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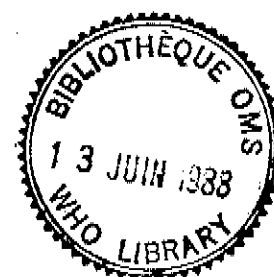
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Guidelines for Regulatory Changes in Nursing Education and Practice to Promote Primary Health Care

Maude Storey
Ruth Roemer
A. Mangay Maglacas
E. A. Paloscia Riccard



Division of Health Manpower Development
World Health Organization
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How to use the Guidelines

These Guidelines are based upon the premise that the law should not place unnecessary barriers to the delivery of health care services to people, but additionally that legislative support is necessary to maximize the contribution of the nurse in the organization, development, and delivery of primary health care.

The Guidelines are intended to assist all those involved in the formulation or reform of legislation governing nursing education and practice to ensure that regulatory systems promote and enhance the role of nurses in meeting health needs of populations.

The Guidelines give recognition to the fact that the intention stated above cannot be fulfilled by the actions of nurses alone. Thus the Guidelines highlight the essential involvement of other individuals and groups who may facilitate the establishment of new law or the reform of current legislation.

The stages in achieving legislative changes are set out for guidance. Options and examples are given, where possible, to enable the user of the Guidelines to assess the need for, and to plan and implement a strategy most appropriate and relevant in a given situation. Thus, not all sections of the Guidelines may be seen to be appropriate for every situation, but they are meant to be comprehensive as well as general. It will be for the user to decide what is essential for fulfilment of a specific National or State need.

The Guidelines are not necessarily intended to form a sequence of actions; many of the activities can and should run in parallel. This is why the five individual sections of the Guidelines (especially sections I, III, and V) contain much in common and may, on initial reading, appear repetitive. This mode of presentation has been deliberate in that it allows for ease of reading and understanding by avoiding complex cross referencing.

The Guidelines are divided into five sections:

- I. Goal and principles of professional legislation and regulation
- II. Legal constraints
- III. Strategy for developing concepts for regulatory and legislative change
- IV. Achieving change
- V. Monitoring and evaluation

First, the section on goal and principles sets out the purpose of a system to regulate the education and practice of nursing and explores the principles which should underlie the regulation of nursing.

Second, "Legal Constraints" deals with the investigation and analysis of current laws and regulations, not solely those directly pertinent to nursing, which may inhibit or restrict the role of the nurse in primary health care. A checklist for reviewing existing laws and regulations is included and suggestions made as to how the review or analysis might be undertaken.

Third, the "Strategy" explains the wide scope of legislation and regulation from the primary act to subordinate regulations and advice and guidance and the possible place for each in the regulatory system; it also explains who generates change and how to prepare for such change. The stages in the preparation of legislation are illustrated in the form of a diagram for ease of reference.

Fourth, "Achieving Change" stresses the need to involve a wide range of other individuals and groups. Stress is placed upon educating them about the need for legislative change and attempting to change their views and opinions where necessary. These are essential steps prior to the introduction of legislative change. This section continues with an explanation of the important stages in seeking to achieve the changes; the involvement of identified allies; and the persuasion of opponents in seeking to achieve the suggested reforms. The importance of presentation and dissemination of the issues are explored and suggestions made on how to handle the different audiences. The important matter of lobbying and use of the media are also covered.

Fifth, "Monitoring and Evaluation" recognizes that securing the passage of legislative reform is of itself not enough; it is necessary to ensure that legislation is implemented and that the intent behind the changes is being met. The means of ensuring these important issues are suggested.

Not all the sections of the Guidelines may be of equal importance in a specific case. Nevertheless, it is recommended that the user should first read the Guidelines as a whole in order to examine each proposed stage before deciding which specific steps should be carried out, in which order, or whether in parallel with other initiatives.

Annex 1 contains one example of defining an educational programme for nurses that states the competencies to be achieved rather than detailing specific tasks. Over-specificity of tasks may inhibit the expansion of the role of the nurse in primary health care.

Annex 2 consists of two parts. Part A gives the conclusion and recommendations of a WHO Study Group on regulatory mechanisms for nursing training and practice. Part B shows the results of a survey undertaken by WHO of the frequency with which 15 nursing tasks relating to primary health care are authorized in 81 countries, and the mechanisms whereby authorization is given. The survey concludes that there is a worldwide tendency to extend the scope of nursing practice and indicates the variety of mechanisms used to achieve this.

Annex 3 also consists of two parts. The first part presents a checklist of the basic elements of a regulatory framework for nursing education and practice. The second part presents examples of legislation concerned with components of the regulatory framework particularly relevant to the education and practice of nurses for primary health care.

Annex 4 offers a list of names and addresses of people and professional organizations and agencies that can be used as a source of information on legislation governing nursing education and practice.

Introduction

- 1 The World Health Organization (WHO) and its Member States attach great importance to the promotion of primary health care strategies to achieve the social goal of Health for All by the Year 2000. This commitment is eloquently set out in the Declaration of Alma-Ata, according to which primary health care is:

“... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”¹

The Declaration specifies eight essential components of primary health care:

- education concerning prevailing health problems and the methods of controlling them;
- promotion of food supply and proper nutrition;
- an adequate supply of safe water and basic sanitation;
- maternal and child health care, including family planning;
- immunization against the major infectious diseases;
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and injuries; and
- provision of essential drugs.

- 2 In order to achieve the goal of Health for All by the Year 2000, it is necessary to enlist the services of all health care personnel. Nurses* constitute an important group of health care providers. They are the most numerous and most widely dispersed health professionals in virtually all countries. The very nature of their work and their closeness to the people in the community provide a unique basis for an effective role in primary health care.

Nurses can play a more dynamic role if the factors that impede them from making the most of their training, experience, and potential are re-

* For the purpose of these Guidelines, a "nurse" is defined as a person who has satisfactorily completed a programme of basic nursing education and who is qualified in his/her country to practise nursing. Where in individual countries it is relevant, the midwife may be included in this definition.

moved. Training in highly specialized settings, geared more to curative rather than preventive services, and the lack of appropriate preparation to provide the necessary orientation, knowledge, and practical experience to work in primary health care settings have, among other reasons, prevented the effective integration of nurses into the primary health care effort.

- 3 There are also legal and regulatory constraints that impede nurses from playing a wider role in primary health care. As a meeting in 1981 on nursing in support of the goal of Health for All by the Year 2000 succinctly said:

“Nursing practice and education are governed by legislation that is often archaic, determined by persons of other disciplines, detrimental to the status of the nurse, and not in tune with the needs of society. The primary health care strategy involves the re-evaluation of old policies and this must certainly include nursing legislation.”²

In 1985, the deliberations of a WHO Study Group led to the issuance of a report on regulatory mechanisms for nursing training and practice to meet primary health care needs.³ Its conclusions and recommendations are given in Annex 2. These Guidelines were produced in accordance with the recommendations of this Study Group.

- 4 These Guidelines provide a focus to examine legal and regulatory constraints on the role and full participation of nurses in primary health care and to consider how these might be removed. The Guidelines are based on the premise that legislative and regulatory support is necessary to maximize the contribution of the nurse in the development of primary health care and community health. The aim of these Guidelines is to ensure full involvement of the nurse in undertaking the essential components of primary health care. Law should not place unnecessary barriers in the way of delivering health care services to people. Furthermore, the law should serve affirmatively to promote the provision of health services and strengthen the role of health care providers.

- 5 These Guidelines are made up of five sections: they discuss the goal of nursing legislation and regulation, and the principles that characterize it; the legal constraints affecting the role and practice of the nurse in the context of primary health care; a strategy to develop regulatory and legislative change; how legislative changes can be promoted and implemented; and how to monitor and evaluate the changes enacted.

These five sections, especially I, II, and III, contain much in common; therefore the discussions should not be regarded as sequential.

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The Guidelines are principally addressed to and for use by:

- nurses at all levels of practice seeking the advancement of primary health care;
- nursing educators and managers;
- administrators involved in developing primary health care strategies;
- nurse associations and trade unions;
- professional and statutory bodies which may be charged with enforcing legal instruments, with regulation of the health professions, and with making proposals for law reform; and
- legislators and Ministry of Health officials concerned with the development of primary health care.

Section I

The Goal and Principles of Professional Legislation and Regulation

- 7 Most countries have legislation to determine the practice of the health professions, including that of nursing. Laws governing the practice of medicine, nursing, and pharmacy, the regulations issued under these laws, and a range of public health enactments may define what nurses can or cannot do. Some laws set out detailed requirements for mandatory licensure in order to practise; other laws are permissive and allow the practice of nursing by unlicensed persons but prohibit the use of the designation "nurse" or "registered nurse", except by duly qualified persons.
- 8 Typically, nursing practice laws define "practice" in broad and often vague terms. In addition to the law regulating the nursing profession, other controls may have a bearing on nursing practice: the laws regulating the professions of medicine and pharmacy; the rules and regulations of a Nursing Board or Council; regulations of the Ministry of Health; professional codes related to standards and ethics; and even the rules or by-laws of an individual hospital.
- 9 Thus, legislative and regulatory practices and mechanisms vary from country to country, and indeed, where regulation is the responsibility of a state or province there may be regional variations even within a single country. There is, however, much in common about the underlying philosophy and rationale of professional regulation which is of universal application.⁴
- 10 The goal of a system to regulate the practice of nursing is to:
- establish, monitor, and enforce essential standards; improve and sustain education, training, and practice; and provide a framework for nursing practice relevant to meeting the health needs of the population and protecting the public;
 - provide public authority, credibility, protection, and support to permit nurses to perform to the maximum extent of their capabilities;
 - promote regulation of the profession of nursing by nurses in order to ensure appropriate standards of education and practice;
 - permit and encourage nurses to participate in, and influence public debate on, health policy; and
 - ensure that each of its practitioners is accountable to the public for nursing practice.
- 11 In addition to the legal and regulatory frameworks and mechanisms to govern the profession, there should be comparable provision in labour regulations to guarantee and safeguard the working conditions of, and

systems of remuneration for, practitioners. These aspects of professional life are of central importance to the role of nurses and need to be considered in the context of developing primary health care and extending health service coverage.

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From these general statements, it is possible to derive a number of general principles and policy objectives that characterize the regulation of nursing. The following ten principles merit consideration:⁵

- (a) *The main objective of regulation is the protection of the public.*

The primary purpose of nursing regulation is the protection of the public by ensuring that nursing care is provided by qualified and competent practitioners. The benefits to individual practitioners and the profession as a whole, which may accrue from professional regulation, are secondary to this overriding principle.

- (b) *Legislation must be conceived and drafted to achieve its stated purpose.*

If regulation is to achieve its stated purpose of protecting the public, the legislative framework must cover a number of activities. These will include:

- (i) the regulation of nursing education and training

These provisions will include admission requirements for entry into programmes of training; the criteria and mechanisms for approving the institutions which provide the training; a definition of the length of training and its content in broad outline, including the kinds and range of clinical experience that may be required; a definition of the objectives, standards, or outcomes of the training, and details of how the training is to be assessed and how each person's eligibility to become a qualified practitioner is to be evaluated (e.g., examination arrangements, whether character assessments will be required).

- (ii) the maintenance and updating of knowledge, skills, and attitudes

This should be accomplished particularly by means of continuing education programmes and continual evaluation and revision of such programmes and practice.

- (iii) the definition of scope and standards of practice

- (iv) the mechanisms for disciplinary actions by reason of personal or legal disability, infractions of standards of practice, or unprofessional conduct.

- (c) *Regulatory standards must be based upon a clear statement of (i) the role and responsibilities of the nurse and (ii) professional accountability.*

The outcome of the training programme, i.e., the competencies to be achieved by the nurse, the areas of practice, and the skills for which he/she is trained should be made clear (Annex 1). The personal responsibility of each practitioner for professional judgements should also be made clear.

The different degrees of professional and managerial accountability of the nurse to the patient, the health care team, the institution, and

the public should be acknowledged and, where appropriate, be defined.

- (d) *Regulatory frameworks should encourage and give scope for the development and the enhancement of competence to achieve safe and effective practice.*

Nursing, like any other profession, should be encouraged to develop and to increase its capacity to serve society. Health care needs change and expand, as do the expectations of society. Nurses should be able to respond to these developments and increase their skills to meet new and emerging challenges.

- (e) *Regulatory mechanisms should acknowledge that nurses work with others in health care and that the legitimate roles and responsibilities of other interested parties and professional groups have to be accommodated.*

However central the role of the nurse may be in the provision of health care, he/she is not the only interested and involved party. Recognition must be given to those in other disciplines, e.g., medicine, pharmacy, social work. Additionally, governments have a role in the overall determination of health care policies and general patterns of care and they are ultimately responsible for formulating and implementing public policy. The rights, duties, obligations, and roles of employers, employees, trade unions, and regulatory bodies have to be taken into account.

- (f) *Regulatory mechanisms must pay due regard to the need for adequate and appropriate representation.*

Laws and regulations establishing regulatory bodies are required to take into account the need to balance different professional nursing interests and areas of professional nursing practice. Where appropriate, the interests of other related disciplines and professions need to be represented as well. It is important to try to ensure that any discipline is not over-represented or under-represented. It is also important that professional regulatory bodies contain some 'consumer' representation of the wider public interest and be able to challenge professional assumptions. However, a profession should seek to achieve self-regulation and the regulatory body should comprise a majority membership of nurses.

- (g) *Regulatory mechanisms must be sufficiently broad and explicit to achieve their objective, but at the same time allow for flexibility for innovation, development, and change.*

Laws, rules, and regulations need to be drafted in such a way that their objectives are clear. The statutory scheme and its provisions should permit the fulfilment of stated objectives. It usually takes a good deal of time to enact legislation and finalize regulations. Once accomplished, it is difficult to introduce legislative changes repeatedly and frequently. Therefore, it is essential that the law provide for a certain degree of flexibility to introduce changes which are beneficial or necessary. A balance needs to be maintained between what is to be incorporated in the principal statutory instrument and what should be left to subsidiary

legislation or administrative regulation. Thus, choices should be made as to what is to be enshrined in the principal statute, usually a Government Act (which is difficult to amend in the short term); rules or regulations with the power of law (relatively easier to change); and codes, and advice and guidelines, which may be more readily modified to meet changing needs (see Figure 1). The positive role of the law can be enhanced if legislation dealing with primary health care contains a requirement that nursing education and standards shall not only be established, but developed and improved. The law should not restrict the reorientation of nursing education designed to equip nurses for work in all health care settings. This reorientation would allow the nurse to carry out the functions as required for the delivery of the essential elements of primary health care as described in the Alma-Ata Declaration.

(h) *Regulatory mechanisms should be comprehensive and coherent.*

Legislation and regulatory mechanisms concerning health and the delivery of services should encompass and include a range of activities and personnel. For example, professional responsibilities should cover both education and practice. Governmental functions and responsibilities relating to the regulation of nursing may be included. However, to minimize confusion, it is important that regulatory mechanisms (i) define and clearly distinguish the roles and functions of different health care providers and others concerned and (ii) help to identify responsibilities, promote cooperation, and foster coordination. There should be a clear definition of the preparation for practice and maintenance of standards for different categories of nursing personnel.

(i) *Regulatory systems should reflect, and be responsive to, a country's health care needs and should seek to promote national standards of performance fostering a national professional identity.*

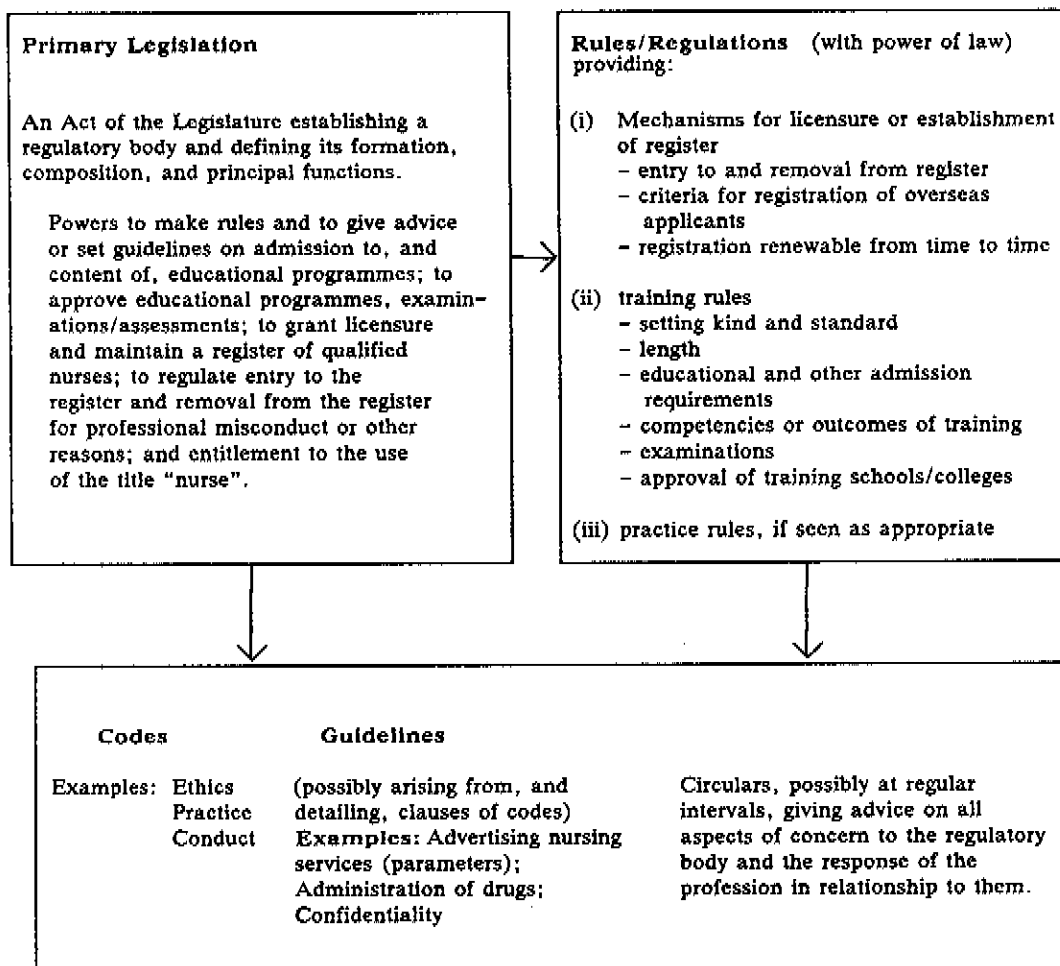
It is an ambitious but nevertheless important goal to develop a consensus on national standards of nursing practice and foster a common professional identity. If the goal of Health for All is to be achieved, it is important that relevant standards of education and practice are set to meet the individual country's health care needs. The development of criteria which have national recognition, consistency, and relevance should assist countries to develop and enhance standards.

(j) *Regulations must be equitable, fair, and reasonable.*

Any regulatory system must not only be fair but also be seen to be fair. The law should provide for procedures so that those who will be involved and affected by the regulatory system will be informed of (i) the standards for practice and the criteria for assessing them, (ii) the regulatory processes, and (iii) the right to appeal from decisions of the regulatory body. Any process of change must take account of existing practitioners, and mechanisms for protecting their rights should be designed.

13 The ten principles enumerated above are not necessarily comprehensive, but they represent the essential requirements that proposed legislation and regulatory mechanisms must seek to satisfy.

Figure 1 Formulation of nursing regulatory mechanisms stemming from legislation that can readily respond to changing needs



Section II

Legal Constraints

- 14 It is important to investigate and analyse the extent to which any current laws and regulations inhibit or frustrate the role of nurses in primary health care. Account needs to be taken not only of the written law, but also of how it operates in practice and the various interpretations which may be given to it. The assistance of a lawyer at the earliest stage of this analysis will prove invaluable.
- 15 There are two main areas to be explored:
- the effect of existing legislation on nursing education and practice;
 - the effect of existing laws and regulations on the preparation of nurses for work in primary health care.

In respect of these two areas, many detailed questions can be considered. For example, are laws and regulations governing nursing education and training and examination and assessment principally concerned with the preparation of practitioners who will function in acute or specialized, mainly hospital-based services? To what extent is there recognition in curricula and training rules of the kind of preparation needed to equip nurses to fulfil an expanded role in preventive, curative, and primary health care services? Is specific provision made in training programmes to ensure practical experience in primary health care settings? Similarly, in looking at regulations concerned with practice, do these unreasonably restrict and hinder the activities or functions of the nurse in primary health care settings to the detriment of patients and clients?

- 16 In reviewing and analysing existing legal provisions, there are four main categories of laws and regulations that need to be scrutinized. They are:
- (a) *Those that regulate the practice of medicine, pharmacy, and other related health care professions*
- Such laws and regulations may affect a nurse's ability to practise fully in primary health care settings, either explicitly, by assigning certain functions to non-nurses, or implicitly, because of a restricted definition of the practice of nursing. In this exercise, it is important to bear in mind the tasks in which nurses should be fully involved. A checklist to assist in this analysis is set out in paragraph 17.
- (b) *Those dealing specifically with primary health care*
- Such laws and regulations may set out the goals and objectives of primary health care that may have a much wider scope than purely clinical matters. It may be that the fulfilment of the nursing role is frustrated through adherence to a traditional, hospital-based orientation of nurses and an excessive dependence upon other health care professionals, or failure to recognize the appropriate contribution of nurses in primary health care.

(c) *Those that are principally concerned with the various aspects of nursing education, training, and practice*

These will differ from country to country, but will include any laws governing nursing education, practice, and professional conduct. Other important and relevant enactments will be concerned with factors such as:

- administration, prescription, and distribution of drugs;
- abortion;
- family planning and contraception;
- registration of births and deaths;
- notification of communicable diseases;
- immunization;
- establishment of relationships with relevant community groups;
- responsibilities for the planning, implementation, and evaluation of care; and
- treatment of primary illness.

(d) *More general laws, regulations, policies, and guidance governing public affairs*

The range and types of documents that will need to be scrutinized and analysed because they might have a bearing on the activities of the nurse within primary health care will include:

- ministry of health regulations;
- public health circulars/codes;
- drugs and medicines acts;
- Governmental decrees;
- opinions of health ministers;
- court judgements that set precedents;
- codes of professional practice and conduct;
- religious and customary law; and
- policies of health departments and other agencies allied to development plans.

17 In reviewing existing laws and regulations, the following checklist of questions may be helpful:

- (a) Are nurses adequately prepared and authorized to perform the basic functions needed in primary health care? namely to:
- recognize accountability to clients, the public, and institutions, and to accept personal responsibility for decisions and actions;

- assess the health care needs of individuals, families, and the community;
- communicate to other professionals all information relevant to ensure coordinated, high-quality care;
- plan, with other members of the health team, the delivery of preventive, promotive, diagnostic, curative, and rehabilitative services;
- administer and manage the provision of health care;
- train and supervise auxiliary nursing personnel, community health workers, and volunteers;
- maintain records and statistics on the delivery of care;
- cooperate with other sectors related to health, including nutrition, social service, housing, water supply, and sanitation;
- involve the patient, family, and community in self-help and the provision of primary health care;
- evaluate the delivery of services; and
- identify issues warranting further study and research.

(b) Are nurses adequately prepared and authorized to perform, as part of their regular role, essential tasks in primary health care? for example:

- diagnose common diseases;
- perform physical examinations;
- undertake simple diagnostic tests;
- refer for X-rays and other diagnostic tests;
- manage common diseases;
- prescribe and administer drugs for common ailments;
- give injections;
- provide immunizations;
- handle trauma in emergencies;
- perform minor surgical procedures;
- prescribe oral contraceptives; and
- insert intra-uterine or other contraceptive devices.

(c) Does a particular law or regulation hamper effective nursing training for, and performance in, primary health care? If so, in what way?

(d) If a particular law or regulation is restrictive, but alternative methods are used to avoid the restriction, such as authorization by the Ministry of Health or standing orders, are the alternative methods clear, unequivocal, and satisfactory? Do they provide sufficient authority for the nurse to act?

- (e) If a restrictive law is not enforced, does its continued existence on the statute books nevertheless deter an appropriate expanded role for nurses and the education necessary for this expanded role?
- (f) What examples can be cited from the experience of primary health care centres and sub-centres of the specific ways in which restrictive laws and regulation have impeded the best provision of primary health care services?

18 The task of describing and analysing the current legal provisions and their influence and effect on the delivery of primary health care and the role of the nurse will not be easy for two main reasons. First, the various laws and regulations will, in all probability, not be collected together; therefore, unearthing them, listing them, and highlighting their deficiencies is likely to become a long and complex task. The person undertaking this work is always vulnerable to the criticism that something has been overlooked or forgotten. Second, the analysis of the effects and implications of regulations will involve questions of interpretation and judgement. In undertaking this work, the skills and experience of lawyers, social scientists, and other professionals should be enlisted. It will be helpful to adopt an analytical framework that will identify existing controls relating to primary health care functions. The tables in Annex 2 identify nursing tasks relating to primary health care, who authorizes each task, and the method of authorization in various countries.

19 There are a number of alternative ways in which this analysis might be undertaken by involving educators, practitioners, representatives of regulatory bodies, and professional associations as well as relevant members of the public. For example:

- national libraries, legislative offices, and national archives may be able to provide comprehensive lists of enactments and appropriate bibliographies;
- questionnaires may be prepared and distributed to gather up-to-date information on the role of the nurse in primary health care;
- a university college or law school may be invited to help with the analysis, and this work might form part of student assignments;
- a working group of nurses may undertake the work, drawing upon the skills and help of other professional disciplines.

20 Such an analysis will help identify existing barriers to the role of the nurse in primary health care; it will also highlight ways in which current laws might be changed and suggest the basis on which new legislation and guidelines might be drafted.

Section III

A Strategy for Developing Concepts for Regulatory and Legislative Change

- 21 This section suggests ways in which the content of any regulatory/legislative change should be considered (see Figure 2).

The scope of legislation and regulatory change

- 22 The terms "legislation" and "regulatory change" cover a wide range of possible activities. The following options need to be considered:
- (a) *Interpretation of existing laws*

It is possible that clarification of the existing law may be sufficient, both to remove any existing barriers, and to stimulate desirable changes in attitudes towards, and practice within, primary health care. This option requires the least change.
 - (b) *Regulations and notes of guidance*

Given that the processes to achieve changes in the law are time-consuming and generally complex, the authority of government departments and statutory regulatory bodies to issue regulations and notes of guidance should be explored. The advantages of this course are clear. First, it is likely to be administratively straightforward and, second, regulations and notes of guidance are easily amended in the light of experience. The possible disadvantages that will need to be looked at most carefully concern the weight and authority that notes of guidance carry, i.e., will they give sufficient authority to allow nurses to perform necessary functions? Such notes of guidance may be deemed to be only advisory by some groups and, lacking the full force of the law, they may be disregarded.
 - (c) *Joint statements by the professions*

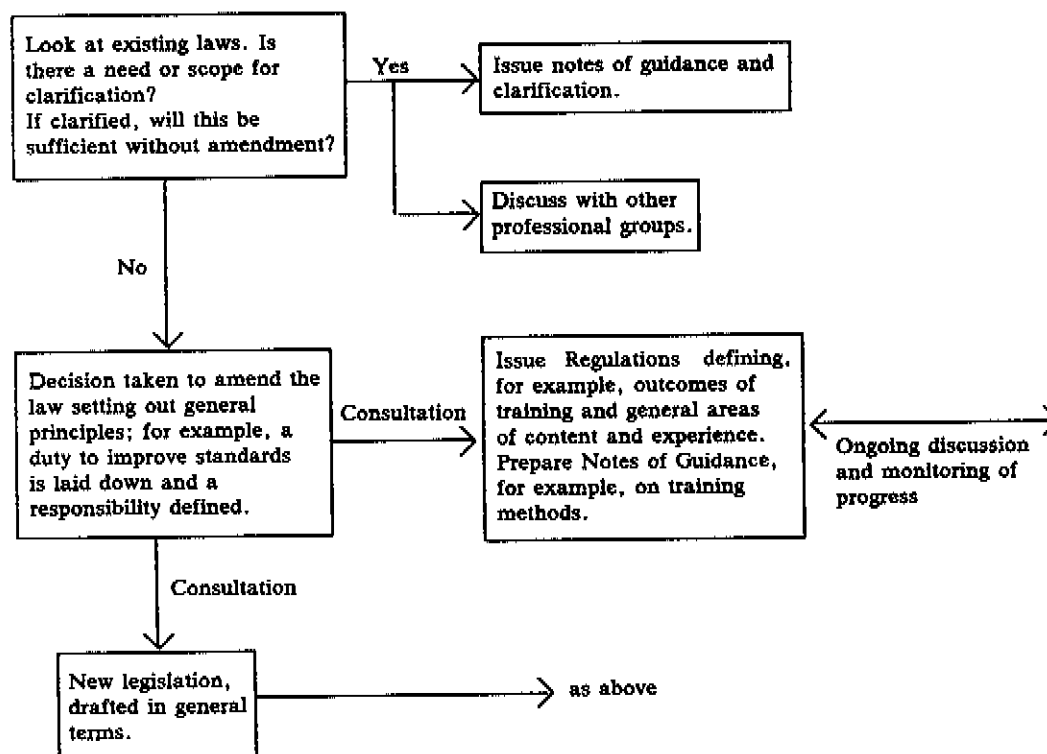
Some of the constraints which inhibit the role of the nurse will be concerned with the roles and responsibilities of different professional groups providing primary health care. It may be that the expanded role of the nurse in health care involves assuming tasks and responsibilities that have been viewed traditionally as the exclusive province of doctors or pharmacists. The various professions will need to meet to discuss such issues and define joint policy statements. Such statements may again lack the force of law, but if jointly issued by professional or statutory bodies, they are likely to be heeded.
 - (d) *To enact new or amended legislation*

The first issue to be considered is the scope of any legislative reform. Is the objective to secure new legislation or is it sufficient to change and amend existing provisions? The procedures and the work involved in either process are comparable, but it is necessary to make a strategic decision about the nature of the reform being sought. It may be that reforming and amending existing laws will

achieve the objective of enhancing the nurse's role in primary health care. A more radical approach might be required and new legislation be seen to be the answer. If so, a judgement will need to be taken about whether any new legislation should be concerned with nursing generally, including primary health care, or whether the focus should be principally on primary health care. In either event, it will be important that an interpretation of the eight essential elements of primary health care be used to enhance all areas of nursing practice, thus ensuring an expanded role for nurses throughout the health care system.

- 23 The principal task in changing regulatory provisions is to clarify what the objectives of legislation should be and what detailed provisions will be required to enable those objectives to be met. A review of existing legal provisions may help to clarify thinking about what is wrong and may help answer questions about what is not needed. Setting out what will be required, and stating objectives positively, may be more difficult. Although there will be an understandable desire to see change introduced as soon as possible, the opportunities to make legislative and regulatory changes do not often occur, and it is vitally important therefore to try to guarantee that the changes being sought are necessary. This requires recognition of the need for deliberation and the study of options before seeking change.
- 24 A further general point about legislation: in view of the time it takes to change a law, careful consideration should be given to the form of any enactment. A law may set out objectives, responsibilities, and tasks in broad terms. Such legislation may be supplemented by regulations and notes of guidance issued by government departments or statutory bodies. This can be facilitated if the law indicates that the bodies concerned have power to detail requirements and issue advice. If minimum standards and responsibilities are enshrined in law – and these principles are unlikely to change dramatically in the short-term – more detailed advice and guidance can be issued in other ways. This detailed guidance will need to address and even anticipate changes in health care needs and services. It is easier to amend supplementary regulations than to change laws. With respect to legislation to regulate nursing education, for example, the law might simply state which body or authority is responsible and the objectives of education might be set out. Detailed information about curricula, teaching methods, etc. are more appropriately handled through notes of guidance/advice (see Figure 1).
- 25 The specific objectives of legislation will vary from country to country, but the following key questions will need to be addressed:
- (a) What type of legislation will be needed to encourage nursing educators to give full recognition to preparation for primary health care? Should regulations governing education require more emphasis on training in primary health care? Should more emphasis be put on multidisciplinary cooperation and shared learning? Should the clinical care setting required in training include placements that stress primary health care?

Figure 2 Manner of consultation to achieve regulatory and legislative change



(b) How is the practice of a nurse to be redefined? For example, should the law specify the functions that a nurse is entitled to perform on her own, and those that she can undertake under direct medical supervision? Should the law give authority to the nurse to undertake certain functions? Should the law seek to define specific functions that a nurse is entitled to perform only in certain settings, for example, a health centre? In answering such questions it is useful to bear the following in mind:

- The advantage of specifying particular functions that the nurse may perform is that the scope of authority is perfectly clear. The disadvantage is that this specification itself may prove restrictive.
- The advantage of authorizing a broadened scope of functions generally (authorizing certain specific functions but not limiting the nurse's functions to these) is that, as new functions are needed, and nurses are trained for them, it is not necessary continually and repeatedly to amend the law or the regulations. The disadvantage is that such a strategy may encounter opposition.

(c) Should medical practice legislation be amended to give greater scope to the nurse in primary health care?

- (d) Should legislation on pharmacy and administration of medicines be changed to allow nurses to prescribe and administer from a specific list of drugs and to prescribe and dispense oral contraceptives?

26 The constraints imposed by legislation discussed in Section II will help to identify and isolate the functions that nurses should be able to carry out in primary health care.

Generators or initiators

27 There is no single authority or focus for change to stimulate primary health care developments. In some countries, initiatives may be taken by the government; in others, a professional nursing association or a statutory body will usually take the lead. In still others, the quest for change may come from a group of nurses.

Preparing legislation

28 The first stage in preparing legislation is to define what the purpose or intent of the new law is or what the amendments should be seeking to accomplish.

Discussions among nurses, health officials, and lawyers will be necessary at an early stage to arrive at a common understanding of the intent and character of the changes desired.

29 The extent to which it is necessary to draft legislation will depend upon the group/body seeking the change and its relationship with, and access to, experts in legislative drafting. For example, it may be sufficient to present a report to a Ministry setting out the purpose and intent of any legislation and it will be for the Ministry to accept responsibility for legislative drafting. In other circumstances it may be necessary to present draft legislation. In certain situations, drafting the legislation may be the responsibility of more than one ministry, e.g., Ministry of Health, Ministry of Education. In such cases there is great need for collaboration and coordination; a bridging mechanism may need to be set up.

30 Preparing legislation in the appropriate form is a skilled task, and expert help should be called upon.

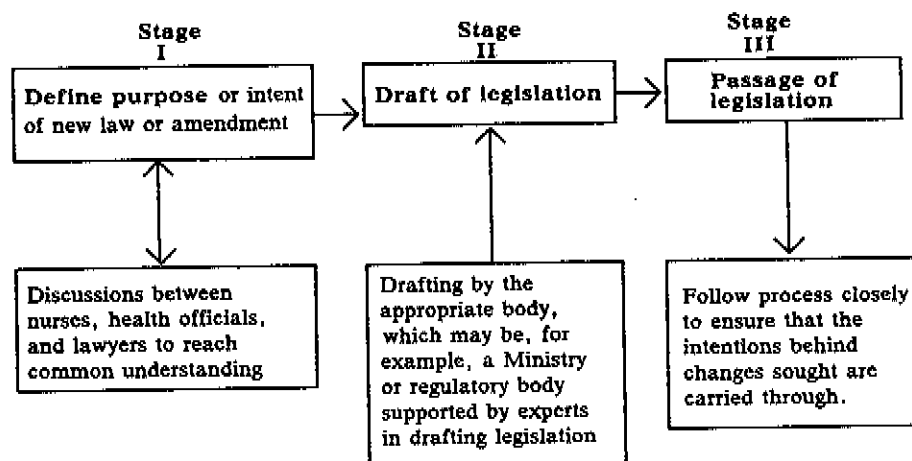
31 It is also important to understand the processes for the consideration of legislation and the opportunities there may be to make amendments. This is important not only for the sponsors of change, but also for any opponents. The passage of any legislation needs to be followed closely to ensure that the intentions behind the changes sought are carried through and that any amendments do not change the character of the legislation (see Figure 3).

32 Whenever and for whatever purpose the desire to provide change comes, any consideration of future legislation should take into account the need to provide for the maintenance and enhancement of professional

standards and where the responsibility for this should lie. Ideally, the responsibility for the regulation of the nursing profession, which will include the establishment, monitoring, and maintenance of standards, should lie with the profession itself. This can be achieved by the establishment of a regulatory body composed principally of nurses and accountable to the public. It may be that the Ministry of Health will accept a more direct responsibility for aspects of professional development. Whatever regulatory mechanisms are developed, responsibility for the various aspects of primary health care should be identified so that effective monitoring systems can be created and proper accountability be instituted. The functions of the regulatory body, which for ease of reference we will refer to as a "Council", should be succinctly defined in the primary legislation. The definition should be a short, facilitative one, giving clear legal powers and allowing for the development of rules, regulations, codes, and guidelines that are relatively simple to change in response to changes in health care needs, particularly those allied to primary health care. For example:

"The principal functions of the Council shall be to establish and improve standards of training, practice, and professional conduct for nurses and the powers of the Council shall include the means of determination by rules, regulations, or provisions of advice to nurses in such manner as it thinks fit."⁶

Figure 3 Stages in the preparation of legislation



A short and seemingly simple definition of functions in this way, enshrined in law, provides a framework of substantial power to a regulatory body. Certain key words in the above definition are highlighted and briefly explored.

"Principal Functions"

By giving expression in this way the definition implies that whilst these are the principal functions, the Council is by no means limited in its role; the inference is that it has other functions.

“Improve”

This gives the Council, having established its standards, legal power and obligations to develop systems to meet change in health care needs, which will facilitate moves towards training and practice in primary health care.

“Rules” and “Regulations”

These give the Council the power to state mandatory requirements associated with its functions.

“Advice”

This gives the Council the facility to issue guidelines on practice, codes of professional conduct, and training and development on a continuum.

In formulating proposals for legislative change, it is useful to take note of the following approaches:⁷

(a) *Provide for authorization*

In order to enable nurses to perform new tasks, they need to be granted special authorization. This can be accomplished by (i) modifying or repealing existing restrictive provisions, (ii) granting special exemptions, or (iii) changing the definition of the scope of nursing practice to include nursing assessments and nursing interventions.

(b) *Expand the scope of training*

Laws and regulations that do not enumerate in detail the individual tasks and functions that may be performed by nurses permit them to perform such tasks and functions for which they have been trained. Thus, by altering the curriculum content nurses will be able legitimately to assume new roles and functions in primary health care.

(c) *Expand opportunities for obtaining qualifications*

Through appropriate opportunities for gaining more experience, nurses can satisfy requirements relating to qualifications in order to become eligible to perform new roles and tasks in nursing assessments and nursing interventions.

(d) *Provide for supervision*

The degree of supervision that may be exercised over the manner in which roles and tasks are performed by allied health personnel varies from country to country, depending on factors such as the availability of such personnel for supervision and the training and skills of those who need to be supervised. By delegating certain tasks and functions to be performed under supervision, nurses will be able to play a broader role.

(e) *Develop a referral system*

Nurses can be authorized to perform new tasks and roles by providing reasonable access to a referral system.

Section IV

Achieving Change

- 33 The stimulus to winning change will inevitably vary from country to country. It may be a professional group, an ad hoc group, a Ministry of Health/Education initiative, or a policy review instituted by a national council or statutory body. Wherever the movement for change originates, the process of gaining acceptance of these changes and implementing them is complex. There is no single "right" approach or logical sequence of steps to be taken. Essentially, all potential sources of support and of opposition have to be identified, and whilst enlisting the support of the former the latter must be persuaded and won over. There are, however, three important points to be noted.

First, try to analyse and understand the decision-making process and identify the critical stages in the process and the important people and institutions influencing the process. Second, the timing of any initiative to seek change is important and judgements may have to be made about withdrawing or postponing activities if the time is not opportune. Third, in seeking legislative changes particularly, an appropriate approach needs to be adopted, using to the maximum extent any opportunities for action presenting themselves. Although plans may not have fully developed, an opportunity may nevertheless occur to present proposals for change. This might come about because an otherwise isolated or insignificant event or incident may suddenly make nursing and/or primary health care an issue of national interest and importance. Any opportunity that enables the changes to be promoted needs to be seized.

- 34 Achieving legislative change involves changing views and opinions. Whilst the law itself can act as a catalyst of change, it is desirable that public attitudes be sympathetic to change and that people know the reasons why changes are being made. Thus, it is important that education of the public should precede the introduction of legislative changes of this nature.

- 35 It is also important that proposals for change should be presented in a positive way. To advance an argument for the further development of primary health care could well be taken as a criticism of the national policy on health. To be overly critical of current practice and systems can be misconstrued as a challenge and may invite opposition on the one hand and undermine public confidence on the other. The case for change must be carefully presented, taking into account sensitivities and feelings of health administrators, other health professionals, and the public.

Define and state objectives

- 36 The first stage in seeking legislative change must be to define and state the changes that are required. The most obvious way of doing this is to write a report. A document on the role of nursing and primary health care will be read by different audiences who will attempt to understand the document from their own particular perspective. First, it is important

that any document should be precise and succinct and avoid technical and professional jargon as much as possible. Second, the reasons for seeking change must be analysed and spelt out with a clear indication of the benefits that will accrue to individuals and society.

37 The status of any document should be made clear. For example, a report, which may set out proposals for change, might be issued as a basis for consultation following which more detailed and definitive proposals can be prepared. If this is the case, the document should clearly indicate its status. If only some proposals in a report are open to consultation and negotiation, this should also be made clear. Consultation which is neither serious nor genuine generates both criticism and antipathy.

38 A fully documented report may be of limited value to a number of potential audiences. Ordinary members of the general public are not likely to read a lengthy document, and a hard-pressed and busy Minister will also demand something shorter. But a fully comprehensive report is needed for some audiences. On the basis of such a document, summaries or shorter reports can be prepared for different audiences.

Identify allies and opponents

39 There must be opportunities for consultation and for involving all interested parties in discussion, particularly when change is anticipated. Individuals, groups, and institutions most likely to be helpful should be identified and strategies for enlisting their help should be worked out. Potential friends and allies should be enlisted by circulating copies of the report and by arranging meetings to encourage them to support change and to lobby for it. They should be asked how they might lend support so that the campaign for change can be well orchestrated.

40 Each country will be able to identify the groups to be addressed and assessments can be made of their likely support or even antagonism to the proposals for change. Groups that need to be considered will include:

- central government: ministries of health, education, justice, development, finance, and women's affairs;
- local authorities and bodies responsible for health;
- political parties;
- professional bodies representing nursing, midwifery, medicine, pharmacy, allied professions;
- nongovernmental organizations in the health sector;
- community and religious leaders;
- consumer groups and patient groups;
- teachers, social workers, and community groups; and
- bar associations and other lawyers' groups.

41 The above groups are potential allies. Each group should be approached individually, after having determined what the best approach is and the type of arguments that are likely to be persuasive. At the stage when any proposal becomes the subject of public debate, it is important that the nursing profession as a whole be fully involved in consultation and discussion. It is perhaps unrealistic to anticipate that nurses will always find common ground on every issue, particularly if the proposals are contentious or are politically sensitive. It is important that the profession have every opportunity to comment on the draft proposals with a view to developing a consensus through reasoned discussion, compromise, and accommodation. Individuals who do not share the final decision should nevertheless abide by the majority view and refrain from publicly condemning the decision.

Make proposals known

42 The proposals for change should be widely disseminated. This can be achieved through a number of ways:

- circulating the full report;
- preparing and circulating summaries of the report;
- preparing a video, tape, or slide presentation explaining the proposals; and
- arranging professional and community meetings to discuss and gain feedback on the proposals.

There will be many different ways of presenting sometimes complex issues in an imaginative and simple way. Lengthy documents are not the sole and most effective means of communicating ideas. It is crucial that the form chosen to disseminate proposals match the audience and be appropriate to it. A simple format may well meet the needs of members of the public and be an effective and low-cost way of eliciting a response. For example, an eye-catching pamphlet might be designed that sets out in a short paragraph the intent behind the changes sought, linking them to issues of concern to the consumer and highlighting the benefits that will accrue. This paragraph could be followed by a list of the important recommendations that support the changes required. The text might end by referring to the detailed published report and indicating where it can be obtained, what arrangements are to be made to discuss the report and its recommendations with the public, and how and where consumers might participate in the consultation. A presentation to a medical association or a ministry of finance, however, will need to address different issues, and the document will have to use a different approach and different terminology.

43 For any audience it is important to put across two essential themes and messages. First, to present the case for change and the underlying reasons. Second, to try to convince people that the proposals being put forward are realistic, attainable, and meet current problems and deficiencies.

44 If the different audiences can be identified in advance, it is useful to demonstrate how any proposals for change would fulfil the interests or

the expectations of any particular audience. The public might be shown that changes would improve patient/client care, ensure safe and competent practitioners, reduce the waiting time for treatment, give greater access to health care services and support, and generally improve health conditions in the community. The Ministry of Finance will be impressed with arguments on the cost-effective use of resources and the development of more relevant and responsive health care services rather than descriptions of the challenge to nursing education. Doctors may need to be reassured that their role is not being undermined and that a changed relationship between doctors and nurses is in the interest of more efficient health care, not an attempt to minimize their status as doctors or their contribution to health care.

45 In addition to disseminating the report – perhaps in a variety of formats – a good deal more can be done to ensure that the proposals for change are made known. For example:

- meetings, seminars, or workshops can be arranged;
- newspapers and magazine articles can be prepared;
- a roster of speakers can be maintained and groups/associations asked whether they are interested in a presentation;
- a register of annual meetings and conferences of professional bodies and groups can be compiled and the sponsors requested to include primary health care issues on the agenda;
- informal sessions can be held with professional groups to discuss proposals for change.

46 In planning activities to promote change, it is important that all those who are involved are fully briefed on their role. Not only does briefing assist individuals and give them more confidence, but it will also help to ensure that a common point of view is adopted in the presentation and discussion of proposals. The preparation of slides, speaker's notes, and a series of likely questions and suggested answers are also useful aids.

47 In trying to promote change, it is necessary to be aware of the resources available. It creates a poor impression if offers to provide speakers or to make presentations cannot be fulfilled. Whatever be the strength or merit of the proposals themselves, they will be judged, in part at least, on the quality of their presentation. Gaining credibility is, therefore, vitally important. Available resources must be rationally used through careful planning and consultation.

Lobbying for change

48 Lobbying involves contacting those who will have an influence on decisions in the legislative process. This can be time-consuming, and it is important to identify those who are directly involved in the decision-making process so that full information can be provided and more influence can be brought to bear on them directly. The people who need to be convinced may not always be the most senior in any organization. The civil servant responsible for policy may be a relatively

junior officer, but can be the best source, making it unnecessary to take up the time of a Permanent Secretary or Head of a Department in order for a policy decision to be taken. Coalitions and networking among groups are effective devices. Where possible, it is helpful to join forces with others who may be seeking parallel professional reforms and changes. It is also useful to enlist the help of individuals or groups that wield power or influence. A friendly member of Parliament or other legislative body is a good advocate to present the case for change to other parliamentarians or legislators. Likewise, a lawyer is better able to communicate with other lawyers, just as a doctor can understand and respond to the anxieties and concerns of medical colleagues.

49 Some legislatures have specialist committees concerned with different aspects of public policy and, where possible, these might be invited to interest themselves in nursing and primary health care issues. A friendly member of the legislature might also be able to initiate a debate or question the appropriate minister or politicians about nursing and primary health care and thereby set in motion discussion of this issue.

50 Nurses themselves are a formidable group to lobby for legislative change, and their power in this direction should not be underestimated.

Face the opposition

51 It is no use pretending that opponents do not exist. If their views and arguments go unchallenged, they are likely to gain credence. As far as possible, the views and arguments of the opponents must be anticipated and addressed. As arguments emerge, an attempt should be made to understand these and to respond to them in a rational and reasoned way. Rigorous and well-prepared attempts to answer arguments can help not only to allay fears, but also to win over opponents and mobilize them in support of change.

Using the media

52 The media - press, radio, television - are potentially a great source of help in trying to educate people and influence public opinion. A relationship of trust needs to be built up, since those seeking the further advancement of primary health care are unlikely to exert ultimate editorial control. This relationship will be fostered in a climate of cooperation.

53 In enlisting the help of the media, it is important to bear in mind the deadlines to which they work and to discuss time-schedules well ahead. It is of little use to produce a wonderful report just a few minutes before a newspaper or journal goes to print. Seeking reforms in nursing and primary health care, however important, is likely to be only one of a number of issues to be dealt with by a journalist/reporter, and every effort should be made to present material succinctly and in a form which a reporter can readily use.

54 Exposure on radio or television is valuable, but unless such appearances are well prepared they can be counter-productive. An interview is likely

to be short and it is important that the essential points which need to be conveyed are well thought out prior to the interview.

- 55 The media thrive on immediacy and tangibles rather than on concepts and ideas. The value of promoting primary health care and the nursing role will be better conveyed by reference to innovative health care projects which demonstrate the benefits of a wider nursing role rather than by reference to a published research study. Wherever possible, the potential benefits of expanding primary health care should be given local colour and relevance so that readers, listeners, and viewers can identify with the issues being discussed and drawn into the discussion.
- 56 There are many ways to publicize and disseminate ideas and to lobby for action. However, any activity to be undertaken must be determined by an analysis of the relevance, local opportunities, and audiences. In seeking to introduce reform, advocates of change must have a conviction about what they are doing and be seen to be committed, motivated, and confident about the merits of their proposals.

Section V

Monitoring and Evaluation

57 Securing the passage of legislation or changes in regulations, whilst an important objective, is not the end of the exercise. It is necessary to ensure that:

- legislative changes are implemented; and
- the new legislation achieves the desired outcome.

58 The effective implementation of new or revised legislation will depend upon a number of factors:

- (a) The willingness and/or ability of governments or health service providers to allocate additional resources needed. Changes in education and training rules, for example, may require that new curricula be drawn up involving additional teaching resources.
- (b) The attitudes and motivation of those directly responsible for implementing the law to ensure that the new policies are translated into action. If there is any reluctance or lack of enthusiasm, this may result in implementation being delayed or frustrated.
- (c) The extent to which the public seek to take advantage of new provisions and use new or extended primary health care services and facilities. If members of the public perceive advantages to themselves, they may exert pressure for implementation.
- (d) The extent to which remedies exist, or to which pressure can be exerted by the community, by nurses, and by other health care professionals to see that the new legislation is implemented and its provisions fully carried out in the way originally intended. The intent of the legislation is as important as adherence to its specific provisions.

59 Any legislative changes to reform and develop nursing to enhance primary health care services will be effective only if the new provisions are widely publicized. It is necessary to sensitize the public to the changes and the services that are available to them.

To publicize the legislative changes, the following measures may be taken:

- education programmes mounted to ensure that nurses understand the implications of the new legislation;
- media support enlisted to promote an awareness of the changes that have been made; and
- leaflets prepared for distribution to the public about the impact of the change.

60 In addition to the immediate task of ensuring that the legislation is implemented, it is prudent and helpful to arrange to monitor the effects

of the legislation over the long term. Attempts to evaluate the impact of the legislation should thus be seen as a continuous and on-going process.

61 The methods that may be employed to evaluate the impact of the legislation will vary, but the following methodologies might be considered:

- (a) Where funds allow, *research projects* might be set up in consultation with universities or other educational institutions to evaluate primary health care services.
- (b) Rather than attempting a national and comprehensive analysis of the effects of legislative changes, a small area, district, or region might be first selected for *in-depth analysis and study*.
- (c) *Surveys and interviews* might be planned to cover the range of questions and issues referred to in Section II of the Guidelines.
- (d) Nurses themselves might be encouraged to monitor the effects of the changes, and *indicators* might be developed to enable those directly involved in health care to evaluate the effects of the legislative changes in the light of experience.

62 The study of the effect of legislation should be a matter for public debate. Any research/evaluation findings should be published. This may be done in specially commissioned reports, articles in professional journals, and conference papers.

63 Having mobilized public opinion and created networks with other professional bodies and interest groups to win changes in legislative and regulatory provisions, it is important to try to maintain the same momentum and to keep alive the dialogue about the development of nursing in primary health care.

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- 3 WHO Technical Report Series, No. 738, 1986 (*Regulatory mechanisms for nursing training and practice: meeting primary health care needs: Report of a WHO Study Group*).
- 4 For a fuller discussion see Styles, M.M. *Project on the regulation of nursing 1984.* Geneva, International Council of Nurses, 1984.
- 5 Ibid, pp. 104-110.
- 6 United Kingdom. *Nurses, Midwives and Health Visitors Act 1979.* Section 2 of the Act.
- 7 See further Paxman, J.M. et al. *The use of paramedicals for primary health in the Commonwealth: a survey of medico-legal issues and alternatives.* London, Commonwealth Secretariat, 1979.

Defining an Educational Programme for Nurses: Project 2000

An example of regulation that outlines: (a) the kind and standard of nursing training and (b) expresses the format of education as 'outcomes' or 'competencies', avoiding over-emphasis on tasks that can limit the extension of the role and functions of the nurse in primary health care, is found in the United Kingdom's *Project 2000*.*

"Courses leading to a qualification which enables an application to be made for registration with the UKCC shall provide opportunities to enable the student to accept responsibility for his/her personal professional development and acquire the competences required to:

- (i) demonstrate knowledge and skills necessary to meet health and sickness requirements of individuals and of groups in a particular area of practice;
- (ii) recognise common factors which contribute to and those which adversely affect physical, mental and social wellbeing of patients or clients and take appropriate action;
- (iii) identify the social and health implications of physical and mental handicap or disease, and pregnancy and childbearing, for the individual, his or her friends, family and community;
- (iv) demonstrate knowledge of the normal development of the foetus, the infant, the child, the adolescent and the young, middle-aged and elderly adult;
- (v) demonstrate an appreciation of research and use relevant literature and research as an aid to practise;
- (vi) demonstrate professional accountability and commitment to continuing professional education and development;
- (vii) demonstrate an awareness of social and political factors which relate to health care;
- (viii) demonstrate knowledge and understanding to meet the requirements of legislation which is relevant to his or her practice;
- (ix) recognise and uphold the personal and confidential rights of patients and clients;
- (x) develop helpful caring relationships with patients, clients and their families or friends; initiate, continue and complete therapeutic relationships with patients using appropriate interpersonal and communication skills;

**Project 2000: a new preparation for practice*. London, United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1987, pp.40-41.

- (xi) identify health-related learning needs of patients, clients, family or friends and participate in health promotion;
- (xii) demonstrate an awareness of the roles of individual members of the team who provide aspects of patient/client care, function efficiently in a team and assist in a multidisciplinary approach where appropriate;
- (xiii) assign appropriate work to helpers and provide supervision and monitoring of assigned work;
- (xiv) identify physical, psychological, social and spiritual needs of the patient or client; be aware of and value the concept of individual care, devise a plan of care, contribute to its implementation and evaluation by demonstrating an appreciation and practice of the principles of a problem-solving approach;
- (xv) enable patients or clients as appropriate to progress from varying degrees of dependence to maximal independence, or to a peaceful death;

All the above will be related to the care of the particular patient or client with whom the registered practitioner* is likely to come in contact when practising in the particular area of practice."

*In the context of this reference, "registered practitioner" refers to the qualified nurse at first level.

Part A

**Conclusion and Recommendations
of a WHO Study Group on Regulatory Mechanisms for
Nursing Training and Practice: Meeting Primary Health
Care Needs**

Conclusion

The effective regulation of nursing training and practice to support primary health care is long overdue. More than eight years have passed since the World Health Assembly adopted its resolution (WHA 30.34) setting the goal of health for all citizens of the world by the year 2000. More than a decade has passed since the WHO Expert Committee on Community Health Nursing recognized the diagnostic and therapeutic responsibilities required of community health nurses and outlined their broad role in primary health care. In the years since these far-seeing actions, however, the reorientation of nursing education and practice in the direction of primary health care has proceeded only slowly.

The urgent health needs of underserved populations call for positive measures to bring about the full participation of nurses in primary health care. The willingness of nurses to assume increased responsibility has been demonstrated by their impressive contributions in the area of primary health care even under the handicaps of inappropriate training and insufficient authority, to say nothing of limited resources. The means to correct this situation are at hand. Changes in the regulations governing nursing education and practice can open the way to harnessing the full potential of nurses in the development of primary health care services.

In urging prompt and effective action by countries, educational institutions, professional associations, and WHO to strengthen the regulation of nursing education and practice relating to primary health care, the Study Group echoed the statement of the Director-General of WHO in 1985.

"If the millions of nurses in a thousand different places articulate the same ideas and convictions about primary health care, and come together as one force, then they could act as a powerhouse for change. I believe that such a change is coming, and that nurses around the globe, whose work touches each of us intimately, will greatly help to bring it about. WHO will certainly support nurses in their efforts to become agents of change in the move towards health for all."

Recommendations

The Study Group recognized the key role of nurses in providing primary health care. As the most numerous, and sometimes the only, professional health personnel available to under-served populations, nurses carry an enormous responsibility for the attainment of "Health for all by the year 2000". The scope of nursing functions has expanded dramatically in a

enormous responsibility for the attainment of "Health for all by the year 2000". The scope of nursing functions has expanded dramatically in a few countries, but is restricted in many others by legal and other barriers. Countries have to develop an overall strategy for strengthening the regulatory mechanisms to promote the education and practice of nurses in primary health care, including the removal of barriers to their effective utilization. The Study Group made the following recommendations.

Regulating nursing education

The Study Group recommended that countries and regulatory bodies governing nursing should reorient the regulatory mechanisms for basic nursing education to prepare all nurses for an expanded role in primary health care as determined by countries' particular health needs.

To give effect to this recommendation, it will be necessary to:

- (a) initiate changes in the content of the basic nursing curriculum to incorporate the concepts of primary health care, ensuring that education, including field practice, is provided in the essential elements of primary health care in accordance with the defined scope of nursing practice;
- (b) provide nurses with training in midwifery, in those countries where traditional birth attendants and auxiliary midwives practise midwifery, to ensure their competence in this area and enable them to teach and supervise traditional birth attendants and auxiliary midwives;
- (c) provide financial and other resources to support the reorientation of educational programmes for nurses to primary health care.

Redesigning educational programmes

The Study Group recommended that educational institutions design educational programmes to prepare nurses for practice in primary health care.

To give effect to this recommendation, it will be necessary to:

- (a) plan the curricula of such educational programmes in collaboration with health service personnel, community representatives, and other health-related sectors;
- (b) orient all teaching staff involved in such programmes to primary health care and ensure their continuing education in this area;
- (c) establish a system to evaluate such programmes, and the graduates, in order to determine whether the training and deployment of the graduates are appropriate for the purpose of meeting the country's health needs.

Regulating nursing functions

The Study Group recommended that countries and regulatory bodies reorient regulatory mechanisms governing the functions of nurses to promote their full contribution to primary health care.

To give effect to this recommendation, it will be necessary to:

- (a) review the utilization of nurses in primary health care, develop a plan for achieving the regulatory mechanisms necessary for their full participation in primary health care, and provide an appropriate budget for the purpose;
- (b) analyse current provisions regulating the practice of nursing, medicine, dentistry, pharmacy, and other health-related professions to identify deterrents to nursing practice in primary health care and take action to eliminate such deterrents;
- (c) enact legislation containing a general statement of the scope of nursing practice that is sufficiently broad to encompass the practice of nurses in all the essential elements of primary health care, and affirm by statute, regulations, or other means the responsibility of nurses for performing preventive and curative functions in primary health care as part of their nursing role;
- (d) set forth in regulations all the essential functions that nurses working in primary health care need to perform, especially those relating to immunization, the management of common illnesses, the provision of family planning services, and the prescription and administration of selected drugs for common conditions;
- (e) revise periodically the regulations governing nursing functions as new needs arise and skills evolve.

Strengthening nursing boards

The Study Group recommended that countries vest the regulation of nursing education and practice in a nursing board or council.

To give effect to this recommendation, it will be necessary to:

- (a) specify the functions of the nursing board or council, including approving training institutions and field practice areas, establishing admission requirements, prescribing the duration and content of curricula, administering licensing examinations, and exercising disciplinary functions over the profession;
- (b) ensure that emphasis is placed, in the regulations, interpretations, and decisions of the nursing board or council, on promoting the development of the full range of nursing functions required in primary health care; and strengthen the capabilities and commitment of the members of the board or council, by providing them with opportunities for better understanding of primary health care as the key to the attainment of the goal of "Health for all";
- (c) provide that the majority of members of the board or council shall be nurses elected by the profession or appointed from nominations made by organizations representing nurses, and that the chairperson of the board or council shall be a nurse;
- (d) where a nursing board or council as described above does not yet exist, specify, in transitional arrangements, the time limit and mechanisms for setting up such a regulatory body for nursing education and practice;

- (e) promote work studies of health personnel and review job descriptions, revising them, where necessary, to reflect the functions required in order to utilize the full working potential of all health personnel engaged in primary health care.

Strengthening the role of national nursing organizations

The Study Group recommended that national nursing organizations give priority to assisting with the revision of the legislation and regulations governing nursing education and practice so that they support primary health care; and provide leadership in educating parliamentarians, other policy-makers, and the public on the role of nurses in primary health care, including use of the report sponsored by the International Council of Nurses under the title *Project on the Regulation of Nursing 1984*.

The role of WHO

The Study Group recommended that WHO collaborate with its Member States in strengthening the regulatory mechanisms governing the education and practice of nurses for primary health care.

To give effect to this recommendation, it will be necessary for WHO to:

- (a) undertake a review of nursing education programmes and the operation of nursing legislation to determine whether they achieve the goal of improving access to, and the quality of, primary health care;
- (b) develop guidelines for use by nurses, professional associations, educational establishments, regulatory and other relevant bodies, and consumer organizations as a basis for regulatory changes governing nursing education and practice to enable nurses to make their maximum contribution to primary health care.

Part B

Authorization of Nursing Tasks Relating to Primary Health Care: Results of a Survey¹

The following extracts, from an unpublished WHO report, summarize the findings, by WHO Region, of a survey of the frequency with which 15 nursing tasks relating to primary health care are authorized and the mechanisms whereby they are authorized. Tabular summaries are included for the five WHO Regions in which ten or more countries replied, and some general comments emerging from the survey are appended.

African Region

In the African Region of WHO (Table 1), 16 countries took part in the survey. Of the 15 tasks, 11 are authorized in all these countries, and the other four tasks are authorized in all but one of them.

The principal mechanisms for authorizing these nursing tasks are nursing practice acts and ministry of health (or hospital) regulations, with slightly more reliance on the latter. Standing orders by a physician and specific orders by a physician for a particular patient are also used by a substantial proportion of the respondents. Prescribing oral contraceptives and inserting IUDs are the only tasks authorized by nursing practice acts in less than 50% of the respondent countries.

Region of the Americas

In the Region of the Americas too few countries replied to permit any significant generalizations to be made. In the USA, in the last 15 years at least 40 jurisdictions have expanded the scope of nursing practice as authorized by state nursing practice acts. In 1983, the Supreme Court of Missouri issued a landmark decision recognizing the independent role of the nurse in performing diagnostic and treatment functions consistent with her education, judgement, and skill under a modernized nursing practice act. Thus, the court held that appropriately trained nurses are authorized to do breast and pelvic examinations, pregnancy testing, Papanicolaou smears, gonorrhoea cultures, blood serology, administration of all kinds of contraceptive methods, and counselling and education of patients.²

The replies from three South American countries indicate that nurses are not allowed to prescribe drugs for common ailments or perform minor surgery. One of these countries also does not allow nurses to diagnose common diseases, to prescribe oral contraceptives, or to insert IUDs. But

¹ Abridged from: Mangay Maglacas, A. & Roemer, R. *Survey of nursing tasks relating to primary health care*. Geneva, World Health Organization, 1985 (document HMD/NUR/SG/2).

² See Cook, R. J. & Dickens, B. Nurses in fertility regulation – legal confirmation of an expanding role. *IPPF Medical Bulletin*, 18: 3-4 (1984).

in a fourth South American country, all the tasks listed are authorized by the nursing practice act, except referral for X-rays or other diagnostic tests, which is authorized by the order of a physician for a specific patient.

Table 1. Nursing tasks relating to primary health care in 16 countries of the African Region of WHO, by number of countries authorizing each task and method of authorization*

Task	Total number of countries authorizing task	Number of countries not authorizing task	Number of countries authorizing task by:				
			nursing practice act	Regulation of ministry of health or hospital	physician's standing orders	specific order of a physician for a specific patient	other authority
Taking blood pressure	16	0	11	12	8	7	1
Giving immunizations	16	0	9	15	8	2	1
Diagnosing common diseases	16	0	9	11	9	2	1
Treating common diseases	16	0	10	11	9	7	1
Prescribing drugs for common ailments	16	0	9	11	11	8	1
Performing minor surgery	16	0	9	10	9	11	1
Handling trauma in emergencies	16	0	9	10	11	9	0
Doing simple diagnostic tests	16	0	10	11	11	8	1
Giving injections	16	0	10	11	11	8	1
Giving oral medication	16	0	10	11	11	8	1
Management of chronic diseases	16	0	8	11	13	9	0
Performing physical examinations	15	1	9	9	10	10	1
Referring for X-rays or other diagnostic tests	15	1	8	8	11	11	1
Prescribing oral contraceptives	15	1	7	8	10	8	1
Inserting IUDs	15	1	7	7	6	10	1

* The numbers for the several forms of authorization do not add up to the total number of countries responding, because a task is usually authorized by more than one method.

South-East Asia Region

In the South-East Asia Region of WHO (Table 2), ten countries replied. Of the 15 nursing tasks relating to primary health care, seven are authorized by one means or another in all ten countries. The other eight nursing tasks are authorized by eight or nine countries each. Authorization is granted mainly through ministry of health (or hospital) regulations, but some reliance is placed on nursing practice acts and, to a lesser extent, on standing medical orders.

The tasks least frequently authorized are referring for X-rays, performing minor surgery, prescribing oral contraceptives, and inserting IUDs. In the eight countries authorizing these tasks for nurses, the principal authorizing mechanisms are ministry of health (or hospital) regulations.

Table 2. Nursing tasks relating to primary health care in 10 countries of the South-East Asia Region of WHO, by number of countries authorizing each task and method of authorization*

Task	Total number of countries authorizing task	Number of countries not authorizing task	Number of countries authorizing task by:				
			nursing practice act	Regulation of ministry of health or hospital	physician's standing orders	specific order of a physician for a specific patient	other authority
Giving injections	10	0	4	6	3	4	
Giving oral medication	10	0	5	7	3	3	
Giving immunizations	10	0	3	5	2	3	1
Handling trauma in emergencies	10	0	3	5	3	6	
Taking blood pressure	10	0	4	6	3	5	
Management of chronic diseases	10	0	5	5	2	3	
Performing physical examinations	10	0	2	5	2	4	
Doing simple diagnostic tests	9	1	2	6	3	4	
Treating common diseases	9	1	1	3	3	4	
Prescribing drugs for common ailments	9	1	0	4	2	3	
Diagnosing common diseases	9	1	1	4	3	3	
Referring for X-rays or other diagnostic tests	8	2	1	3	2	4	
Performing minor surgery	8	2	1	2	0	0	
Prescribing oral contraceptives	8	2	1	6	2	3	
Inserting IUDs	8	2	1	6	3	3	

* The numbers for the several forms of authorization do not add up to the total number of countries responding, because a task is usually authorized by more than one method.

European Region

In the European Region of WHO (Table 3), 18 countries replied. The tasks most frequently authorized by all or nearly all countries are: taking blood pressure, giving injections, giving oral medication, giving immunizations, handling trauma in emergencies, doing simple diagnostic tests, and managing chronic diseases. For almost every task the principal source of authorization is a nursing practice act, although other forms of authorization are used as well.

The nursing procedures least frequently authorized are: prescribing oral contraceptives, performing minor surgery, inserting IUDs, and prescribing drugs for common ailments. Half or fewer than half of the countries authorized nurses to perform these procedures. Where they are authorized, various mechanisms are used, including those listed in the survey, and also others, such as a civil law authorizing nurses to handle trauma in emergencies, approval of a nursing curriculum that teaches nurses to perform many of these functions, and authorization by a health centre. But nursing practice acts constitute the source of authority more frequently in the European Region than in any of the other WHO Regions.

Table 3. Nursing tasks relating to primary health care in 18 countries of the European Region of WHO, by number of countries authorizing each task and method of authorization*

Task	Total number of countries authorizing task	Number of countries not authorizing task	Number of countries authorizing task by:				
			nursing practice act	Regulation of ministry of health or hospital	physician's standing orders	specific order of a physician for a specific patient	other authority
Taking blood pressure	18	0	15	2	5	4	2
Giving injections	18	0	13	5	4	7	2
Giving oral medication	18	0	13	4	4	7	2
Giving immunizations	17	1	5	6	6	9	2
Handling trauma in emergencies	17	1	10	3	4	7	3
Doing simple diagnostic tests	17	1	11	4	4	5	2
Management of chronic diseases	17	1	7	2	3	9	2
Referring for X-rays or other diagnostic tests	14	4	0	3	4	8	1
Performing physical examinations	13	5	6	3		2	1
Treating common diseases	11	7	2	1	4	5	2
Diagnosing common diseases	9	9	3	1	1	2	1
Prescribing drugs for common ailments	8	10	1	0	1	3	
Inserting IUDs	8	10	1	3	2	3	1
Performing minor surgery	7	11	3	1		3	
Prescribing oral contraceptives	6	12	0	2	1	2	

* The numbers for the several forms of authorization do not add up to the total number of countries responding, because a task is usually authorized by more than one method.

Eastern Mediterranean Region

In the Eastern Mediterranean Region of WHO (Table 4), 20 countries replied. Of the 15 tasks, seven are authorized by at least 18 of the respondent countries. The predominant mechanisms for authorizing these tasks are nursing practice acts and ministry of health (or hospital regulations), but some reliance is also placed on standing or specific medical orders.

The other eight tasks are authorized by at least 12 of the 20 countries. The least frequently authorized tasks are prescribing contraceptives and inserting IUDs, but even these are authorized in 13 and 12 countries, respectively, most frequently by regulation or on medical orders, rather than by nursing practice acts. For all the procedures authorized, nursing practice acts are the source of authorization in less than 50% of the countries, except for the performance of simple diagnostic tests.

Table 4. Nursing tasks relating to primary health care in 20 countries of the Eastern Mediterranean Region of WHO, by number of countries authorizing each task and method of authorization*

Task	Total number of countries authorizing task	Number of countries not authorizing task	Number of countries authorizing task by:				
			nursing practice act	Regulation of ministry of health or hospital	physician's standing orders	specific order of a physician for a specific patient	other authority
Giving injections	20	0	9	8	2	3	
Giving oral medication	20	0	9	8	2	4	
Giving immunizations	20	0	8	10	2	2	2
Handling trauma in emergencies	20	0	7	5	3	7	
Doing simple diagnostic tests	20	0	10	7	3	2	1
Management of chronic diseases	19	1	6	7	4	5	2
Taking blood pressure	18	2	7	4	6	2	
Performing physical examinations	17	3	4	4	4	1	3
Treating common diseases	17	3	3	5	4	2	3
Referring for X-rays or other diagnostic tests	16	4	1	1	1	5	2
Performing minor surgery	15	5	1	1	1	4	2
Prescribing drugs for common ailments	14	6	2	2	4	2	3
Diagnosing common diseases	14	6	1	4	3	2	3
Prescribing oral contraceptives	13	7	1	3	3	6	5
Inserting IUDs	12	8	1	1	3	5	5

* The numbers for the several forms of authorization do not add up to the total number of countries responding, because a task is usually authorized by more than one method.

Western Pacific Region

In the Western Pacific Region of WHO (Table 5), 12 countries replied. Of the 15 nursing tasks relating to primary health care, seven are authorized by one means or another in all 12 countries. At least 10 of the 12 countries authorize six additional tasks. The principal mechanism for authorization is the nursing practice act, but heavy reliance is also placed on all the other mechanisms. The tasks least frequently authorized are inserting IUDs (eight countries) and prescribing oral contraceptives (nine countries). Where these functions are authorized, it is usually by means other than the nursing practice act.

Table 5. Nursing tasks relating to primary health care in 12 countries of the Western Pacific Region of WHO, by number of countries authorizing each task and method of authorization*

Task	Total number of countries authorizing task	Number of countries not authorizing task	Number of countries authorizing task by:				
			nursing practice act	Regulation of ministry of health or hospital	physician's standing orders	specific order of a physician for a specific patient	other authority
Taking blood pressure	12	0	8	4	6	5	1
Giving injections	12	0	7	4	6	5	1
Giving oral medication	12	0	7	7	5	5	1
Giving immunizations	12	0	7	6	2	3	
Handling trauma in emergencies	12	0	6	5	5	6	2
Doing simple diagnostic tests	12	0	5	4	5	5	1
Performing minor surgery	12	0	4	3	4	4	1
Management of chronic diseases	11	1	6	5	6	6	1
Referring for X-rays or other diagnostic tests	11	1	2	4	3	2	1
Performing physical examinations	10	2	2	4	3	3	2
Treating common diseases	10	2	5	4	3	4	2
Diagnosing common diseases	10	2	4	3	1	2	1
Prescribing drugs for common ailments	10	2	4	3	4	4	1
Prescribing oral contraceptives	9	3	3	5	3	4	
Inserting IUDs	8	4	1	4	3	5	

* The numbers for the several forms of authorization do not add up to the total number of countries responding, because a task is usually authorized by more than one method.

Comments

1. The principal conclusion to be drawn from this survey is that there is a worldwide tendency to extend the scope of nursing practice. As the education of nurses becomes more comprehensive (and as new technology in health becomes available), nursing functions in primary health care and in clinical settings are being expanded. This is true in both developing and developed countries.
2. A variety of mechanisms are used to authorize new and expanded tasks for nurses. In fact, more than one mechanism may authorize a particular task. Sometimes a task is authorized at first by standing orders and later governed by statute or by a regulation of the ministry of health. As regards regional differences, nursing practice acts are the source of authority in the European Region more frequently than in any other.
3. There are several reasons why it is important for extensions in the scope of nursing practice to be authorized: to provide the population with broader access to health care; to use the potentialities of nurses to the full; and to protect nurses against any liability associated with their work. Several countries expressed concern in this survey about the legal liability involved in performing certain functions in the absence of clear authorization.
4. In general, nurses are authorized to carry out a wider range of functions in remote areas where there are no physicians than in areas where physicians are available. Nevertheless, even in countries

where the supply of physicians is adequate, an extension of nursing functions may represent the most cost-effective use of health personnel.

5. The replies to the questionnaire indicate that nurses are authorized to perform more tasks in public services provided by government and in organized frameworks, such as health centres, than in private offices and facilities.
6. While the survey has examined experience with 15 nursing tasks relating to primary care services in 81 countries, it should not be assumed that these include all the potential tasks. The reply from one country (USSR) pointed out that, in addition to the tasks listed in the survey, nurses there perform two other important tasks in primary health care: (a) ascertaining risk factors and (b) providing health education to groups and individuals. Moreover, in the future the performance of still other tasks may be deemed appropriate for the nurse. In view of the dynamic character of nursing education and practice, the question arises whether authorization for additional nursing tasks should be specific to each task or whether it should be open-ended to accommodate new needs and practices.
7. The necessity for new or revised mechanisms for the authorization of nursing functions relating to primary health care should be evaluated in each country. In some countries, the existing regulatory mechanisms may be appropriate and adequate. In others, new or revised legislation, regulations, or other authorization may be required to ensure the best use of nursing personnel, to protect the nurse, and to ensure greater coverage of the population by primary health care. A periodic review of nursing practice and of authorization for needed nursing functions is advisable in order to keep regulatory mechanisms abreast of progress in health care.

Countries participating in the survey, by WHO Region

African Region

(16 out of 45 countries)

Botswana, Cameroon, Congo, Gambia, Ghana, Guinea-Bissau, Guinea, Kenya, Lesotho, Liberia, Nigeria, Sierra Leone, Swaziland, Uganda, United Republic of Tanzania, Zaire;

Region of the Americas

(5 out of 34 countries)

Bolivia, Colombia, Ecuador, Peru, United States of America (California);

South-East Asia Region

(10 out of 11 countries)

Bangladesh, Bhutan, Burma, India, Indonesia, Republic of Korea, Mongolia, Nepal, Sri Lanka, Thailand;

European Region

(18 out of 35 countries)

Austria, Belgium, Czechoslovakia, Finland, France, Federal Republic of Germany, Greece, Hungary, Ireland, Israel, Italy, Poland, Spain, Sweden, Turkey, United Kingdom, Union of Soviet Socialist Republics, Yugoslavia;

Eastern Mediterranean
(20 out of 22 countries)

Afghanistan, Bahrain, Cyprus, Democratic Yemen, Djibouti, Egypt, Iraq, Kuwait, Libyan Arab Jamahiriya, Jordan, Lebanon, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Somalia, Tunisia, Yemen;

Western Pacific Region
(12 out of 20 countries)

Australia (Victoria), Cook Islands, Fiji, Lao People's Democratic Republic, Malaysia, New Zealand, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Vanuatu.

Part A

Basic Elements of a Regulatory Framework for Nursing Education and Practice – a Checklist*

Article I

Title, Description, and Purpose

- Section 1. Title of Act
- Section 2. Description of Act
- Section 3. Intent
- Section 4. Relevance of other laws

Article II

Definitions

- Section 1. Practice of Nursing
- Section 2. Registered Nurse
- Section 3. Other categories of nursing personnel
- Section 4. Board or Council
- Section 5. Approval of educational programmes
- Section 6. Licence to practise
- Section 7. Registration
- Section 8. Definition of other terminology as needed

Article III

Board or Council of Nursing

- Section 1. Membership; Appointment/ elections; Nominations; Terms of office; Removal from office; Vacancies; Qualifications; Immunity from individual liability
- Section 2. Powers and Duties
 - (a) to make rules and regulations
 - (b) To carry out the terms of the Act
- Section 3. Executive Director
- Section 4. Appointment or election of Chairman/President, and Deputy
- Section 5. Meetings; Notices; Quorum; etc.
- Section 6. Fees and reimbursement of expenses

Article IV

Licensure to Practise

- Section 1. Qualifications
- Section 2. Examinations
- Section 3. Renewal of licences
- Section 4. Reinstatement of lapsed licensure
- Section 5. Temporary licences
- Section 6. Rights and duties of licensees
- Section 7. Suspension or cancellation of licences

Article V

Maintenance of a Register

- Section 1. Purpose
- Section 2. Format
- Section 3. Entry to Register

Article VI

Titles and Abbreviations

- Section 1. Registered Nurse
- Section 2. Other categories of nursing personnel, where relevant
- Section 3. Temporary Registered Nurse

Article VII

Approval of Nursing Education Programmes

- Section 1. Approval standards
- Section 2. Approval required
- Section 3. Monitoring and evaluation of nursing programmes
- Section 4. Denial or withdrawal of approval
- Section 5. Reinstatement of approval
- Section 6. Provisional approval

Article VIII

Violations of the Act and Penalties

- Section 1. Violations
 - (a) false representation
 - (b) knowingly employing unlicensed nurses
 - (c) concealment of relevant information
- Section 2. Penalties
- Section 3. Criminal prosecution
- Section 4. Civil penalties

Article IX

Discipline and Proceedings

- Section 1. Grounds
- Section 2. Procedure
- Section 3. Range of sanctions applicable
- Section 4. Reinstatement following a cancellation of licence
- Section 5. Immunity of complainant, witness, Board/Council member, staff acting in good faith

Article X

Reporting Required

- Section 1. Employers of nurses, nursing associations, and insurance companies
- Section 2. Court Order
- Section 3. Penalty
- Section 4. Immunity of reporters acting in good faith

Article XI

Exemptions

- Section 1. Students
- Section 2. Emergency care
- Section 3. Other

Article XIII

Revenue, Fees

- Section 1. Revenue of Board or Council
- Section 2. Disposition of licensing fees

Article XIII

Implementation

- Section 1. Effective date
- Section 2. Provisions for persons licensed under a previous law
- Section 3. Severability (if any provision is invalid, the remaining provisions are unaffected)
- Section 4. Repeal of laws made unnecessary by the new Act

*This checklist is adapted, with permission, from the Table of Contents of *The Model Nursing Practice Act*, published by the National Council of State Boards of Nursing, Inc., Chicago, Illinois, U.S.A., 1982.

Part B

Components of the Regulatory Framework Relevant to the Education and Practice of Nurses for Primary Health Care

The following excerpts from legislation governing nursing education and practice show various approaches to expanding the role of the nurse in primary health care. These legislative examples may be helpful to countries that have not enacted licensing laws for nurses and also to countries wishing to review the adequacy of their legislation. The excerpts are grouped in the following categories:

- I. General provisions in nursing practice acts and the powers of nursing boards/councils
- II. Nursing education
- III. Nursing functions
- IV. Rural services
- V. Continuing education
- VI. Career structure

Unless otherwise stated, all statutes are taken from the *International Digest of Health Legislation*, hereinafter cited as IDHL, published quarterly by the World Health Organization, Geneva. These statutes may not be the latest enactments, but they have been selected from available information. These examples are presented for information only and to illustrate alternative approaches by different countries.

I. General provisions in nursing practice acts and the powers of nursing boards and councils

Most countries have laws regulating nursing practice. Not all, however, have a Board/Council that is concerned solely with the regulation of the nursing profession. Some countries regulate the practice of nursing through laws also covering other health care professions. There are still others that exert control through Acts/Decrees that are primarily pertinent to medicine and dentistry, nurses being seen as auxiliary workers to these professions. In some of these situations, change in nursing education and practice are initiated solely by doctors and/or dentists.

It is difficult to envisage how a nurse can function legally at basic level when certain tasks are specifically, legally ascribed to the doctor or dentist, for example: the examination of the oral cavity and teeth; the administration of curative or preventive medication; and the taking of substances from the human body for medical examination.

There are, however, in many countries, developments in self-regulation of nurses with encouraging signs that the Board/Council that is set up has powers vested in it that facilitate the preparation of nurses to function more effectively in primary health care.

Nursing Boards/Councils or similar bodies, where established, have the essential powers to govern the education and practice of nursing: approval of training programmes; admission requirements; duration and content of training; examinations; licensing, nursing functions; and disciplinary mechanisms.

Few of the countries, however, even in recently enacted legislation, mention specifically primary health or community care as within the province of the regulatory body. But in many instances it is in the regulations formulated subordinate to the statute where most initiatives are expressed. Examples of these two approaches follow:

GUATEMALA: Order No: SP-M-153-80 of 30 December 1980 prescribing Regulations on the National Nursing Council attached to the Ministry of Public Health and Social Welfare, *IDHL*, 1981, 32(4), 664.

“ . . . to propose any necessary changes designed to improve the practice of nursing.”

KENYA: An Act (No. 3 of 1983) of Parliament to make provision for the training, registration, enrolment, and licensing of nurses to regulate their conduct and ensure their maximum participation in the health care of the community and for connected purposes. Dated 18 May 1983 (The Nurses Act 1983) *IDHL* 1983 34(4), 736-738.

“ . . . to establish and improve the standards of professional nursing and of health care in the community.”

II. Nursing education

A number of countries are moving towards preparation of the nurse for an enhanced role in primary health care.

As early as 1977, Senegal, by legal decree, changed the emphasis of the preparation and practice of its nurses in order to meet more effectively the specific primary health care needs of its population. The revised training programme places great weight upon the need to prepare the nurse to deal with tropical diseases and primary health care. It stresses prevention, public health and hygiene, and clinical experience to be gained in rural communities. This initiative had an additional motive, which was to retain a qualified nursing workforce better able to cope with the real health problems of the country. Previous hospital-based, curative-centred training had resulted in the loss of qualified nursing personnel to other countries. Other examples of the laws redirecting the education of nurses to primary health care follow.

LESOTHO: The General Nurses (Training Examination and Student Registration) Regulation 1981. Legal Notice No. 48 of 1981. September 1981 *IDHL*, 1982, 33(4), 247.

“. . . the following are to be emphasized throughout the course . . .
. . . the preventive, promotive . . . aspects of the profession.”

TRINIDAD AND TOBAGO: The Nurses and Midwives Registration Regulations, 1977, Government Notice No. 176, dated 20 June 1977, *IDHL* 1981, 32(2) 239-242.

“An institution may be designated to be a recognized place of training for nurses if the Council is satisfied that. . . : the institution is associated with a district service approved by the Council for the provision of experiences in the field of public health and community services.”

MEXICO: Order 18 October 1983, establishing the Inter-Institutional Commission for the Training of Human Resources in the Health Sector, *IDHL* 1986, 37(2), 255.

“. . . establishing the Inter-institutional Commission for the Training of Human Resources in the Health Sector (includes nurses).”

“. . . to identify areas of coordination between teaching and health establishments and between the educational and health sector to ensure the training of appropriate manpower resources for the national health system.”

“. . .to contribute to defining the necessary qualifications and experience of health professionals.”

“. . . to ensure that social service forms part of the training of health professionals and principally benefits population groups in need of health services.”

ZIMBABWE: Statutory Instrument 196 of 1985 – State Certified Nurses' (Training) Regulations, 1985 – Health Professions Council, Zimbabwe.

“Objective of Training

To produce a health worker who is primarily a nurse who will be able to function as a primary health care worker at a Health Centre, and where necessary, in other health facilities. This will involve training in all aspects, including prevention, health promotion, treatment, rehabilitation, and study of important diseases and health problems in Zimbabwe.”

III. Nursing functions

The definition of the practice of nursing and the scope of nursing functions is critical to determining the role of the nurse in primary health care.

Two basic approaches are used. One is to list in the statute the specific functions that the nurse may perform. For example, Belgium and France list specific traditional nursing tasks in detail. A few examples of the use of this method relating to tasks in primary health care are presented in (a) below. The other method is to define in the statute the responsibilities or competencies that the nurse has achieved by reason of her educational preparation. Selected examples of this method are presented in (b) below. See paragraph 25 of the Guidelines for the advantages and disadvantages of these approaches.

(a) Examples of laws indicating specific tasks in primary health care.

DOMINICA. An Act (No. 34 of 1982) further to amend the Medical Ordinance, Cap. 149, dated 21 October, 1982. (The Medical (Amendment) Act, 1982). *IDHL*, 1983, 34(2), 241-242.

Sec. 2 of the Medical Ordinance is amended by insertion of definitions of "Dominica Family Nurse Practitioner's Formulary" ("a list of drugs issued by the Medical Board from which the Family Nurse Practitioner is permitted to prescribe in the treatment of common complaints. These common complaints and their course of medication are detailed within the Family Nurse Practitioner's Protocol") and "Dominica Family Nurse Practitioner's Protocol" ("a written presentation in booklet or manual form issued by the Medical Board that defines the standards by which the quality of care can be measured and includes plans of clinical management of the common conditions that the Family Nurse Practitioner is allowed to diagnose and treat. It specifies the problem, gives guidelines for care and the expected outcome and indicates at what stage the case should be referred to a Medical Practitioner"). The following new Parts are inserted in the Ordinance:

Part VIII

Family Nurse Practitioners

- 59
- (1) Notwithstanding the provisions of paragraph (a) of section 26, it shall be lawful for the Medical Board to issue a licence, in the form set out in Schedule F, to any person who is a qualified Family Nurse Practitioner and who has applied in writing to the Medical Board for such a licence.
 - (2) Any application under this section shall be accompanied by evidence satisfactory to the Medical Board of the applicant's qualification as a Family Nurse Practitioner.
 - (3) For the purposes of this section, a person is qualified to be licensed as a Family Nurse Practitioner, who
 - (a) is a registered nurse; and
 - (b) has completed a course of training approved by the Medical Board; and
 - (c) has passed the prescribed examinations.

- (4) Licences under this section may only be issued to those qualified persons for the purposes of working in the employment of the Government of the Commonwealth of Dominica and shall be of a year's duration renewable annually on application thereafter.
 - (5) Any Family Nurse Practitioner licensed under this section shall be allowed to treat those diseases listed in Schedule G of this Ordinance, and in the manner specified in the Dominica Family Nurse Practitioner's Protocol.
 - (6) In performing their duties under subsection (5) all Family Nurse Practitioners shall perform such duties under the general supervision of a registered Medical Practitioner who is employed by the Government of the Commonwealth of Dominica.
 - (7) Every Family Nurse Practitioner licensed under this section shall be allowed to prescribe only those drugs included in the Dominica Family Nurse Practitioner's Formulary.
 - (8) All medical prescriptions from any Family Nurse Practitioner shall only be dispensed or made up only at Government institutions by chemists, druggists or pharmacists employed by the Government of the Commonwealth of Dominica.
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- (1) Any registered chemist, druggist or pharmacist who is employed in that capacity by the Government of the Commonwealth of Dominica may make up or dispense a medical prescription signed with the name of or with the initials of any duly licensed Family Nurse Practitioner licensed under section 59. Provided that such prescription includes only those drugs that appear in the Dominica Nurse Practitioner's Drug Formulary.
 - (2) An alphabetical list of all licensed Family Nurse Practitioners shall be sent to all Government employed chemists, druggists and pharmacists by the first day of February of each year, so as to facilitate the proper implementation of this section.

UNITED STATES OF AMERICA (NEW HAMPSHIRE). An Act (Chapter 129 of the Laws of 1983) authorizing advanced registered nurse practitioners to prescribe medication in certain circumstances. Date of approval: 7 June 1983. *IDHL*, 1984, 35(2), 324.

"Under the terms of this Act, an advanced registered nurse practitioner who functions in connection with protocols established jointly with a collaborative physician may prescribe medications from the formulary for a specialty area which has been jointly agreed upon by the Board of Registration in Medicine and the Board of Nursing Education and Nurse Registration. This Formulary is to be kept on file with the above-mentioned Boards and is to be reviewed and updated annually."

UNITED STATES OF AMERICA (NEW YORK). Part 400 (All facilities - General Requirements) of Article 1 of Subchapter A (Medical Facilities - Minimum Standards) of Chapter V (Medical Facilities) of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York. *IDHL*, 1985, 36(3), 585-586.

Part 400 is amended by the addition of a new Sec. 400.10, reading as follows:

"Section 400.10. The provision of primary health care services by the qualified registered professional nurse.

- (a) Notwithstanding other provisions of this Chapter, a licensed and currently registered professional nurse may provide primary health care services as defined by this section and as approved by the governing authority, if the registered professional nurse:
 - (1) has successfully completed a supplemental clinical program or master's degree program approved by the State Education Department which prepares the registered professional nurse to provide primary health care services or a program determined to be equivalent by the Department of Health; or
 - (2) is qualified by education and experience for certification or has received certification in a specialty which includes the provision of primary health care services from either the American Nurses Association or other certifying body determined to be equivalent by the Department of Health; and
 - (3) is qualified by experience and demonstrated competence as determined by the governing authority.
- (b) The governing authority shall ensure that all primary health care services performed by the qualified registered professional nurse are provided in accordance with written policies and procedures approved by the nursing department and medical director or where applicable the medical staff and other health professionals as appropriate.
- (c) For purposes of this section, primary health care services shall mean the following activities inclusive of all related written documentation, to the extent approved by the governing authority:
 - (1) taking histories and performing physical examinations;
 - (2) selecting clinical laboratory tests; and diagnostic radiologic procedures;
 - (3) choosing regimens of treatment.
- (d) Nothing in this section shall alter a physician's responsibility for the medical care of his/her patient."

(b) Examples of laws setting forth the responsibilities or competencies of the nurse.

BOLIVIA: Regulations on the practice of nursing. Dated 15 March 1982. *IDHL*, 1983, 34(3), 491-494.

Under the provisions of Sec. 2 of these Regulations, nursing is defined as "the dispensing of services to individuals, the family, and the community for the restoration or preservation of health, the quantity and quality of care being important factors that contribute to the improvement and extension of services to the population".

Sec. 3 defines "nurse" as a person who, having completed a programme of education and basic training in nursing provided by a teaching institution recognized by the Supreme Government, is qualified and licensed to provide professional services requiring responsibility and competence in the field of health promotion and restoration, prevention, and rehabilitation.

Sec. 57 reads as follows:

"57. The functions of nursing personnel shall be as follows:

- (a) to dispense direct care to the individual, the family, and the community, by applying nursing techniques for health promotion and restoration, prevention, and rehabilitation;

- (b) to dispense primary health care to the individual, the family, and the community at health care levels I, II, and III;
- (c) to supervise pregnant women in normal health, attend normal deliveries, and supervise women during the puerperal period;
- (d) to monitor the growth and development of the healthy child;
- (e) to participate in the development of the community, by guiding its members in identifying their health needs and problems and in using their resources to solve these;
- (f) to participate in the health planning of health education programmes and carry out educational activities on disease prevention and health promotion among individuals, families, and the community;
- (g) to participate in the health planning and programming process, and take a leading role in the planning and programming of nursing services;
- (h) to advise health personnel, individuals, and the community on aspects of nursing;
- (i) to participate in the drawing up of the budget for each administrative level;
- (j) to organize and administer nursing services at the various administrative and health care levels;
- (k) to determine the nursing information and evaluation system within each institution;
- (l) to supervise nursing personnel and other personnel and individuals carrying out nursing activities;
- (m) to participate in the planning of basic, postbasic, and in-service programmes in nursing education;
- (n) to organize, administer, implement, and evaluate programmes in nursing education;
- (o) to participate in drawing up, implementing, and evaluating training programmes for health promoters, traditional birth attendants (*parteras empiricas*), and other members of the community;
- (p) to participate in the planning or redesigning of buildings intended for health programmes;
- (q) to participate in the acquisition of equipment and supplies; and
- (r) to establish and maintain continuity in nursing research and participate in other related studies."

Sec. 62 prescribes that the following activities, *inter alia*, are contrary to nursing ethics: administering injections, medicaments, etc. in the absence of medical instructions; carrying out or promoting illegal practices and acts, including abortions; and failing to observe professional confidentiality, except where so required by the judicial or other authorities (in cases of communicable diseases, they are to notify the competent authorities).

CANADA (MANITOBA). The Registered Nurses Act. Dated 29 July 1980. *IDHL*, 1983, 34(2), 241.

Sec. 1 (Definitions) or Part I (Interpretations) of this Act includes the following clause:

- (g) 'nursing practice' or the 'practice of nursing' means representing oneself as a registered nurse while carrying out the practice of those functions which, directly or indirectly in collaboration with a client and with other health workers, have as their objective, promotion of health, prevention of illness,

alleviation of suffering, restoration of health and maximum development of health potential and without restricting the generality of the foregoing includes:

- (i) collecting data relating to the health status of an individual or groups of individuals,
- (ii) interpreting data and identifying health problems,
- (iii) setting care goals,
- (iv) determining nursing approaches,
- (v) implementing care, supportive or restorative of life and well-being,
- (vi) implementing care relevant to medical treatment,
- (vii) assessing outcomes, and
- (viii) revising plans''.

MONTSERRAT. The Nurses and Midwives Rules, 1981. Statutory Rules and Orders No. 8 of 1981. Dated 9 March, 1981 *IDHL*, 1983, 34(1), 54-55.

The terms defined in Rule 2 (Interpretation) include "nurse" ("a person who has completed a programme of basic nursing education and is qualified to supply responsible service of a nursing nature for the promotion of health, the prevention of illness, and the care of the sick") and "family nurse practitioner" ("a nurse practitioner who is prepared under the direction of a medical practitioner to be responsible for and take decisions concerning preventative, curative, and restorative health care for people in the community generally, at all ages").

UNITED STATES OF AMERICA. The Model Nursing Practice Act, National Council of State Boards of Nursing, Inc., Chicago, Illinois, 1982.

Article II

Definitions

Section 1. Practice of Nursing. The "Practice of Nursing" means assisting individuals or groups to maintain or attain optimal health throughout the life process by assessing their health status, establishing a diagnosis, planning and implementing a strategy of care to accomplish defined goals, and evaluating responses to care and treatment.

Section 2. Registered Nurse. "Registered Nurse" means a person who practices professional nursing by:

- (a) Assessing the health status of individuals and groups;
- (b) Establishing a nursing diagnosis;
- (c) Establishing goals to meet identified health care needs;
- (d) Planning a strategy of care;
- (e) Prescribing nursing interventions to implement the strategy of care;
- (f) Implementing the strategy of care;
- (h) Maintaining safe and effective nursing care rendered directly or indirectly;
- (i) Evaluating responses to interventions;
- (j) Teaching the theory and practice of nursing;
- (k) Managing the practice of nursing; and
- (l) Collaborating with other health professionals in the management of health care.

Comments

The most important part of a practice act is the definition of the practice that it seeks to regulate. The definition should distinguish nursing practice from the practice of other health professions, yet should be stated in terms sufficiently broad to include all levels of practice, including that of the Registered Nurse, Licensed Practical Nurse and all extended and expanded nursing roles. A broad definition will enable the Board of Nursing to adopt implementing rules and regulations to meet changing practice. This definition is based on information found in the report, "Critical Requirements for Safe/Effective Nursing Practice", 1978, a research project conducted for the Council of State Boards of Nursing by Angeline M. Jacobs and others. It does not include reference to educational preparation or responsibilities that are common to all health professions, such as knowledge of biological, physical, behavioral, psychological and sociological sciences; supervision, administration, delegation and teaching; and performing interdependently with other health professionals. It is believed that execution of the medical regimen does not describe the essence or unique elements of nursing that distinguish it from other health professions and for which regulation is required in order to safeguard the public health, safety and welfare. Others, such as pharmacists, medical social workers, and physical therapists, also execute aspects of the medical regimen, but this Act does not describe their particular practices. However, the process of implementing a strategy of care may encompass collaboration with the profession of medicine in carrying out certain aspects of the medical regimen. In many instances the welfare of the health care recipients necessitates medical and nursing care synergism. Assisting other health professionals in providing care should be a legally recognized component of practice not only for nurses, but for all health professionals.

This definition describes the responsibilities and scope of practice of professional nurses and entrusts them with overall responsibility for nursing care. It outlines certain essential responsibilities which professional nurses have the educational preparation to undertake and for which they are held accountable. In addition, it enables the Registered Nurse to authorize nursing measures that may be performed by others under appropriate supervision. Such a definition clearly distinguishes the differences between a Registered Nurse's practice and the practice of others within the field of nursing such as Licensed Practical Nurses and auxiliaries.

UNITED KINGDOM. The Nurses, Midwives and Health Visitors Rules Approval Order 1983. S.I. 1983/873. Dated 18 May 1983. *IDHL*, 1984, 35(1), 28-32.

- "18. (1) Courses leading to a qualification the successful completion of which shall enable an application to be made for admission to Part 1, 3, 5 or 8 of the register shall provide opportunities to enable the student to accept responsibility for her personal professional development and to acquire the competencies required to:
- (a) advise on the promotion of health and the prevention of illness;
 - (b) recognize situations that may be detrimental to the health and well-being of the individual;
 - (c) carry out those activities involved when conducting the comprehensive assessment of a person's nursing requirements;
 - (d) recognise the significance of the observations made and use these to develop an initial nursing assessment;
 - (e) devise a plan of nursing care based on the assessment with the cooperation of the patient, to the extent that this is possible, taking into account the medical prescription;
 - (f) implement the planned programme of nursing care and where appropriate teach and coordinate other members of the caring team who may be responsible for implementing specific aspects of the nursing care;
 - (g) review the effectiveness of the nursing care provided, and where appropriate, initiate any action that may be required;

- (h) work in a team with other nurses, and with medical and para-medical staff and social workers;
- (i) undertake the management of the care of a group of patients over a period of time and organise the appropriate support services;

related to the care of the particular type of patient with whom she is likely to come in contact when registered in that Part of the register for which the student intends to qualify.

IV. Rural service

In order to remedy to some extent the geographic maldistribution of health personnel and the under-servicing of rural populations, countries may require a period of rural service following completion of training. Granting of licensure may be conditional on satisfactory completion of such mandatory service. Examples of laws requiring such service for nurses follow.

BOLIVIA. Regulations on compulsory social service in rural health. Dated 24 July 1981. *IDHL*, 1983 34(3), 489.

Sec. 1 of these Regulations prescribes that compulsory social service in rural health (*Servicio Social de Salud Rural Obligatorio*) is intended to compensate to some extent for the resources spent by the Bolivian University on the professional training of physicians, dentists, and nurses. Sec. 2 requires all successfully qualified physicians, dentists, and nurses to undertake the service referred to. Sec. 3 defines the service as the provision of professional services in a rural area for one calendar year. Under the provisions of Sec. 4, Bolivian nationals who have obtained their qualifications abroad must complete this service before their qualifications may be recognized by the Bolivian University. Similar provisions are applicable under Sec. 5 to foreign nationals wishing to practise in Bolivia.

Sec. 7 prescribes that, where no appropriate post is available in a rural area, the persons concerned may be exempted from the service provided that they pay a sum equivalent to 5% of the total annual salary earned by "reference professionals". The sums thus collected are to be used for the supervision of the service.

NIGER. Order No. 9 MSP/AS of 13 July 1979 requiring midwives and nurses to practise for at least one year in a rural environment following completion of their studies. (*Journal Officiel de la Republique du Niger*, 1 August 1979, No. 15, p.591). *IDHL*, 1981, 32(1), 57.

See also NIGER. Order No. 009/MSP/AS of 17 april 1981 amending Order No. 009/MSP/AS of 13 July 1979 requiring midwives and nurses to practise for at least one year in a rural environment following completion of their studies. (*Journal Officiel de la Republique du Niger*, 1 May 1981, No.9, p. 316). *IDHL*, 1985, 36(2), 371.

This Order amends the Order of 13 July 1979 (see *IDHL*, 1981, 32, 57, Niger 81.4) by extending the above-mentioned obligation to cover assistant social workers, environmental sanitation officers, and laboratory technicians.

PERU. Law No. 23330 of 10 December 1981 (*El Peruano (Normas Legales)*, 11 December 1981, No. 359, pp. 5505-5506. *IDHL*, 1983, 34(1), 56.

Sec. 1 of this Law established a system of rural and urban peripheral service in the health field (*Servicio Rural y Urbano Marginal de Salud*), to be undertaken by newly-qualified health professionals. Such service must be undertaken in order to be eligible for employment in a public establishment, participation in subspecialization programmes, and State study grants or equivalent aid. Sec. 4 prescribes that rural and urban peripheral service in the health field is to be of not more than one year's duration and is to be undertaken immediately following graduation. Sec. 5 prescribes that regulations governing the service are to be laid down by the Executive in consultation with, *inter alia*, the National Health Council.

V. Continuing education

Legislation requiring continuing education is an effective mechanism for assuring that the knowledge and skills of health personnel are continually updated. Licensing laws governing nursing may require a certain amount of approved continuing education as a condition for renewal of a license. Following are some examples of laws providing for continuing education of nurses.

BOLIVIA. Regulations on the practice of nursing. Dated 15 March 1982. *IDHL*, 1983, 34(3), 491-494.

Sec. 34 provides that institutions employing nursing personnel are responsible for their training.

Sec. 35 prescribes that training is to take the following forms: (a) initial training for nursing personnel on first entering a health establishment; (b) in-service training to improve efficiency; and (c) further training, both in Bolivia and abroad, to keep personnel abreast of scientific and administrative programmes."

COUNCIL OF EUROPE. Recommendation No. R (83)5 of the Committee of Ministers to member states on further training for nurses. Adopted by the Committee of Ministers on 26 May 1983 at the 360th meeting of the Ministers' Deputies. *IDHL*, 1984, 35(3), 568-577.

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering the generally increasing level of education in member states, the growing expectations of the population with regard to health care, and believing that the quality of nursing care can be improved by further nursing training in particular in the fields of clinical nursing specialisation, nursing education, nursing management and administration;

Recommends to governments of member states:

- that, for suitably experienced, qualified nurses, further training be provided especially in the field of clinical nursing, nursing education and nursing management/administration, and that such education or training should be available as either full or part-time study;
- that the content of such training be based on and include research in nursing and the development of conceptual models; the nursing education should develop the ability of students to recognise the distinctive characteristics of the various types of client/patient and their environment, integrate theory with practice and develop team work;
- that following satisfactory completion of the nursing student's period of training, a national certificate be provided corresponding to the level attained in further training;
- that they take the initiative in co-operating with the other member states, particularly neighbouring states having linguistic and cultural affinities, to create further training centres for the above categories of nurses;
- that the measures outlined in the appendix hereafter be considered when implementing the present recommendation.

The Council of Europe set forth its prescriptions for further training for different categories of nurse: clinical nurse specialist, community nurse, infection control nurse, and midwife and obstetric nurse. Further

education for three levels of nurse manager/administrator is also prescribed: first-level nurse manager, middle-management, and top-level nurse administrator. We present below the Council of Europe's recommendation for further training of the first-level nurse manager because she is the one most frequently involved in primary health care.

1. First level nurse manager

Definition

The goal of this nurse manager is the organization and the maintenance of quality patient care.

Entry requirements

Qualification in general nursing care (first level nurse).

Content of educational programme

- Behaviour sciences,
- management of care,
- ability to assess, plan, execute and evaluate nursing care,
- decision-making,
- teaching methodology,
- manpower management,
- research techniques.

Place of education

Institute of higher education, but will depend on the structure of basic nursing education.

Duration of the course

Variable, may take place in modules.

TUNISIA. Order of 31 December 1981 of the Minister of Public Health establishing a national council and regional committees for the continuing education of health personnel. (*Journal Officiel de la République Tunisienne*, 8-12 January 1982, No. 2, pp. 84-85). *IDHL*, 1982, 33(3), 462.

Sec. 2 of this Order prescribes that the National Council for the Continuing Education of Health Personnel is responsible for submitting proposals intended to ensure that health personnel in the State and private sectors have access to such continuing education as is necessitated by advances in knowledge in the field of health and is in the public interest (in particular, the Council is to draw up annual training programmes). Sec. 3 makes the regional committees responsible for submitting proposals to the National Council in order to ensure continuing education of health personnel at the regional level and, in particular, submitting proposals concerning annual training programmes and monitoring their implementation.

VI. Career structure

Career structure does not figure largely in current legislation concerned with the regulation of the nursing profession. Most initiatives related to career structure arise from the activities of national and international nursing associations and trade unions. In some countries these organizations are engaged in debate or in making proposals on career structure to ministries of health or legislatures. The proposals frequently emphasize the extension of the clinical career ladder rather than reserving the top rungs for those undertaking management and teaching.

Several countries are taking the view that nurses should combine nursing practice, teaching, research, and management within senior roles. As has been indicated in other parts of this Annex, primary health care is seen in several countries as an essential part of the basic education of the nurse. Additionally, some countries have for many years believed it to be important to build upon the basic education programme to produce a specialist nurse concerned with primary health and community care. Such a nurse can combine management and teaching of others, engage in research allied to primary health care, and thus provide true leadership. Legal barriers to the development of nurse leadership in primary health care should be removed.

To further career development, it is important that collaboration between labour organizations, such as nurses' associations, and regulatory bodies and employing agencies be fostered. Examples of laws concerning career structure of nurses follow.

PERU. Law No. 23586 of 29 December 1982 laying down general standards to regulate the work and career of health professionals. (*Revista Juridica del Peru*, October-December 1982, Vol. 33, No. IV, pp. 410-437). *IDHL* 1983, 34(3), 498.

" . . . the following are considered as health professionals for the purpose of this law. . . .nurses. . . ."

PORTUGAL. Decree-Law No. 305/81 of 12 November 1981 approving the career structure of nursing personnel. (*Diario da Republica*, Part I, 12 November 1981, No. 261, pp. 2998-3004). *IDHL* 1985, 36(1), 25-26.

" . . . This Decree-Law, which repeals certain earlier texts, contains detailed provisions on the administrative organization of the careers of nursing personnel and their training and specialization. Sec. 19 (Final provision) prescribes *inter alia* that provisions for the implementation of the Decree-Law are to be laid down by order of the competent Ministers after consultation with the trade unions concerned."

**Sources of Information on Legislation Governing
Nursing Education and Practice**

Canadian Nurses' Association
50, The Driveway
Ottawa, Ontario K2P 1E2
Canada

National Council of State Boards of Nursing, Inc.
625 North Michigan
Suite 1544
Chicago, Illinois 6061
USA

Mr S. S. Fluss, Chief
Health Legislation
World Health Organization
1211 Geneva 27
Switzerland

International Council of Nurses
3, Place Jean-Marteau
1201 Geneva
Switzerland

Mr C. Ralph
Registrar and Chief Executive
United Kingdom Central Council for Nursing,
Midwifery and Health Visiting
23 Portland Place
London W1N 3AF
United Kingdom

Miss Maude Storey, C.B.E.
14 Conifer Drive
Tilehurst
Reading, Berks. RG2 6YU
United Kingdom

American Nurses' Association
2420 Pershing Road
Kansas City, Missouri 64108 USA
USA