nursing and midwifery care. In most countries, there are limited formal mechanisms to ensure service-led education. This is especially true for basic nursing and midwifery education.

The longer nursing/midwifery educators remain uninvolved in practice, and practising nurses and midwives remain uninvolved in education; the greater the gap, and curricula and field/clinical experiences become increasingly irrelevant and meaningless. On the other hand, often there are also insufficient numbers of qualified teachers and inadequate teaching-learning resources, compounding the challenge.

Education programmes that are not service led result in tension between education and service settings. This happens at several levels. There is often tension between newly graduated nurses and midwives and their more experienced colleagues, as the new graduates adjust to the reality of service provision equipped with skills and competencies that do not always match service requirements.²⁵ The tension for the government is that their return on investment in nursing and midwifery education for the achievement of good health services is not realized.

Possible mechanisms to strengthen the coordination include (i) joint appointments in education and practice settings; (ii) joint (education and



service) planning committees that assess overall service needs (including post-basic specialty education and continuing education needs to meet changing service needs); (iii) Course Advisory Committees for each education programme consisting of nursing/midwifery educators and clinical nurses/midwives; (iv) joint research between educators and clinicians; (v) shared continuing education for nurse/midwife educators and clinicians; and (vi) possible renewable licensing based on evidence of continuing education, and maintenance and enhancement of clinical competency.

2.2 Student recruitment

In most SEAR countries, there are more potential students than there are available student places. However, student recruitment is not only to do with quantity. The quality of nursing/midwifery students is also critical. Recruiting the most talented people to nursing/midwifery is becoming increasingly important and is not always a focus. Equity issues are not usually addressed in this context. Strategies should be developed to enable students from poorer socioeconomic backgrounds, who have the potential to qualify as nurses and midwives, to do so.

Experience from other countries shows that as more career options become available for women, not only do nurse/midwife student applications decline, but the quality of applicants also declines. Paradoxically, as health, scientific, and nursing/midwifery knowledge and community expectations increase, the educational standards of students, and their general talent and



aptitude for nursing and midwifery becomes even more important for the sustainability of well-managed nursing and midwifery workforces.

The recruitment challenge becomes more complex where nursing/midwifery is perceived to be of low status, where working conditions are perceived to be relatively poor, and where salaries are low and incentives weak. In many developed countries, as the pool of younger people seeking entry to nursing decreases, and the demand for nurses and midwives increases as health services strengthen, older or 'mature' students are targeted for recruitment, and refresher courses developed to recruit nurses and midwives who have not practised for some time (for example, because of raising families).

In some SEAR countries, the methodology of nurse education (e.g. didactic teaching and lack of encouragement for critical thinking) and working conditions will be added disincentives as more career options become available, to women in particular.

In addition, maldistribution of the nursing/midwifery workforce is as important as in other health professions and sectors. Recruitment from local areas with incentives to work there on graduation could be a successful strategy. Providing safe housing in rural and remote areas is another strategy.

The numbers of nurse/midwife students recruited is monitored in most countries. Their quality, education, potential and retention is more rarely monitored and analysed. Monitoring systems for both quantity and quality are required for informed decision-making about the future nursing and midwifery workforce.

2.3 Competency-based education

Most SEAR countries have revised their nursing and midwifery curricula over the past five years or so. However, many teachers use didactic classroom teaching methods, and practical skills are developed by repetitive learning of discrete tasks.

Competency-based education takes a different approach. Curricula, teaching methods and applied learning are designed to develop competencies, where knowledge and skills can be applied flexibly across an almost limitless range of clinical circumstances. Critical thinking capacity is an essential element, is encouraged and developed in the student, and is a





foundation for their clinical practice after graduation.²⁶

Competency-based education and practice requires standards of nursing and midwifery care. These should be jointly developed by educators and nurse/midwife clinicians. In SEAR, there are Standards of Midwifery Practice for Safe Motherhood, which are valuable education and practice tools within SEAR, and increasingly in other Regions. Myanmar and Thailand have developed standards of care and are now strengthening them. Bangladesh, India, the Maldives and Sri Lanka are at various stages of developing and implementing standards of nursing care.

A competency-based approach gives a greater foundation to nursing and midwifery regulatory procedures and enables better development of quality assurance programmes and strategies for continuous quality improvement in the nursing and midwifery services.



Competency-based education lays the foundation for lifelong learning. It requires and reinforces service-led education, and strong and expert nursing/midwifery boards or councils to regulate nursing and midwifery practice standards.

Training of educators in new learning and teaching methodologies is required



and organizational development strategies implemented to build a culture of continuous quality improvement in nursing schools as well as in practice settings. Continuing education programmes are required for nurses/midwives in service settings to teach them a competency-based approach for their own practice, and so that they can support new graduates.

2.4 Multidisciplinary learning

Generally, each category of health worker is educated in isolation from other categories. Each category usually does not understand well the knowledge base, skills, values and, consequently, attitudes and behaviours in other categories. Nor is there usually a clear understanding of these between (i) providers and consumers; and (ii) providers and governments.^{27,28} Teamwork is therefore problematic.

These differences can make information exchange between the various parties problematic, at policy and planning level, and within clinical settings.

The knowledge, values, and attitudes of nurses and midwives are somewhat different from other health providers, and often from those in senior policy and management positions. This creates communication barriers, including on policy and management issues. Increased understanding between different categories of health workers improves communication. Its lack is often an impediment to progress.

Multidisciplinary education is a strategy that positively influences team building, socialization, mutual understanding and improved communication. This, in turn, has a major impact on the culture of both education and service facilities, and the integrated and well thought-out care that consumers receive, or not. Multidisciplinary education also provides economic benefits, through sharing of classes and teachers, and through improved efficiency from better teamwork.

Clearly, it is inappropriate for different categories of health workers to share all education. However, some basic and post-basic/continuing education can, and should, be shared. Leadership and management development programmes are a good vehicle for multidisciplinary learning, and building strong and effective organizational cultures.

As with all change, there needs to be a country-specific mechanism to develop new approaches for multidisciplinary education, which involves the education and practice sectors.



2.5 Lifelong learning culture

A culture of lifelong learning is essential in all health professions. Knowledge is increasing at such a rate that even with a culture of lifelong learning, keeping abreast of new knowledge is challenging for all health professionals and health workers.

Not all SEAR countries enjoy a nursing/midwifery culture of lifelong learning. If they did, then many of the challenging issues that this document addresses would be resolved. In essence, a change in the culture of nursing and midwifery education and practice settings is needed. Critical-thinking capacity is an integral part of this—the encouragement of research, the instilling of the element of curiosity to always do better, to find out more, to gather more evidence for quality care—and should be the driving force of the nursing/midwifery culture.



Experience in other countries and other sectors demonstrates that relatively simple change, for example in curricula, is insufficient. A suite of integrated organizational development and change management strategies are needed, which encompass leadership and management development, new and enhanced technical skills, new knowledge, and also target attitude and behavioural change. Changes are needed in the work environment, including how care is provided, the efficiency and quality with which it is delivered, and the interdependent team work within which it is delivered.

Within a culture of lifelong learning, nurses and midwives are imbued with, and act on, the concept of continuous quality improvement in knowledge and its application to practise. The impact of HIV/AIDS on the required nursing supply and the skills and knowledge needed is a good technical example of why the capacity for lifelong learning is critical.²⁹



2.6 Continuing education system

A continuing education system is essential to achieving, maintaining, and continuously improving well-managed nursing and midwifery services. However, where there is no culture of lifelong learning, continuing education may not be of particular interest to nurses and midwives.

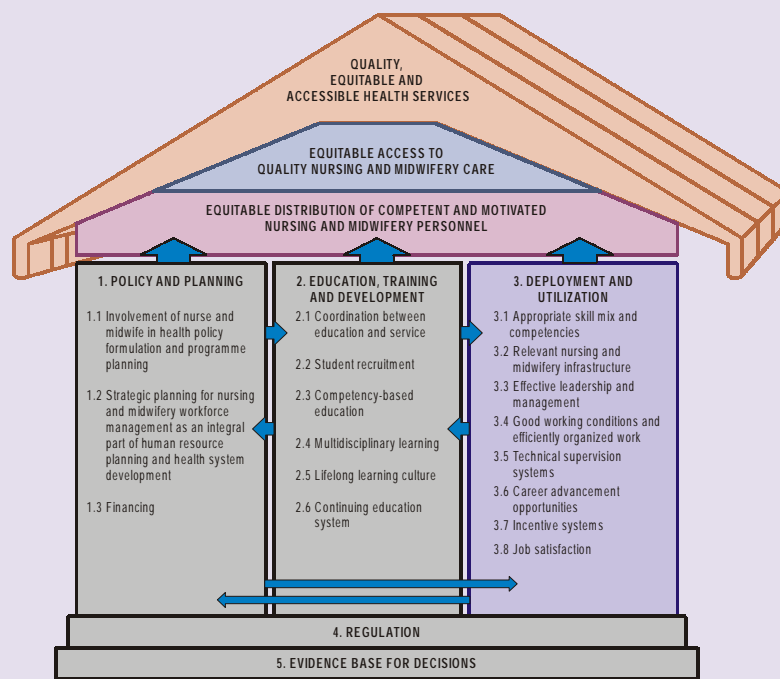
A well-designed *system* of continuing education is needed, as distinct from ad hoc lectures, which are not strategically linked and are therefore not particularly developmental. A developmental approach facilitates professional and personal growth in nurses and midwives, and the development of the organization in which they work. A system of continuing education is therefore part of the suite of organizational development strategies, where theory, skills, knowledge, attitudes and behaviours are strategically aligned, within nursing and midwifery, and across disciplines, to achieve positive and continuous change.



A strategy to develop a system of continuing education is through a multidisciplinary committee, the members of which have the required knowledge and skills. It is in the interests of all that the competency of health professionals and health workers move forward equally. If postoperative nursing/midwifery care is weak, for example, it matters less that the surgeon had expertise and the operation was a success. Postoperative infection control, prevention of pulmonary embolism, wound care, etc. are all dependent on skilled nursing care.

Nursing/midwifery councils also can play a key role, with a lifetime license to practise through registration, replaced by practising registrations that are applied for, say, every five years. The granting of practising registrations would be dependent on providing evidence of satisfactory continuing education in the preceding period (*see* section 4 on Regulation, p. 33).





3. DEPLOYMENT AND UTILIZATION

3.1 Appropriate skill mix and competencies

Skill mix refers to the complementarity of skills across the health team. Skill mix, therefore, applies as much to the different categories within nursing and midwifery, as it does to the optimum complementarity of skills between categories and doctors, ancillary workers and allied health workers. Skill mix has always been important. It has assumed a new importance as governments address increasing costs and demands for quality, and there are increasing gaps in the supply and demand of nurses/midwives, and continued or growing imbalance in doctor:nurse/midwife ratios. The various roles and competencies of nurses and midwives, and other health professionals and workers require both definition and differentiation to ensure an effective skill mix.



Staffing profiles in health centres, hospitals and other health facilities are obviously central to ensuring effective health services. Where there are many categories of health workers, each with a somewhat narrow range of skills and competencies, skill mix may be appropriate, but more staff is required. Where there is no competency-based training, this will be more prevalent.

As standards of medical practice improve, the medical profession is becoming more acutely aware of the impact that poor nursing/midwifery standards and inappropriate skill mix have on patient and community health outcomes. In Sri Lanka, for example, senior officials and other leading medical doctors are taking a leadership role in supporting the strengthening of the nursing/midwifery workforce.³⁰

Skill mix is dependent on adequate numbers of staff with the right spread, or mix, of skills and competencies. There are various tools that can be used to determine the required skill mix.

Rosters are an important tool in achieving the right skill mix at an affordable cost and maximizing the use of existing human resources, particularly in 24-hour services, e.g. hospitals.³¹ In many SEAR countries, rosters are not based on research on motivation, or on patient acuity, admission and discharge patterns. The changing pattern of rosters is often a sensitive issue, but one that should be addressed, in full consultation with



nurses and midwives. Rosters can both reflect and drive more effective and efficient work patterns.

The inadequate number of nurses/midwives is creating increasing concern. Countries experiencing acute shortages include South Africa, the UK, the USA, Australia, Ireland, the Netherlands and Canada. Africa and Central America are recruiting from Cuba and Guyana. Aggressive intercountry recruitment, including from SEAR countries, is having a global ‘knock-on’ effect, negatively affecting health services in a surprisingly large number of countries.

There is an acute shortage of nurses in Sri Lanka (around 50%) and some recruitment effort has been made there from overseas countries. In Myanmar and Bangladesh, nurses say the number of sanctioned nursing posts is inadequate. India is supplying a large number of countries with nurses.

There are often cultural challenges for patients and the nurses and midwives in the recruiting country. Both affect that country’s recruitment aim of maintaining or improving health services.³²

Several high-level discussions have been held on the shortage, and on intercountry recruitment, including through the European Commission. There is also some criticism of the ethics of intercountry recruitment of nurses and midwives to overcome home-country shortages.³³

The call is (i) for those countries with shortages to develop strategies that achieve a well-managed nursing and midwifery workforce, and (ii) for those countries not yet experiencing shortages, to quickly develop mid- and long-term strategies to lay the foundation for a well-managed nursing and midwifery health workforce.

3.2 Relevant nursing and midwifery infrastructure

Nurses and midwives need an appropriate infrastructure to provide good services, in the same way as in other services. Relevant infrastructure includes good local and national leadership, modern and innovative management at all levels, appropriate policy frameworks, a clear and shared sense of purpose and direction, and the tools to support good education and practice (in the same way that surgeons need instruments, or a carpenter needs carpentry tools). Some infrastructural requirements are therefore very basic, some less so.





Lack of relevant infrastructure at the strategic and operational levels is hampering many SEAR countries' efforts at achieving a well-managed nursing and midwifery workforce. For example, in a country where there is no focal point to lead and facilitate development of the nursing and midwifery services at the national level, this can result in fragmented and uncoordinated development.

In one SEAR hospital, senior nurses/midwives said that they spent about 50% of their time trying to find basic equipment for nurses and midwives: linen, simple pain relief drugs, kidney dishes, stethoscopes. Linen is a good example of improving efficiency and quality. In many SEAR hospitals, linen supply is perceived to be insufficient, and not regularly available. This results in linen being hoarded, in case there is no more, or an insufficient quantity, supplied the next day. As a consequence, large amounts of linen are removed from the available supply. In turn, this means that nurses/midwives spend a large amount of time each day trying to find more linen.

At both strategic and operational levels, competent nurse/midwife leadership and management is crucial. This requires the creation of both local and national posts for competent nurse/midwife leaders and managers, and an environment that is well-led and managed at senior medical and multidisciplinary levels.

3.3 Effective leadership and management

Good leadership and management are important and are in short supply in nursing and midwifery, as well as in other health and related sectors.³⁴ These include achieving results through oneself and others; inspiring confidence in others; and moving towards a particular, future-oriented, strategic direction.

There are many strategies to increase leadership and management capacity in nursing and midwifery. Some aim to increase individual capacity (e.g. a university management degree). Others aim to increase individual, team and organizational capacity through experiential programmes, based on action-learning principles.

The latter can be unidisciplinary, i.e. nursing/midwifery specific,³⁵ or multidisciplinary. In 1988, when the New Zealand government began its



wide reforms in all sectors, the government invested heavily in multidisciplinary, experiential leadership and management development programmes to ensure that a large cadre of people had the capacity to lead and manage in the reformed environment. Nurses/midwives were included in this and have gone on to become chief executives of various health facilities, or to become senior policy and planning people in the health ministry.

Based on data from the SEAR country analyses for WHA 49.1 in 2000, it is clear that all SEAR countries would benefit from further experiential leadership and management development programmes. For those SEAR countries that have developed national strategic plans for nursing and midwifery development, improving their leadership and management capacity is a common element in all plans. Countries such as Bangladesh, Myanmar, Nepal, Sri Lanka and Thailand have introduced leadership and management development programmes for their nurses and midwives.



3.4 Good working conditions

Good working conditions for nurses and midwives include a range of issues from equipment to management. Salary is important both for its absolute value and symbolic value of recognizing nurses/midwives as important members of the health team. Low salaries for nurses/midwives are more the norm than not in SEAR countries. Low salaries need to be addressed as a country's socioeconomic strength increases. Salaries are an integral part of working conditions.



Many see working conditions in physical terms only: buildings, amenities, cleanliness, light. These are a part of working conditions. Another element of working conditions is safety: safety while travelling to work, safety while going home from work, safety at work, safety when one is working in rural or remote areas, often alone, and often when a young female is working alone. The last point is a major recruitment and retention issue for rural and remote areas in some SEAR countries.³⁶ In turn, local people have learnt not to rely on the health services because there is no guarantee that a health worker will be available after they have perhaps walked three hours to the health station.



Increasingly, the overarching issues in working conditions in many countries are safe nursing: patient ratios, a good management and organizational environment, and respect and courtesy from the medical profession and others.³⁷ Education and career development opportunities make a substantial contribution to enhancing working conditions.

Achieving a substantial change in working conditions is thus multidimensional, and is achievable through targeting each element, building up a suite of integrated strategies over time.

3.5 Technical supervision systems

Effective technical supervision systems relate to many of the discussions above: standards and their quality; competencies; attitudes and behaviours of nurses/midwives towards patients and other health team members; critical thinking capacity; identification of continuing education needs; coordination between education and service; and leadership and management.

In many SEAR health facilities, technical supervision is dependent on the capacity and interest of individuals, as distinct from there being a systematized approach to technical supervision. Systematized technical supervision becomes part of the management and quality assurance approach of an organization. To be successfully implemented and sustainable, linkages through all of the above elements are required.



Particular requirements include development of skills and competencies in those providing the supervision, clear guidelines and standards, and a supportive technical supervision approach based on a continuous quality improvement philosophy (as distinct from punitive).



Some countries in SEAR (for example, Myanmar and Thailand) and elsewhere such as China, are developing, or have developed, patient-centred wards, where the work of nurses/midwives is reorganized around the needs of the patients, quality systems are introduced, attitudes and behaviours are addressed, and interdependent teamwork is a baseline requirement. In these pilots, technical supervision was a key part of their success.

3.6 Career advancement opportunities

Traditionally, career advancement in nursing and midwifery is through promotion to more senior management or education positions. Both of these mean leaving clinical practice. Senior positions are few, and those remaining in clinical practice have limited career advancement opportunities within current structures.

Career development can take place within jobs or by lateral moves (i.e. to learn a new skill and assume a different responsibility). Progression in a clinical career should be developed to provide incentive and motivation for clinical excellence, and be rewarded and valued in status and monetary terms. To work well, more is required than simple reclassification of jobs. Introducing new senior clinical roles requires redesigning of jobs at the clinical level, within the context of the clinical team, so that the new role and responsibilities can flourish.

Traditionally, in SEAR, nurses and midwives are not perceived as possible candidates for senior positions other than those specified as requiring nursing and/or midwifery qualifications. Many countries (New Zealand, South Africa, Canada, the UK, Australia, parts of South America,



Zimbabwe and some other parts of Africa) appoint experienced and qualified nurses and midwives to broader senior management and policy positions such as Permanent Secretary and Director-General, hospital Chief Executive, and a range of second- and third-level management and/or policy positions.

All health professionals should have the opportunity for appointment to a wide variety of positions, assuming they have the appropriate qualifications and potential. Nurses and midwives are frequently disadvantaged due to lack of value attached to their professions and the low status of women in a particular country. This creates the innovation and fresh thinking needed to overcome the challenges in achieving equality for women and nurses and midwives, as well as in achieving quality health services based on equity and accessibility.

3.7 Incentive systems

Incentive systems relate to individual, team, and organizational motivation factors. As such, some incentive systems work for some, and not for others. However, well-designed incentive systems can be powerful strategies to achieve and maintain a well-managed nursing and midwifery workforce. Incentive systems might include team rewards for achievement of quality indicators; international education opportunities for nurses and midwives; payment for additional studies and qualifications, etc.

Incentives target either intrinsic or extrinsic factors in an individual or team. They can be either monetary or non-monetary incentives. For some, an invitation to participate in national policy discussions is an incentive. For others, educational opportunities are incentives. Ideally, there should be a package of general incentives, complemented by individual, team and organizational incentives.

Much of the discussion in the sections above address incentives and motivation (e.g. salaries, safety in rural and remote areas, good technical supervision, educational opportunities, and career advancement opportunities).

3.8 Job satisfaction

Job satisfaction is arguably the most complex issue to address. Any organization or health system has three levels against which strategies can



be developed to improve job satisfaction:

- Practices and procedures (operational level)
- Purpose and direction (strategic level)
- Unity and identity⁹ (attitudes and behavioural level)



These three levels are applicable to all of the elements in this conceptual model. All require different strategies. The choice of which level, and therefore what strategy, depends on which problem is the priority. Strategies to strengthen practices and procedures are the easiest to implement (e.g. linen imprest systems). Strategies to strengthen an organization's or health system's purpose and direction are more complex but still logical and rational (e.g. a national health plan; national strategic plans for nursing and midwifery development).

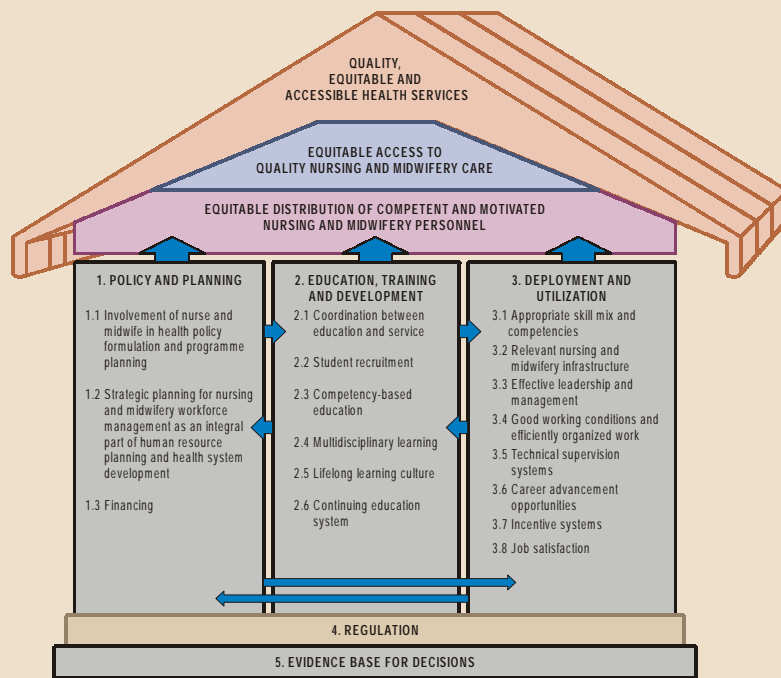
The 'unity and identity' level is the foundation of any organization's culture and perhaps most strongly influences people's job satisfaction. Strategies are more complex for this level and less rational. This is because they include human emotions, feelings and values, people's sense of self-worth and how they are acknowledged and valued by the organization in which they work and by the overall health system, and whether the work they do and the environment achieves extrinsic and intrinsic satisfaction for them.

Job satisfaction is dependent on an individual's perspective of their job and life, and how the organization provides a climate in which that individual, or group of individuals, can flourish.

Leadership, management, communication, incentives, working conditions, workload, team or individual work, job and education opportunities, etc. all play their part in an individual's job satisfaction. Professional autonomy and greater involvement in the management of patient care have been found to be closely linked to job satisfaction.

A recent study into hospital quality-of-care and working conditions in five countries found that (i) job satisfaction was the key to attraction, recruitment and retention of nurses/midwives; (ii) simplistic approaches to improve job satisfaction did not produce sustainable results; and (iii) increasing job satisfaction requires multiple and integrated strategies, as this conceptual model incorporates.³⁹





4. REGULATION

A regulatory framework, legislation and/or other mechanisms underpin all aspects of the conceptual model and are required to assure the quality of nursing and midwifery services.

Robust mechanisms need to be in place to protect the public. Policies for the management and delivery of health, and the nursing and midwifery services, and for the management of the nursing and midwifery workforce, for example, may require a regulatory framework.

In many SEAR countries, nursing and midwifery councils have been established (Bangladesh, India, Maldives, Myanmar, Nepal and Thailand), with varying degrees of effectiveness in terms of public protection, strengthening of nursing and midwifery, and workforce management. In others (e.g. Sri Lanka), mechanisms exist but have not been implemented for various reasons.

The most basic function of a nursing/midwifery council is to place nurses/midwives on the register, if they have reached a predetermined minimum standard of education, knowledge and competencies. Registration is usually for life and ignores whether competencies have been maintained or if those registered are still practising. Some countries are investigating the possibility of introducing periodic re-registration, whereby nurses and midwives would be required to produce evidence that competencies have been maintained and enhanced to remain on the register and to acquire a current certificate/license to practise. Such a 'live' register would provide useful information for workforce planning.

Registration requires nursing/midwifery councils to articulate the standards required before they will register a nurse/midwife. Increasingly, this is being done through the development of competencies and implementation of competency-based curricula. Clinical career development and career progression can be linked to advanced competency and capability. Some countries are exploring the value of having separate nursing and midwifery councils.

Nursing/midwifery councils play an important part in defining the roles and responsibilities of nurses and midwives. They also have a key role in establishing and monitoring mechanisms for the licensing, accreditation, or recognition of schools of nursing/midwifery. This is an important mechanism for countries to consider, where there is increasing private sector provision of nursing/midwifery education (e.g. Nepal).

Service-led education programmes are advocated. Service reality therefore



has to inform competency development. One mechanism for this is through a continuous quality improvement approach. 'Quality assurance' is one part of this. Quality assurance often means retrospective measurement of education programmes, or ensuring minimum qualifications of educators, or assessing the quality of care, or a health facilities' overall quality against

predetermined standards (e.g. re-admission rates per hospital discharge, number of immunizations given per target population, etc.).



Few SEAR countries have sufficiently rigorous quality-assurance systems of their nursing standards and their nursing and midwifery education programmes, nor have they the information systems to evaluate the adequacy, or otherwise, of service-led education. It is necessary to set quality goals and targets, analysing the gap between what is and what

should be, developing relevant and appropriate education programmes that ensure service standards are met, and having mechanisms and information systems to ensure a system where evidence-based care and continuous quality improvement becomes the norm.

Standards are the basis of quality-assurance programmes. In some SEAR countries, nursing and midwifery regulatory bodies (e.g. councils) are developing, or have developed, standards against which education programmes can be accredited. Education programmes should assure that students graduate with the competencies required in the health system. If the programme does not meet the set standards, they should not be accredited, or should be given additional time to reach the required standards.

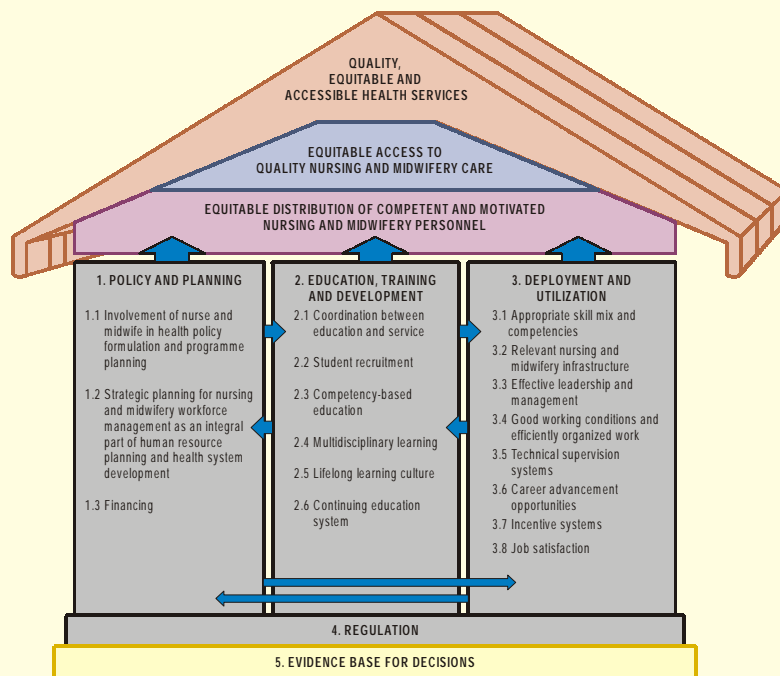
This creates positive pressure to ensure nurse educators are competent, curricula are relevant and service-led, and the culture within faculties and schools becomes one of lifelong learning and continuous quality improvement.

Cost-effectiveness of data gathering, usefulness of information, feedback and action are four key factors in effective quality-assurance programmes.



Each country should have formal mechanisms that drive the degree of excellence in nursing and midwifery education schools, encourage strong formal and informal relationships with clinical counterparts, and achieve rigorous assessment of the relevance of educational programmes. Quality-assurance programmes also need to be developed in practice settings and enabling environments created.





5. EVIDENCE BASE FOR DECISIONS

The need for evidence as a basis for decisions is a constant theme in the health sector and beyond. This includes evidence-based policy-making, evidence-based management, as well as evidence-based practice. Evidence can be easy to obtain when there is a simple cause-and-effect relationship, or some other direct relationship, between a variable and its impact. What is harder to measure is the attitudinal and behavioural impact on patients, on nurse/midwife job satisfaction, on organizational efficiency and effectiveness; or, the impact of insufficient or inappropriate skills on costs, morbidity and mortality.

In nursing and midwifery, most often the focus is on the lack of evidence of the quality and cost-effectiveness of the nursing and midwifery services.⁴⁰ While this is one essential area where evidence needs to be developed to guide clinical practice, costs and quality, there is also evidence from other bodies of knowledge and from simple analysis that can, and should, be applied to nursing and midwifery and to the health services in general.

For example, in the UK in 1997–1999, an analysis of reasons for lengthy waiting times for elective surgery revealed that the major blockage was inadequate numbers of nurses working in operating theatres. Acting on this ‘evidence’, the quantity issue was addressed through vigorous recruitment, including that of nurses who had left the profession. Quality and competency issues were addressed through effective short-term training of the newly recruited registered nurses, upgrading the skills of the existing workforce to acquire broader competencies so that they could be utilized more flexibly, changing rosters and opening theatres in the evenings and on weekends, and ultimately changing the ‘skill mix’ and introducing a ‘substitution’ element.

Evidence of this nature abounds in the health system when people look, think, analyse and act. Often this is not done until there are visible symptoms of system failure, as in the example above. A better approach is to use a continuous quality improvement approach, avoiding crises from system failure.

Poverty and health are closely related.^{41–44} Well-trained primary health care and public health nurses can make a considerable difference to a community’s health, contributing directly and indirectly to poverty reduction, as can well-trained community midwives.⁴⁵ Some SEAR countries (e.g. Myanmar) are strengthening community-based nursing. There are opportunities for improvement in all SEAR countries, including for long-term home-based care to support care of the elderly and people





with HIV/AIDS and other chronic illnesses. Their evaluation will provide evidence to support future directions.

The WHA 49.1 country analysis demonstrated that there is very little research-generated evidence for policy, education, or practice in nursing and midwifery, while there is much anecdotal, and some qualitative, analysis. WHA Resolution 54.12 calls for the development and enhancement of a nursing/midwifery evidence base, to

provide the basis for policy, planning, management and clinical decisions.⁴⁶

Baseline information is needed, such as categories and numbers of staff, and their range of skills and competencies. From these data, the existing situation can be analysed, trends identified, and planning and policy informed. A key challenge is effective information systems, including data capture between integrated workforce planning and health service planning and delivery.

In SEAR, there is insufficient publishing by nurses and midwives to lend support to the growing evidence base on nursing and midwifery from other countries. Research and analysis in SEAR by nurses and midwives needs active encouragement by nurse/midwife leaders in education and practice including through collaborative research; through nurses and midwives collaborating with other health professionals; through specialist post-basic and continuing education; and through practice settings encouraging, indeed requiring, clinically based applied research. Evidence from systems analysis also provides a basis for decision-making, as in the earlier example.



E. CONCLUSION

This document provides a framework to guide countries in managing their nursing and midwifery workforce more effectively and a strategic context for in-depth country assessment. It reflects the complexity of issues underpinning effective workforce management. Used in conjunction with its companion documents *Guidelines* and *Analysis of Country Assessments*, it enables countries to develop strategic responses tailored to meet the varying needs of individual countries. It accommodates the fact that the combination of problems, causes, solutions and priorities will differ according to the country context.



ANNEX 1: List of Advisory Group Members

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(Provided technical input)

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ANNEX 2: Nursing and Midwifery Personnel in Countries of the South-East Asia Region

A. Personnel with midwifery in the job title					
No.	Personnel	Entry requirement	Duration of training (months)	Country	Note
1.	Auxiliary Midwife	Literate women	6	Myanmar	
2.	Auxiliary Nurse-Midwife	9th grade	24	Bhutan	
		Assistant Nurse with 5 years' experience	6	Maldives	
		10th grade	24	Nepal	
3.	Midwife	Health Nurse	12	Indonesia	Rural community-based village midwife
		Health Nurse with Midwifery	24	Indonesia	D-III
		D-III Midwifery	18	Indonesia	D-IV
		12th grade	36	Indonesia	D-III
		11th grade	24	DPR Korea	
		10th grade	18	Myanmar	
4.	Public Health Midwife	10th grade	18	Sri Lanka	
5.	Supervising Public Health Midwife	Public Health Midwife with 10 years experience	3	Sri Lanka	
6.	Nurse Midwife	Nurse (10th grade + 3 years nursing training)	12	Bangladesh	
		12th grade	42	Bhutan	
		12th grade	36	India	GNM
		12th grade	48	India	BSc Nursing
		10th grade	36	Maldives	
		Trained Nurse + 2 years' experience	6	Myanmar	Post-basic
		12th grade	36	Myanmar	Diploma
		12th grade	48	Myanmar	BSc Nursing
		10th grade	36	Nepal	
		Qualified Nurse	12	Post-basic	

D-III: Diploma; D-IV: Advanced Diploma; GNM: General Nurse-Midwife



**B. Personnel without midwifery in the job title
(But they may have various degrees of midwifery responsibilities)**

No.	Personnel	Entry requirement	Duration of training (months)	Country	Note
1.	Maternal Child Health Worker	8th grade	3	Nepal	
2.	Family Health Worker	6th–7th grade	4	Maldives	
3.	Community Health Worker	9th grade	24	Maldives	
4.	Family Welfare Visitor	10th grade	18	Bangladesh	
5.	Multipurpose Health Worker (Female)	10th grade	18	India	
6.	Basic Health Worker	8th grade	12	Bhutan	
7.	Health Assistant	8th grade	24	Bhutan	
8.	Lady Health Visitor	Senior Midwife + 3 years' experience	9	Myanmar	
9.	Health Supervisors (Female)	Auxiliary Nurse-Midwife with 5 years' experience	6	India	
10.	Assistant Nurse	7th grade	24	Bhutan	
		9th grade	12	Maldives	
11.	Health Nurse	9th grade	36	Indonesia	
12.	Technical Nurse	12th grade	24	Thailand	
13.	Professional Nurse	12th grade	48	Thailand	BSc Nursing
		Technical Nurse	24	Thailand	Post-basic
14.	Nurse	10th grade	36	Bangladesh	
		11th grade	24	DPR Korea	Nurse level 4
		11th grade	48	DPR Korea	Senior nurse level 2 (programme has now been discontinued)
		12th grade	36	Indonesia	D-III
		12th grade	54	Indonesia	S-I (BN)
		D-III Nurse	30	Indonesia	Post-basic S-I
		Health Nurse	24	Indonesia	Post-basic D-III
		10th grade	36	Sri Lanka	



15.	Public Health Nurse (PHN)	GNM with 2 years' experience	10	India	
		12th grade	48	India	BSc Nursing (Same as No. 6)
		GNM	24	India	Post-basic BSc
		Nurse-Midwife with 5 years' experience	9	Myanmar	
		Nurse-Midwife with 3 years' experience	24	Nepal	Post-basic BSc
		Diploma Nursing-Midwifery	12/24	Thailand	Post-basic BSc (PHN)
		Technical Nurse 12th grade	12/24	Thailand	Post-basic BSc (PHN)
16.	District Public Health Nurse	Nurse with 3 years' experience	24	Bangladesh	BSc (PHN)
17.	Community Health Nurse	Nurse-Midwife + 5 years' experience	12	Myanmar	
18.	Public Health Nursing Sister	Nurse-Midwife + 5 years' experience	12	Sri Lanka	

S-I (BN): Bachelor of Nursing; Post-basic S-I: Post-basic Bachelor of Nursing;
 Post-basic D-III: Post-basic Diploma



ANNEX 3: Complexity of Contextual Issues: A Case History

There are many case histories that could be used to illustrate the severity of the problem in some countries, and the low base from which many are starting. One case history from SEAR is presented below, and this could be supplemented by many others. The case history presented is unique to the particular country but, while details differ in other countries, for most there is the same degree of complexity in finding strategies and solutions to the challenge of strengthening the management of the nursing and midwifery services. The challenge is to strengthen the health system as well as develop strategies specifically targeting nursing and midwifery.

In this country, the aim for the health system is decentralization but, despite legislative changes, actual decentralization is minimal. While structurally, fairly even access to the health services appears assured, the reality differs. There is weak capacity for strategic planning, policy development, leadership and management, finance and other resource disbursement, analysis and decision-making at all levels. The geographical location of health facilities is not always ideal to meet the population health needs. Staff availability is inconsistent and absenteeism is high.

Centralized management continues. Personnel administration, including staff deployment and transfer, is centralized. Family, economic, social and security disadvantages of working in rural and remote areas make staffing problematic. Problems in drug and other supplies, transport and financial disbursements, together with low or absent staff, compromise services, including outreach services.

There are over 40 different health worker cadres and the majority of them have limited training.

There is a shortage of absolute numbers of nurses. There is an oversupply of doctors, with increasing production of both doctors and nurses in the pipeline through private medical colleges. There are perceptions that standards of new medical, nursing and other health worker graduates are uneven. There is no overall health workforce planning to facilitate the balance between supply and demand.

There is geographical maldistribution of all health workers in favour of urban areas. Staffing levels are further compromised by poor motivation and widespread absenteeism because of poor wages in the public sector, higher wages and incentives in the private and nongovernmental sectors, and staff not taking



up positions when transferred to rural and remote areas with which they are not familiar.

Most health workers supplement their incomes in the private sector. For nurses, this often means dual employment. For doctors, it often means public sector employment and private practice, even where some public providers provide financial incentives for them not to concurrently run a private practice.

Donors emphasize training. This translates into a myriad of discrete and non-integrated training courses, usually directed at the less-educated health cadres who frequently must leave their health centre unattended and travel long distances, including on foot, to attend them.

The higher wages paid by nongovernmental organizations (NGOs) and the proliferating private hospital sector attract the talented and able away from the public health system.

Finances are a major constraint in improving health services. Because of the poor administrative and management capacity, strategies to strengthen aspects of the health system follow an ad hoc pattern.

Staff reluctance to serve in remote areas far from home and families, where there are no financial incentives to do so, usually no accommodation (provided for doctors but not for nurses or midwives), and security fears, means that health facilities may have no staff or ad hoc staffing patterns, constraining access. Illiteracy and poverty in a user-pays system further constrains access. Travel distance and the terrain, and perhaps no staff, no drugs and no other supplies when one arrives, complete the access constraints.

For staff, their low wages have recently been increased to a minimum living wage. This has yet to be paid. Despite the low wages, there are more applicants to study medicine and nursing than there are student positions.

Clinical standards are low in nursing and midwifery as is motivation for, and availability of, ongoing structured and strategic learning after graduation. There is little education available to strengthen the leadership and management capacity of the health workforce, including nurses and midwives.



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