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GUEST EDITORIAL AND DISCOURSE

International Nursing: The Benefits of Working Together to Improve Nursing Globally

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Nursing around the world is experiencing many common problems and challenges in its growth as a profession. The predominant issues, internationally, in nursing are: generation, dissemination, and utilization of relevant nursing knowledge; nursing's limited influence on policy formulation and implementation and on planning; the need for enhancement of nursing education (basic and post-basic); imbalances between supply and demand and maldistribution in favour of urban-based and curative services; poor working conditions; and the substitution of unregulated health-care workers for professional nurses. These issues reflect the state of nursing human resource development (NHRD) around the world, the three major components of which are: planning and policy; production — that is, the preparation of nurses to meet the health needs of a population; and management, which addresses all aspects of nurses' work — practice, recruitment, retention, utilization, and the work environment.

The state of nursing knowledge varies internationally. Countries in the North have developed highly specialized bodies of knowledge, including nursing concepts, models, and theories. In these countries research is integral to the profession and nurses are strongly urged to engage in reflective practice and to base that practice on scientific evidence generated through a rigorous research process. New knowledge is being generated on nursing interventions as well as on education, organization of nursing services, and all dimensions of nurses' work life. At the other end of the continuum are countries in which nursing relies almost exclusively on knowledge generated elsewhere. Often, that knowledge is accepted without critical appraisal of its local relevance or awareness that it is outdated. The result may be nurses who are inadequately prepared to deal with the health problems of the population they serve. I vividly recall visiting a rural health unit in the South in the early 1980s and being informed by the nursing personnel that they had finally overcome the traditional practice of women using

a squatting position for childbirth. The nurses were using 1970s textbooks and had no idea that a number of the traditional practices they had strived to eliminate were highly valued at birthing centres in the North.

Nursing in the North has a plethora of resources for not only the generation of knowledge but also the dissemination of that knowledge. The vast majority of learning resources, including textbooks, journals, and audio- and videotapes, are produced in the North. Frequently, differential stages of development result in the profession in the North thinking of international nursing in terms of a one-way transfer of knowledge and skills, from the North to the South. We fail to recognize that the knowledge and skills of nursing in the South could be beneficial to nursing in the North. Even when forums such as journals and International Council of Nurses conferences are available, in many countries nursing lacks the resources to generate, compile, or share information.

There is a dearth of information on nursing from a global perspective. Nursing collaboration among countries within the North or the South or between the North and the South is a means of generating and sharing information and acknowledging the reciprocal nature of the exchange. International research poses special problems — for example, variation in interpretation of concepts, means of collecting and storing data, and responses of subjects to specific data-collection methods or instruments. For instance, mailed questionnaires are an effective survey tool in North America but not in Pakistan. However, the articles in this issue of *CJNR* show that the benefits of being able to compare dimensions of nursing across countries do outweigh the difficulties inherent in conducting research internationally.

Planning refers to the process of estimating the number of nursing personnel and the type of knowledge, skills, and attitudes needed to meet predetermined health targets (Hall & Mejia, 1978). Policy refers to statements made by relevant authorities to guide the allocation of resources (World Health Organization [WHO], 1990). Policy formulation and implementation and planning occur at the international, national, regional, and local level. Frequently, there is a gap between policy and implementation. The political influence of nursing varies internationally, ranging from little or no influence at any level to some degree of influence at every level. Tornquist and associates report that the lack of nursing influence at the policy and planning levels can have significant consequences for recruitment and retention, basic and post-basic education, working conditions, and legislative support for nursing practice (Tornquist et al., 1997). In Canada the profession does

have influence; for example, its input into national policy on health-care reform has been accepted (Canadian Nurses Association, 1988). In some countries, in contrast, nursing has little or no influence, even at the institutional level, over the policy and planning decisions that affect nurses' work lives.

The value placed on nursing's contribution to health care by society, politicians, bureaucrats, administrators, and other health professionals — especially physicians — is a major determinant of its influence. The development of nursing tends to be influenced by three factors: power, gender, and the medicalization of health services (WHO, 1994). Globally, nursing is seen primarily as women's work, and women's work is undervalued. In countries in which women have lower social status and less power than men, nursing has lower status and less power than male-dominated occupations. The degree to which health services are medicalized with the concomitant dominance of medicine (primarily male physicians) affects the status and practice of nursing. Recognition and acceptance of the importance of primary health care and the role that nursing can play in achieving health impacts on the status of nursing. For instance, in Iran after the revolution of 1979 nursing was seen by the government as having an integral role to play in the restructured health services. The status of nursing was enhanced, and significant changes were made in both nursing education and the work life of nurses, reflecting the government's valuing of nursing and its commitment and support to the development of nursing as integral to the national health-care system (Salsali, 1998).

Tornquist et al. (1997) identify four developments necessary for nurses to contribute as policy-makers: national political will and recognition by politicians and other decision-makers of nursing's contribution to health care; possession by nurses of the knowledge and skills to participate in policy-making; possession by nurses of leadership skills at all levels; and nursing education at the basic level stressing the importance of policy formation and the need for leadership in the profession. The last three suggested developments have major implications for basic and post-basic nursing education, including continuing education.

In a survey conducted by the International Council of Nurses (1995), professional nursing organizations identified education as the top priority. Globally, there is much diversity in nursing education. Many countries are changing or seek to change the focus of education; move education away from service institutions to institutions of higher learning, including universities; elevate educational entry requirements; and adopt more student-centred, interactive approaches to learning.

Many countries have an inadequate recruitment pool, while in other countries the pool is adequate but a situation of ever-increasing career options leads to under-enrolment. In most countries nursing is viewed as women's work and the applicant pool is dependent on the educational level of young women. In Paraguay, for instance, as the level of general education rises, nursing is altering the minimum educational standards for entry. Nursing education, especially the ratio of male to female students and the approach to teaching and learning, is greatly influenced by its socio-cultural environment. The transition to higher education is no easy feat, as recent experience in the United Kingdom demonstrates (Draper, 1996). In countries that have made the transition to exclusively university-based fundamental nursing education — for example, Chile, Colombia, and Australia — the key variables were government support and a unified position by nursing leaders. In the U.S. and Canada, on the other hand, nursing has advocated for university-level preparation for entry to the profession but for numerous reasons has yet to fully realize the transition.

The move to higher educational standards is associated with the following factors: changes in the health status of populations; greater attention to health promotion and disease prevention; restructuring of health services; rapid advances in knowledge and technology; the need for research and evidence-based practice; and resultant changes in the knowledge, skills, and attitudes required for the practice of nursing. In addition to changes in basic nursing education, nursing education around the world is placing increasing emphasis on specialty preparation, especially clinical specialization, and on post-graduate preparation.

The nature of professional education is also changing, with increased recognition of the need for professionals to possess the attributes of the liberally educated (Gillis, Lellan, & Perry, 1998), to be life-long learners, to be effective utilizers of research, and, for some, to generate nursing knowledge. More attention is being paid to the learning process and the facilitative role of faculty. The need for nurses to be life-long learners is resulting in increased emphasis on continuing education. Thus nursing is attempting to change its approach to basic education while simultaneously providing advanced education at the levels of graduate and continuing education — a formidable task, particularly when working conditions place considerable strain on the profession.

Fluctuating imbalances between supply and demand in nursing personnel is a universal problem. In countries where nurses are viewed as an exportable human resource, supply may exceed demand (Marsden, 1994), but the more common situation is a nursing shortage. Countries in which nursing is not well established, such as the United

Arab Emirates, must recruit the vast majority of their nurses from other countries. Even countries in which nursing is well established, such as the U.S., the U.K., and Canada, experience fluctuating imbalances between supply and demand. Myriad factors contribute to such imbalances, but certainly the lack of health human resource development (HHRD) in general and NHRD in particular are pre-eminent factors. Increasingly more attention is being given to coordinating HHRD with the development of a country's health services (Hall & Mejia, 1978). A coordinated approach to HHRD is a challenge at the conceptual stage. In nursing, attempts have been made to coordinate NHRD with the development of health services, but NHRD is at an embryonic stage in its development.

In most countries, health-care services and nursing have evolved with a strong bias in favour of curative and institution-based care. Despite deeply entrenched hospital-based curative systems, health services around the world are placing greater emphasis on health promotion, disease prevention, and primary health care. Nursing has recognized these shifts and is attempting to make the necessary changes to support the goal of health for all (e.g., Salvage, 1993). Nursing in countries of the North is encountering difficulties moving from a disease-curative orientation to a health-promotion/prevention one, while countries in the South, such as Pakistan, with their limited resources and/or a less highly developed nursing profession, are experiencing even greater problems.

Nurses work in many different settings, their role ranging from medical assistant to autonomous practitioner providing comprehensive health services. Globally, nursing personnel endure poor working conditions, and working conditions are associated with a low status, while low status is, in turn, associated with the status of women (Tornquist et al., 1997). A major debate within nursing is whether the presence of more men in the profession will raise the status of nursing or result in just another instance of male dominance. The male:female ratio is relatively small in the majority of countries; for instance, only 4.2% of registered nurses employed in nursing in Canada in 1997 were men. However, in Spain, Italy, and Malta the percentage is 15% or higher. Research shows that upward mobility within the profession differs for men and women, with men occupying leadership positions disproportionately to their numbers (Marsden, 1994). Around the world, the majority of nurses work in hospital settings, which have what Acker (1990) refers to as a gender substructure reproducing gender divisions and inequalities. Surveys have shown that working conditions are affected by an insufficient number of nurses in key positions to influ-

ence policies concerning the employment of nurses, inadequate preparation of nursing leaders for their roles, and inadequacies in basic nursing education with respect to political influence and leadership (Tornquist et al.). The gender distribution in nursing and the structures within which nurses work make it difficult to differentiate issues peculiar to nursing and its work environments from issues of women in general. Much of the research on the role of nursing personnel and working conditions has been conducted in the North and among nurses employed in hospital settings.

In many countries, nursing has various levels of personnel and the nature and scope of practice by each cadre is not always discerned by members of the public or by other health-care providers. The resulting role diffusion affects the status accorded nursing — for example, nursing may be seen as an occupation that requires little education. In a number of countries, especially those in the South, nursing has for years been dealing with the issue of unregulated health-care workers, whereas in North American countries the presence of unregulated health-care workers in the delivery of health services is a relatively new phenomenon. The de-professionalization of nursing services that results when poorly qualified staff are substituted for professional nurses is associated with insufficient information to support the value of professional nursing on patient outcomes. Investigation of the relationship between nursing services and patient outcomes (e.g., Blegen, Goode, & Reed, 1998) is difficult to conduct, but the findings of such research are paramount in demonstrating the value of nursing.

The four articles selected for the focus of this issue of the Journal illustrate the value of international collaboration in generating nursing knowledge and the issues involved in conducting international research. All address one or more dimensions of NHRD. The article by O'Brien-Pallas et al. illustrates the gap between policy and its implementation, even when the policy arises from a highly authoritative body such as the World Health Organization; the difficulties involved in obtaining cross-country information on policy implementation; and the value of examining the current situation as part of the planning process. Their study also demonstrates the international variation in availability and accessibility of accurate information on nursing. Developing a data-collection tool applicable to diverse groups is always a challenge, even more so in the face of multiple languages and nuances of language. This study also illustrates the problems inherent in gathering data across multiple settings when one does not have firm control over the process.

Globally, nursing education is moving away from teacher-centred approaches to those that focus on the learner and the learning process. Carpio et al., in their study of learning styles among students and faculty in Canada and in Chile, provide evidence on why we need to pay attention to differences in how persons learn. While this study dealt with basic nursing education, its results have relevance for lifelong learning and all levels of nursing education — including continuing education, which is recognized as essential for any health professional today.

Most of the research on the factors that affect the quality of the work environment and/or intention to leave nursing has been conducted in the North American/European context. The study by Al-Ma'aitah et al. provides important information on the work life of nurses in Jordan, identifies the similarities of work life there with that of nurses in other countries, and makes an important contribution to our understanding of the different or similar experiences of female and male nurses. It illustrates how researchers capitalizing on a unique environment in the South can generate information of value to nursing everywhere. The 4:1 female:male ratio of Jordanian nurses allows for the study of gender differences in an occupational group within one particular societal and work environment. The study also confronts the issue of establishing validity and reliability of research instruments developed for use in another culture or country. Although as researchers we are forewarned to establish validity and reliability of instruments for populations that differ from that used in developing the tool, this caution is often overlooked.

The description of the international multi-site study by Sochalski et al. to explicate the role of the organization of nursing on differential patient outcomes provides valuable information on conducting rigorous international research and effectively using national expertise. One of the most contentious issues in nursing is that of evaluating the impact of nursing on the health outcomes of the population being served. This study involving several countries of the North addressed outcomes in relation to the organization of services. The findings will be of great interest to nursing, governments, and other entities. The evolution of the study illustrates a keen awareness of country differences and the value of rigour at the planning stage — for example, careful attention to design, instrument-development and data-collection measures, and sampling frame.

The issues that confront nursing worldwide are not easily resolved. By working together and sharing information we stand to learn valuable lessons from one another. Enhanced technology as well as increas-

ing international mobility of professionals allows for greater collaboration, but that collaboration will not occur unless nursing recognizes and values the reciprocal nature of the exchange. The contributors to this issue of *CJNR* have experienced firsthand the challenges and benefits of collaborative research.

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