DIPLOMA IN REGISTERED NURSING

e- LEARNING PROGRAM

COURSE TITLE: **PROFESSIONAL PRACTICE**

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BEATRICE ZULU

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ABBREVIATIONS AND ACRONYMS

AMREN- African Midwives Research Network

ANC- Antenatal care

AIDS- Acquired Immune Deficiency Syndrome

BMI- Body Mass Index

CBD- Communality Based Distribution

CBoH- Central Board of Health

CNR- Council of National Representative

CHW- Community Health Worker

DHMT- District Health Management Team

DRGs- Diagnosis Related Groups

ECSACON- East, Central and Southern Africa Collage of Nursing

GNC- General Nursing Council

ICN- International Council of Nurses

ICM- International Council of Midwives

IMF- International Monitory Fund

MoH- Ministry of Health

PAC- Post Abortal Care

PMTCT- Prevention of Mother to Child Transmission

PSDA- Patient Self Determination Act

TBA- Traditional Birth Attendants

WHO- World Health Organisation

ZDHS- Zambia Demographic Health Survey

ZMRA- Zambia Medicines Regulatory Authority

ZOTNG- Zambia Operating Theatre Interest Group

ZUNO- Zambia Union of Nurses

COURSE INTRODUCTION

Welcome to Professional Practice course! This is a course that provides, a student nurse like you , with knowledge, skills and professional understanding so that they are able to care for the clients and interact with other stake holders within the health

care system and should always conform to the standards of the nursing profession. This course will equip you with knowledge and skills that will uphold and foster your professionalism in nursing. It is therefore, hopped that with the knowledge that you will acquire from this course you will uphold high standards of professionalism and consequently provide high quality of nursing care to clients. The knowledge gained will also help in preventing you from bringing reproach to the nursing profession due to lack pf professionalism.

COURSE OBJECTIVES

At the end of this course, you should be able to:

1. Describe the historical development of the nursing profession
2. Explore the role of the nurse in health care delivery system
3. Explain the professional code of conduct for nurses and midwives
4. Describe legislation and regulation governing nursing practice in Zambia

Course Content

This course has six (6) units as follows:

Unit 1: The development of Nursing

In this unit we will define terms related to the development of nursing, describe the development of nursing and discuss nursing as a profession.

Unit 2: Policies, Legislation and Regulations for Nursing Practice

Well learner, in this Unit we will define the concepts law and the constitution. We will introduce you to the Zambian constitution, the Nurses and Midwives Act, Health and Allied Profession Act, Disability Act and the Child Protection Act. We will also cover other regulations such as the professional code of conduct, International Code of Ethic and practice, Professional Regulatory Framework, various policies on health and the regulatory organisations.

Unit 3: Professionalism

In this unit we shall define terms related to professionalism, outline the characteristics of a profession, and state the responsibilities of a profession. We will further discuss the ethical and legal aspects of nursing practice and the following

rights; human rights, rights of the nurse and clients' rights. Lastly, we will discuss the professional organisations and interest groups.

Unit 4: Attitudes

Learner, in this Unit we will define the concept attitude and other terms related to it , explain the development of attitudes, discuss the positive and negative attitude and the factors influencing attitudes formation.

Unit 5: Interpersonal Relationship

In this Unit we will define terms related to interpersonal relationship, look at the types of relationships and state the characteristics of interpersonal relationship and the roles of the nurse in interpersonal relationship. We will also discuss the importance of these relationships and the barriers to the same.

Unit 6: Assertiveness

In this Unit we will define the concept assertiveness, discuss assertiveness versus other styles of interpersonal behaviours and discuss how to learn assertive behaviours, explain the barriers to assertive behaviour and the techniques for practicing assertiveness.

Core competencies

At the end of this course, as a learner you are expected to have the following competencies:

1. Exhibit hospital etiquette and use the principle of ethics when interacting with clients, family, community and health care team.
2. Utilise the beliefs, norms and values enshrined in the code of ethics in the provision of quality health care.
3. Observe the legal and statutory standard through which nursing professional practice is regulated.
4. Exhibit interpersonal relationships with the client, community, family and health care team in a courteous and respectful manner when providing care in all health settings.
5. Display positive attitude in the delivery of care to individuals, families and groups.
6. Collaborate and work with other agencies in the provision of health care.

Course Duration

Dear learner, you will be expected to spend forty-five (45) hours to complete this course.

Assessments

In this course you will be required to write two (2) tests and two (2) assignments which will make a total of forty (40%) percent of the final examination. You final examination will carry sixty (60%) percent.

Prescribed Readings

1. Kay,K.C (1997). Professional Nursing: Concepts and Challenges. Philadelphia: W.B Saunders.

2. Potter, P.A and Griffin,A.P. (2001). Fundamentals of Nursing, St. Louis: Mosby Company.

3. Searle,C. (2000). Professional Nursing, Johanesburg: Heineman.

UNIT 1: DEVELOPMENT OF NURSING

1.1 Unit Introduction

Hello learner, welcome to this interesting discussion on profession practice and in particular the development of nursing. Feel at ease and relax as we go through the discussion. In this unit you will acquire knowledge on the nursing profession and its historical development

1.2 Unit Objectives:

By the end of this unit you should be able to:

1. Define terms in the nursing profession
2. Describe the historical development of nursing
3. Describe nursing as a profession

1.3 Definition of Terms

There are a number of terms that we use in our nursing practice. Before we go in detail to learn about them, let us do the following activity.

Activity 1

In your own words, write down the meaning of nursing in your notebook

Well done! Now compare your definition with the ones we shall discuss below.

1.3.1 Nursing

a) Florence Nightingale defined nursing as "the act of utilizing the environment of the patient to assist him in his recovery" (Nightingale, 1860-1969). Nightingale considered a clean, well- ventilated and quiet environment essential for recovery.
b) Virginia Avenel Henderson defined nursing as "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge and to do this in such a way as to help him gain independence as rapidly as possible" (Henderson, 1966, p. 3).
c) "Nursing is the diagnosis and treatment of human responses to actual or potential health problems" (ANA, 1980, p. 9).
d) "Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" American Nurses Association (ANA, 2003, p. 6).

e) Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles(International Council of Nurses date....)

f) The uses of clinical judgment in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death." Royal College of Nursing, UK(date?)

1.3.2 Profession

A profession is composed of a disciplined group of individuals who adhere to themselves and are accepted by the public as possessing special knowledge and skills in a widely recognized, organized body of learning derived from education and training at a higher level and these skills are in the interest of others (http://dictionary.reference.com/browse/profession)

1.3.3 Professional:

A professional is a person formally certified by a professional body of belonging to a specific profession by virtue of having completed a required course of studies and/or practice and whose competence can usually be measured against an established set of standards.

(http://www.businessdictionary.com/definition/professional).

1.3.4 Professionalism:

This is the competencies and professional conducts acquired through training and education which ensures that an individual is able to perform according to ethical standards recognized by the professional association or council."

Professionalism refers to the conduct, aims, or qualities that characterize or mark a profession or a professional person (http://merriam-webster.com/dictionary/professionalism).

1.4 Historical Development of Nursing

Well learner, now that we have defined terms that we use in nursing practice, let us now describe the historical development of nursing. Nursing is one of the world's most enduring professions. There is a long history of people devoting their lives to the care of the sick. Through the centuries, nursing has evolved from practices based on tradition and myths to today's rigorously trained professionals.

Nursing, as an activity that provides help to the ill, has existed since the earliest times. Nursing today is far different from nursing as it was practiced years ago and it is expected to continue changing. To comprehend present-day nursing and at the same time prepare for the future, one must understand not only the past events but also contemporary nursing practice and the sociological and historical factors that affect it.

We shall start by looking at the historical development of nursing internationally, and then move on to its development regionally and nationally.

1.4.1 International Perspective

(a) Early History

In ancient times, there were no professional nurses. People cared for the ill in their homes or brought them to temples for healing. In the early days of Christianity, nursing and care of the sick began to be seen as an act of charity and women were given the task of nursing. Hospitals began to be built adjacent to monasteries and convents and nuns and brothers cared for the poor and sick who were brought to them.

During the Protestant Reformation, as monasteries and convents were wiped out, so too were the hospitals. While the study of medicine flourished in the universities, the practice of nursing did not. Nursing was not considered a suitable profession, and those nurses who were not in religious orders were seen as illiterates, drunken and immoral. Many were prostitutes.

There were many religious orders that did continue nursing the sick, including the order of St. Vincent DePaul, the Order of the Visitation of Mary, the Sisters of Charity and the Hospitallers of St. John. However, training was limited to traditions passed down from prior generations. The sick, the mentally ill, the dying and the indigent were often seen as a burden on society and were often neglected.

Nursing has undergone dramatic change in response to societal needs and influences. A look at nursing's beginnings reveals its continuing struggle for autonomy and professionalization. In recent decades, a renewed interest in nursing history has produced a growing amount of related literature. This section highlights only selected aspects of events that have influenced nursing practice. Recurring themes of women's roles and status, religious (Christian) values, war, societal attitudes, and visionary nursing leadership have influenced nursing practice in the past. Many of these factors still exert their influence today (Ancho, 2000).

(b) Women's Roles

Traditional female roles of wife, mother, daughter, and sister have always included the care and nurturing of other family members. From the beginning of time, women have cared for infants and children; thus, nursing could be said to have its roots in "the home." Additionally, women, who in general occupied a subservient and dependent role, were called on to care for others who were ill in the community (Ancho, 2000). Generally, the care provided was related to physical, maintenance and comfort. Thus, the traditional nursing role has always entailed humanistic caring, nurturing, comforting, and supporting.

(c) Religion

It is important to note that religion has also played a significant role in the development of nursing. Although many of the world's religions encourage benevolence, it was the Christian value of "love thy neighbour as thyself" and Christ's parable of the Good Samaritan that had a significant impact on the development of Western nursing. During the third and fourth centuries, several wealthy matrons of the Roman Empire, such as Fabiola, converted to Christianity and used their wealth to provide houses of care and healing (the forerunner of hospitals) for the poor, the sick, and the homeless. Women were not, however, the sole providers of nursing services.

The Crusades saw the formation of several orders of knights, including the Knights of Saint John of Jerusalem (also known as the Knights Hospitalers), the Teutonic Knights, and the Knights of Saint Lazarus. These brothers in arms provided nursing care to their sick and injured comrades. These orders also built hospitals, the organization and management of which set a standard for the administration of hospitals throughout Europe at that time. The Knights of Saint Lazarus dedicated themselves to the care of people with leprosy, syphilis, and chronic skin conditions. The deaconess groups, which had their origins in the Roman Empire of the third and fourth centuries, were suppressed during the middle Ages by the Western churches. However, these groups of nursing providers resurfaced occasionally throughout the centuries, most notably in 1836 when Theodore Fliedner reinstituted the Order of Deaconesses and opened a small hospital and training school in Kaiserswerth, Germany (Ancho, 2000). Florence Nightingale received her "training" in nursing at the Kaiserswerth School.

Early religious values, such as self-denial, spiritual calling, and devotion to duty and hard work, have dominated nursing throughout its history. Nurses' commitment to these values often resulted in exploitation and few monetary rewards. For some time, nurses themselves believed it was inappropriate to expect economic gain from their "calling."

(d)War

Throughout history, wars have accentuated the need for nurses. During the Crimean War (1854-1856), the inadequacy of care given to soldiers led to a public outcry in Great Britain. The role Florence Nightingale played in addressing this problem is well known. She was asked by Sir Sidney Herbert of the British War Department to recruit a contingent of female nurses to provide care to the sick and injured in the Crimea war. Nightingale and her nurses transformed the military hospitals by setting up sanitation practices, such as hand washing and washing clothing regularly. Nightingale is credited with performing miracles; the mortality rate in the Barrack Hospital in Turkey, for example, was reduced from 42% to 2% (Donahue, 1996, p. 197).

During the American Civil War (1861-1865), several nurses emerged who were notable for their contributions to a country torn by internal strife. Many women served as nurses in the hospitals of both the Union and Confederate Armies, often also performing their humanitarian service close to the fighting front or on the battlefields themselves – earning the undying respect and gratitude from those whom they served. Harriet Tubman and Sojourner Truth provided care and safety to slaves fleeing to the North on the Underground Railroad. Mother Bieker dyke and Clara Barton searched the battlefields and gave care to the injured and dying soldiers. Notable authors Walt Whitman and Louisa May Alcott volunteered as nurses to give care to injured soldiers in military hospitals. On June 10, 1861, two months after the Civil War began, the Secretary of War appointed Dorothea Lynde Dix as Superintendent of Women Nurses for the Union Army. She became the Union's Superintendent of Female Nurses responsible for recruiting nurses and supervising the nursing care of all women nurses working in the army hospitals. Around 6,000 women performed nursing duties for the federal forces. It is estimated that some 181 black nurses served in convalescent and U.S. Government hospitals during the war.

The arrival of World War I resulted in American, British, and French women rushing to volunteer their nursing services. These nurses endured harsh environments and treated injuries not seen before. Progress in health care occurred during World War I, particularly in the field of surgery. For example, there were advancements in the use of anesthetic agents, infection control, blood typing, and prosthetics (Holder, 2004, p. 915).

World War II casualties created an acute shortage of caregivers, and the Cadet Nurse Corps was established in response to a marked shortage of nurses. Also at that time, auxiliary health care workers became prominent. "Practical" nurses, aides, and technicians provided much of the actual nursing care under the instruction and supervision of better prepared nurses. Medical specialties also arose at that time to meet the needs of hospitalized clients.

During the Vietnam War, approximately 90% of the 11,000 American military women stationed in Vietnam were nurses. Most of them volunteered to go to Vietnam right after they graduated from nursing schools. This made them the youngest group of

medical personnel ever to serve in wartime (Vietnam Women's Memorial Foundation).

(e) Societal Attitudes

Society's attitudes about nurses and nursing have significantly influenced professional nursing. Before the mid-1800s, nursing was without organization, education, or social status; the prevailing attitude was that a woman's place was in the home and that no respectable woman should have a career. The role for the Victorian middle-class woman was that of wife and mother, and any education she obtained was for the purpose of making her a pleasant companion to her husband and a responsible mother to her children. Nurses in hospitals during this period were poorly educated; some were even incarcerated criminals. Society's attitudes about nursing during this period are reflected in the writings of Charles Dickens. In his book Martin Chuzzlewit (1896), Dickens reflected his attitude toward nurses through his character. She "cared" for the sick by neglecting them, stealing from them, and physically abusing them (Donahue, 1996, p. 192). This literary portrayal of nurses greatly influenced the negative image and attitude toward nurses up to contemporary times.

In contrast, the guardian angel or angel of mercy image arose in the latter part of the 19th century, largely because of the work of Florence Nightingale during the Crimean War. After Nightingale brought respectability to the nursing profession, nurses were viewed as noble, compassionate, moral, religious, dedicated, and self-sacrificing individuals.

Another image arising in the early 19th century that has affected subsequent generations of nurses and the public and other professionals working with nurses is the image of doctor's handmaiden. This image evolved when women had yet to obtain the right to vote, when family structures were largely paternalistic, and when the medical profession portrayed increasing use of scientific knowledge that, at that time, was viewed as a male domain. Since that time, several images of nursing have been portrayed. The heroine portrayal evolved from nurses' acts of bravery in World War II and their contributions in fighting poliomyelitis, in particular, the work of the Australian nurse Elizabeth Kenney. Other images in the late 1900s include the nurse as sex object, surrogate mother, tyrannical mother, and body expert.

During the past few decades, the nursing profession has taken steps to improve the image of the nurse. In the early 1990s, the Tri-Council for nursing (the American Association of Colleges of Nursing, the American Nurses Association, the American Organization of Nurse Executives, and the National League for Nursing) initiated a national effort (titled "Nurses of America") to improve the image of nursing. More recently, the Johnson & Johnson corporation contributed $20 million in 2002 to launch a "Campaign for Nursing's Future" to promote nursing as a positive career choice (Anonymous, 2003; Fitzpatrick, 2002). In addition, nursing schools and hospitals are targeting men in their recruitment efforts (Meyers, 2003).

(f)Nursing Leaders

Florence Nightingale, Clara Barton, Lillian Wald, Lavinia Dock, Margaret Sanger, and Mary Breckinridge are among the leaders who have made notable contributions both to nursing's history and to women's history. These women were all politically astute

pioneers. Their skills at influencing others and bringing about change remain models for political nurse activists today. Contemporary nursing leaders, such as Virginia Henderson, created a modern worldwide definition of nursing, and Martha Rogers, a catalyst for theory development.

Florence Nightingale (1820-1910)

It was not until Florence Nightingale served as a nurse in the Crimean War (1854-56) that nursing began to be seen as a profession that required training. She and her nurses dressed wounds and pressed the British Government for better food and hygiene for its soldiers. After the war, she opened the Nightingale School of Nursing, the first formal nurse training program. She also reformed midwife practices and established a health visitor service in Britain.

Florence Nightingale's contributions to nursing are well documented. Her achievements in improving the standards for the care of war casualties in the Crimea earned her the title "Lady with the Lamp." Her efforts in reforming hospitals and in producing and implementing public health policies also made her an accomplished political nurse: She was the first nurse to exert political pressure on government. Through her contributions to nursing education perhaps her greatest achievement was to be recognized as nursing's first scientist-theorist for her work Notes on Nursing: What It Is, and What It Is Not (1860/1969).

Nightingale was born to a wealthy and intellectual family. She believed she was "called by God to help others . . . [and] to improve the well-being of mankind" (Schuyler, 1992, p. 4). She was determined to become a nurse in spite of opposition from her family and the restrictive societal code for affluent young English women. As a well-travelled young woman of the day, she visited Kaiserswerth in 1847, where she received 3 months' training in nursing. In 1853 she studied in Paris with the Sisters of Charity, after which she returned to England to assume the position of superintendent of a charity hospital for ill governesses. When she returned to England from the Crimea, a grateful English public gave Nightingale an honorarium of 4500. She later used this money to develop the Nightingale Training School for Nurses, which opened in 1860. The school served as a model for other training schools. Its graduates travelled to other countries to manage hospitals and institutes of nurse-training programs.

Nightingale's vision of nursing, which included public health and health promotion roles for nurses, was only partially addressed in the early days of nursing. The focus tended to be on developing the profession within hospitals.

Clara Barton (1812-1912)

Clara Barton was a school teacher who volunteered as a nurse during the American Civil War. Her responsibility was to organize the nursing services. Barton is noted for her role in establishing the American Red Cross, which linked with the International Red Cross when the U.S. Congress ratified the Treaty of Geneva (Geneva Convention). It was Barton who persuaded Congress in 1882 to ratify this treaty so that the Red Cross could perform humanitarian efforts in time of peace.

Linda Richards (1841-1930)

Linda Richards was America's first trained nurse. She graduated from the New England Hospital for Women and Children in 1873. Richards is known for introducing nurse's notes and doctor's orders. She also initiated the practice of nurses wearing uniforms (American Nurses Association, 2006a). She is credited for her pioneer work in psychiatric and industrial nursing.

Mary Mahoney (1845-1926)

Mary Mahoney was the first African American professional nurse. She graduated from the New England Hospital for Women and Children in 1879. She constantly worked for the acceptance of African Americans in nursing and for the promotion of equal opportunities (Donahue, 1996, p. 271). The American Nurses Association (2006b) gives a Mary Mahoney Award biennially in recognition of significant contributions in interracial relationships.

Lillian Wald (1867-1940)

Lillian Wald is considered the founder of public health nursing. Wald and Mary Brewster were the first to offer trained nursing services to the poor in the New York slums. Their home among the poor on the upper floor of a tenement, called the Henry Street Settlement and Visiting Nurse Service, provided nursing services, social services, and organized educational and cultural activities. Soon after the founding of the Henry Street Settlement, school nursing was established as an adjunct to visiting nursing.

Lavinia L. Dock (1858-1956)

Lavinia L. Dock was a feminist, prolific writer, political activist, suffragette, and friend of Wald. She participated in protest movements for women's rights that resulted in the 1920 passage of the 19th Amendment to the U.S. Constitution, which granted women the right to vote. In addition, Dock campaigned for legislation to allow nurses rather than physicians to control their profession. In 1893, Dock, with the assistance of Mary Adelaide Nutting and Isabel Hampton Robb, founded the American Society of Superintendents of Training Schools for Nurses of the United States and Canada, a precursor to the current National League for Nursing.

Margaret Higgins Sanger (1879-1966)

Margaret Higgins Sanger, a public health nurse in New York, has had a lasting impact on women's health care. Imprisoned for opening the first birth control information clinic in America, she is considered the founder of Planned Parenthood. Her experience with the large number of unwanted pregnancies among the working poor was instrumental in addressing this problem.

Mary Breckinridge (1881-1965)

After World War I, Mary Breckinridge, a notable pioneer nurse, established the Frontier Nursing Service (FNS). In 1918, she worked with the American Committee for Devastated France, distributing food, clothing, and supplies to rural villages and

taking care of sick children. In 1921, Breckinridge returned to the United States with plans to provide health care to the people of rural America. In 1925, Breckinridge and two other nurses began the FNS in Leslie County, Kentucky. Within this organization, Breckinridge started one of the first midwifery training schools in the United States.

The Knights of Saint Lazarus (established circa 1200) dedicated themselves to the care of people with leprosy, syphilis, and chronic skin conditions. From the time of Christ to the mid-13th century, leprosy was viewed as an incurable and terminal disease.

Harriet Tubman (1820-1913) was known as "The Moses of Her People" for her work with the Underground Railroad. During the Civil War of 1861-1865, she nursed the sick and suffering.

Sojourner Truth (1797-1883), abolitionist, Underground Railroad agent, preacher, and women's rights advocate, was a nurse for over 4 years during the Civil War and worked as a nurse and counsellor for the Freedmen's Relief Association after the war. (Randall Studio (1805-1875).

In 1919 Nurses' Registration Act was passed. Each country had to set up a register of qualified nurses and compiled curricula for instruction and examination.

1.4.2 Regional perspective

In 1974, the East, Central and Southern Africa College of Nursing (ECSACON) was formed. It was inaugurated in 1990 in Malawi. The aim was to promote and sustain excellence in the nursing education, nursing practice, nursing education, nursing administration and nursing research (ECSACON, 2001).

It has 14 member countries and these are Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. It speaks authoritatively for the nursing profession. The programme aims to strengthen human capacity development in the health sector in the region. The programme objectives are to:-

a) Coordinate and strengthen capacities of member states to train and manage human resources for health and advocate for and develop policies that promote HRH development and capacity building for improved health services delivery.

b) Contribute towards improving quality of care through professional regulate, standards development and harmonization of training and education programmes and basic competencies.

c) Enhance information dissemination, networking and promote sharing of best practices and evidence based policies and programmes.

It consists of the Council of National Representatives (CNR) – President, Vice President, Treasurer, and four chairpersons of the four regional constituent Faculties, the National Council Representatives from the member states and four ex-official members who include:

i. The immediate past president of the college

ii. The Executive Director of the college

iii. The Coordinator, Human Resource and Capacity Building

iv. The Senior Program officer

v. The National Nurses Associations

1.4.3 National perspective

Before missionaries came to Zambia, the women folk nursed their sick relatives in their own homes using herbs and some roots. This knowledge was passed down from generation to generation. Although some of these roots and herbs actually cured the sick, most of these herbs killed them due to over dosing because no written instructions about the use of these medications were available.

Disease was thought of being brought by evil spirits and supernatural powers. It was believed to be a punishment for wrong doing. Treatment was prescribed by witch doctors and other family members with use of herbs and ancestral worshipping.

With the arrival of some of the missionaries in 1800 and teaching of Christianity, European Christian women started to go out in small groups attending to the sick in their own homes, using herbs and simple hygiene.

This was met with a lot of resistance by the local people who feared to lose their own methods of treatment culture and beliefs.

(a) Apprentice Nursing

Missionaries brought up the apprentice nursing. Those initially trained were called Dressers who provided care.

(b) Educated Nursing (Modern Nursing)

Nurse education in Zambia dates back to the 18th century with the arrival of missionaries. Initially, in the early days there were no hospitals so patients were treated in open ground or as outpatient under a tree. Years later, missionaries started to build hospitals to try and accommodate the very sick, and most of these were also covering long distances to seek health services. Since there were so many people needing health services, missionaries started to train local villagers to help them care for the increased number of patients. One of the very first hospitals was Mbereshi Mission Hospital in 1900.This was the first hospital which showed interest in training female helpers. Helpers were first trained in hygiene skills so that they are able to care for their families and the missionaries. They also used to go round the villages to see that better hygiene was being practiced.

In 1936, the first organized training for medical assistants was opened in Lusaka. Many medical assistants were trained who later converted to Registered Nurses at Lusaka School of Nursing. They were specifically trained to work at the native

hospital. Zambian girls could not be trained because they could not meet the educational requirements.

In 1947, Salvation Army Hospital in Chikankanta started training female medical assistants, by that time; few Zambian girls had few necessary qualifications. In 1952 St Francis hospital in Katete opened a training school for medical assistants. There was a provision to enroll both male and female candidates. The emphasis on training was on nursing. Although schools were opened, the trend of training continued, Zambian girls were still being trained as helpers. These were referred to as Dressers. In 1951, Chikankata started training midwives. Mrs. Bridget Mphande Ngwisha was one of the prominent nurses trained at Chikankata. Other Enrolled Nursing programs opened by Missionaries were Chilonga (1962), Mwami (1962) and Chitambo. Between 1950-1960 some of the Zambian females and males had to go to Southern Rhodesia (Zimbabwe), South Africa and UK for education and train as Registered Nurses. Those who went to SA, UK and Southern Rhodesia (Zimbabwe) most of them have retired. The notable ones are; Mrs. Elizabeth Matanda, Mrs. Mary Zyongwe, Mrs.Kapelwa Sikota and Mr.John Muasa who also served as inspector of Nursing Schools and Registrar of The General Nursing Council of Zambia. Mrs. Kapelwa Sikota was the first to train as a registered nurse and Midwife at McCord Zulu in Durban and came to work in Zambia at Lusaka African Hospital in 1952. She was later appointed as first African Assistant Chief Nursing Officer in 1966 and Chief Nursing Officer in 1968.

Between 1963 and 1964 the government realized the need to start training schools for nurses in the country because the cost of sending girls to UK was too high. In preparation to start nursing schools, the MOH invited Mrs. Lizzy M. Bell who was WHO Regional Representative to come. She recommended starting a registered nursing school at Llewellyn Hospital or Kitwe Central Hospital today and government took the recommendation. On 12th September, 1964, the first 12 Zambian girls enrolled for the basic training programme. Most of them had junior secondary certificates although the requirements were to have a full certificate. So they enrolled for the course because they had Form 3 certificates. Three months later 6 dropped out because the course was too difficult and they could not understand. In January 1965, 22 students enrolled for the course and the 6 students that had remained joined them. Supervision of the nursing school was done by the nursing committee of the Medical Council of Zambia. In 1964, the government made a declaration to train males as assistants and females as registered or enrolled nurses. Other registered nursing schools opened during this period were; Lusaka (1969), Mufulira (1969) and Ndola (1972).

In 1950 Zambian Nurses Association (ZNA) was founded by the British nurse named Dora Norman. By then ZNA was known as Northern Rhodesia Nurses Association (NRNA) and changed its name after independence. ZNA became a member of the International Council of Nurses in 1953. In the same year; ZNA was registered with the Registrar of Societies as a nongovernmental organization and was affiliated to NGOCC. The first major task was to fight for a separate body to train and register nurses and midwives. In 1965, the Medical Council of Zambia was born. Nurses continued to fight for their own council or institution to manage their affairs. With the cooperation of the Zambian Government, the General Nursing Council of Zambia was formed through the enactment of Cap 538 of 1970 chapter 2 dealing with nursing affairs. In 1997 this Act was repealed and was replaced by the Nurses and

Midwives Act of 1997 No. 31. This act has given autonomy and broadened the scope of practice of nursing and midwifery.

Other important developments in nursing include the introduction of post basic nursing courses. A community nursing school was introduced in 1969 to offer post basic certificate for enrolled nurses. It was phased out in 1971.

In 1976 and 1977 Post Basic Diploma in Nursing Education and Post Basic Certificate in Public Health were introduced at the University of Zambia respectively. In 1981, the Post Basic Diploma in Nursing was elevated to Bachelor of Science in Nursing (BSc N). In 2004, the Master of Science in nursing programme was introduced. In 2014, PhD programmes were introduced in the Department

SELF ASSESSMENT: 1

Indicate true (T) or false (F) in the following statements.

1. ----------Nursing is the diagnosis and treatment of the responses to actual or potential health problems.

2. ----------Nursing is the unique function of the nurse which is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible.

3. ---------- a profession is a person formally certified by a professional body of belonging to a specific profession by virtue of having completed a required course of studies and/or practice and whose competence can usually be measured against an established set of standards.

ANSWERS 1. True 2. True 3. False

1.5. Nursing As a Profession

Well learner, in this sub unit we shall discuss the current trends in nursing, factors impacting on the profession, status of the nurse in society and the challenges in nursing practice. Before we go in detail in our discussion, let us do the following activity:

Activity 2

List 4 trends that affect the nursing profession. Write down your answers in a note book.

Good! Now compare your answers as you read.

1.5.1 Current Trends

One of the great things about nursing is its diversity. There is truly something for everyone in this profession and in the past few years, we have seen an influx of new specializations, career paths and degree programs to meet the needs of a changing world. Transformations taking place in nursing and nursing education have been driven by major socioeconomic factors. The trends to be discussed under this topic are the following four pillars of nursing:

- Nursing practice
- Education
- Research
- Leadership and management

1.5.1.1. Nursing Practice

This is the first pillar of nursing, which requires that nurses are trained as they to continue their educational studies whilst working in the practicum areas. This means that faculty for training schools or Universities should supervise these nurses as they practice (Smith, 2008).

Population shifts in some countries have affected health care priorities as well as the practice of nursing. Due to advances in public health and clinical care, the average life span is increasing rapidly.

Greater life expectancy of individuals with chronic and acute conditions will challenge the health care system's ability to provide efficient and effective continuing care. Significant increases in the diversity of the population affect the nature and the prevalence of illness and disease, requiring changes in practice that reflect and respect diverse values and beliefs. Disparities in morbidity, mortality, and access to care among population sectors have increased, even as socioeconomic and other factors have led to increased violence and substance abuse. Nursing practice, education, and research must embrace and respond to these changing demographics, and nurses must focus on spiritual health, as well as the physical and psychosocial health of the population.

The rapid growth in information technology has already had a radical impact on health care delivery and the education of nurses. Advances in processing capacity and speed, the development of interactive user interfaces, developments in image storage and transfer technology, changes in telecommunications technology, and the increased affordability of personal computers have contributed to the explosion of information technology applications. Advances in digital technology have increased the applications of Tele-health and telemedicine, bringing together patient and provider without physical proximity. Nanotechnology will introduce new forms of clinical diagnosis and treatment by means of inexpensive handheld biosensors

capable of detecting a wide range of diseases from miniscule body specimens (Potter, 2001).

Dramatic improvements in the accessibility of clinical data across settings and time have improved both outcomes and care management. The electronic medical record will replace traditional documentation systems. Through the Internet, consumers will be increasingly armed with information previously available only to clinicians. Electronic commerce will become routine for transacting health care services and products.

Nurses of the 21st century need to be skilled in the use of computer technology. Already, distance learning modalities link students and faculty from different locales and expand the potential for accessible continuing professional education. Technically sophisticated preclinical simulation laboratories will stimulate critical thinking and skill acquisition in a safe and user-friendly environment. Faster and more flexible access to data and new means of observation and communication are having an impact on how nursing research is conducted.

1.5.1.2. Education

Even though nurses receive initial training and education to get into the profession and receive credentials to get into the job, on-going professional education is required to keep them abreast on new developments in medicine, drugs, technologies, procedures, rules and regulations to ensure provision of quality care to patients. Experienced nurses, mentor and share knowledge with new colleagues to ensure their success in the field of nursing (Smith, 2008).

Student demographics are also changing. Ethnic and racial diversity of nursing schools has increased dramatically, creating a rich cultural environment for learning. Students are entering schools of nursing at an older age and are bringing varying college and work experiences, as well as more sophisticated expectations for their education. They are typically employed in full-time careers, and many are raising families, which places constraints on their educational experiences and necessitates greater flexibility in scheduling.

Schools of nursing must be prepared to confront the challenges associated with today's more mature student body, and educational methods and policies, curriculum and case materials, clinical practice settings, and research priorities need to value and reflect the diversity of the student body, as well as the population in general. At the same time, schools must focus recruitment efforts on the more traditional, younger student.

1.5.1.3. Research

Research provides nurses with information to improve their job. It assists nurses, change the methods of treating their patients and the nursing procedures for future practice (Smith, 2008).

Nursing science needs to address health care issues, such as emerging and re-emerging infections, that result from globalization. Nursing education and research

must become more internationally focused to disseminate information and benefit from the multicultural experience.

1.5.1.4. Leadership and Management

Nurse Managers who work in the administration branch of the field advocate on behalf of the organisation in the delivery of health services. These nurses in administration are concerned with providing the logistics that are needed in the delivery of quality nursing care. They also act as the voice of the profession in order to bring change and better health care policies for the nurses who provide the care and the patients or clients who receive it (Smith, 2008).

1.5.2 Factors Impacting on the Profession

To understand nursing as it is practiced today and as it will be practiced tomorrow requires an understanding of some of the social forces currently influencing this profession. These forces usually affect the entire health care system, and nursing, as a major component of that system, cannot avoid the effects. The factors that are impacting on the nursing profession are:

- Economics
- Consumer demands
- Family structure
- Science and technology
- Information and telecommunication
- Legislation
- Demography and
- Current nursing shortage

1.5.2.1 Economics

Greater financial support provided through public and private health insurance programs has increased the demand for nursing care. As a result, people who could not afford health care in the past are increasingly using such health services as emergency department care, mental health counselling, and preventive physical examinations.

Costs of health care have also increased during the past two decades. In 1982, the Medicare payment system to hospitals and physicians was revised to establish reimbursement fees according to the client's medical diagnosis. This classification system is known as diagnostic-related groups (DRGs).The system has categories that establish pre-treatment diagnosis billing categories. With the implementation of this legislation, clients in hospitals are more acutely ill than before and clients once considered sufficiently ill to be hospitalized are now treated at home; however, health care costs continue to rise.

These changes present challenges to nurses. Currently, the health care industry is shifting its emphasis from inpatient to outpatient care with preadmission testing, increased outpatient same-day surgery, post-hospitalization rehabilitation, home health care, health maintenance, physical fitness programs, and community health education programs. As a result, more nurses are being employed in community-based health settings, such as home health agencies, hospices, and community

clinics. These changes in employment for nurses have implications for nursing education, nursing research, and nursing practice.

1.5.2.2 Consumer Demands

Consumers of nursing services (the public) have become an increasingly effective force in changing nursing practice. On the whole, people are better educated and have more knowledge about health and illness than in the past. Consumers also have become more aware of others' needs for care. The ethical and moral issues emanating from poverty and neglect phenomena have made people more vocal about the needs of minority groups and the poor.
The public's concepts of health and nursing have also changed. Most believe that health is a right of all people, not just a privilege of the rich. The media emphasize the message that individuals must assume responsibility for their own health by obtaining a physical examination regularly, checking for the signs of cancer, and maintaining their mental well-being by balancing work and recreation.

Interest in health and nursing services is therefore greater than ever. Furthermore, many people now want more than freedom from disease, they want energy, vitality, and a feeling of wellness.
Increasingly, the consumer has become an active participant in making decisions about health and nursing care.

1.5.2.3 Family Structure

New family structures are influencing the need for and provision of nursing services. More people are living away from the extended family and the nuclear family, and the family breadwinner is no longer necessarily the husband. Today, many single men and women rear children, and in many two-parent families both parents work. It is also common for young parents to live at great distances from their own parents. These young families need support services, such as day-care centres.
Adolescent mothers also need specialized nursing services, while they are pregnant and after their babies are born. These young mothers usually have the normal needs of teenagers as well as those of new mothers. Many teenage mothers are raising their children alone with little, if any, assistance from the child's father. This type of single-parent family is especially vulnerable because motherhood compounds the difficulties of adolescence. And because many of these families live in poverty, the children often do not receive preventive immunizations and are at increased risk for nutritional and other health problems.

1.5.2.4 Science and Technology

Advances in science and technology affect nursing practice. For example, people with Acquired Immune Deficiency Syndrome (AIDS) are receiving new drug therapies to prolong life and delay the onset of AIDS-associated diseases. Nurses must be knowledgeable about the action of such drugs and the needs of clients receiving them. Biotechnology is affecting health care. For example, nurses are exposed to emerging genetic technology such as the field of cancer gene therapy. Nurses will need to expand their knowledge base and technical skills as they adapt to meet the new needs of clients.

In some settings, technological advances have required that nurses be highly specialized. Nurses frequently have to use sophisticated computerized equipment to monitor or treat clients. As technologies change, nursing education changes, and nurses require increasing education to provide effective, safe nursing practice.

1.5.2.5 Information and Telecommunications

The information superhighway or Internet has already affected health care, with more and more clients becoming well informed about their health concerns. As a result, nurses may need to interpret Internet sources of information for clients and their families. Because not all of the Internet-based information is accurate, nurses need to become information brokers so they can help people to access high-quality, valid websites; interpret the information; and then help clients evaluate the information and determine if it is useful to them.

Telecommunications is the transmission of information from one site to another, using equipment to transmit information in the form of signs, signals, words, or pictures by cable, radio, or other systems (Chaffee, 1999, p. 27).
Tele health uses telecommunication technology to provide long-distance health care. It can include using video conferencing, computers, or telephones. Tele nursing occurs when the nurse delivers care through a telecommunication system. Examples of Tele nursing include the nurse who telephones clients at home to assess their progress or to answer questions, the nurse who participates in a video teleconference where consultants or experts at various sites discuss a client's health care plan, and the nurse who uses video phone technology to assess a client living in a rural area.

1.5.2.6 Legislation

Legislation about nursing practice and health matters affects both the public and nursing. Changes in legislation relating to health also affect nursing. For example, the Patient Self-Determination Act (PSDA) requires that every competent adult be informed in writing on admission to a health care institution about his or her rights to accept or refuse medical care and to use advance directives. This law, which in many institutions is implemented by nurses, affects the nurse's role in supporting clients and their families.

1.5.2.7 Demography

Demography is the study of population, including statistics about distribution by age and place of residence, mortality (death), and morbidity (incidence of disease). From demographic data needs of the population for nursing services can be assessed. For example:
• The population is shifting from rural to urban settings. This shift signals an increased need for nursing related to problems caused by pollution and by the effects on the environment of concentrations of people. Thus, most nursing services are now provided in urban settings.
• Mortality and morbidity studies reveal the presence of risk factors. Many of these risk factors (e.g. smoking) are major causes of death and disease that can be prevented through changes in lifestyle.

1.5.2.8 Current Nursing Shortage

The multiple factors influencing the current nursing shortage are different from nursing shortages. Registered nurses make up the largest group of health care providers. Fewer nurses, however, are entering the workforce, and certain geographic areas are experiencing acute nursing shortages. The supply is inadequate to meet the demand, especially for specialized nurses (e.g. critical care). Addressing the nursing shortage requires collaborative activities among health care systems, policy makers, nursing educators, and professional organizations. Recommendations include:

a) Develop mechanisms for nursing students to progress to and through educational programs more efficiently and quickly.
b) Recruit young people to nursing early (e.g., grade twelve school leavers).
c) Improve the nurse's work environment: Provide greater flexibility in work hours, reward experienced nurses who serve as mentors, ensure adequate staffing, and increase salaries.
d) Increase nursing education funding.

1.5.3 Status of a Nurse in Society

Dear learner, it is important to understand that nurses are the largest group of health professionals in Zambia. They promote health, prevent disease and provide care to society. The World Bank identified nursing as the most cost-effective resource for delivering high quality public health and clinical care. However, despite increasing recognition by some actors, the effective delivery of nursing services is negatively affected by many factors.

The absence of nurses from policy-making in health care systems, shortage of qualified nurses, insufficient resources for education and development and undervaluing of nursing may be some of them.

Some of the characteristics affecting nurses in the provision of services just like other female-dominated occupations are: –

i. Low pay
ii. Low status
iii. Poor working conditions
iv. Few prospects for promotion
v. Lack of continuing education structure

In Sub-Saharan Africa, there are 2.3 health workers per 1,000 people. Zambia, a country with a population of approximately 13 million, the current doctor and nurse population ratios stands at 1 to 15,000 and 1 to 1,500 respectively. This is far lower than the WHO recommended doctor population ratio of one doctor to 5,000 and one nurse to a population ratio of 700 (Makasa E. 2014).

Zambia is facing serious human resources for health (HRH) crisis, both in the numbers and skills mix. The critical shortage of skilled manpower is a major obstacle to the provision of quality healthcare services and to the achievement of the national health objectives and MDGs. There are three main problems, namely the absolute shortages of health workers, inequities in the distribution of health workers and skills-mix, which all favour urban areas, than rural areas.

Health systems (in developing countries) are on the brink of collapse due to lack of skilled personnel. In some countries, like Zambia, deaths from preventable diseases are rising and life expectancy is dropping. It has been difficult to get all nurses to register with the GNC and since 2004 a re-registration of all nurses in Zambia has been going on in order to get an accurate number of nurses in the country. The current number of nurses registered at the GNC is 14,752. However, not all nurses who are registered with the GNC are working within Zambia as nurse practitioners.
In 2005 a number of 6,096 nurses were on payroll in Zambia, which includes both private and public staff (excluding minor private for profit providers). The number of nurses on payroll gives a good picture of how many nurses are *working within the country.* Their remuneration consists of the salary and regular uniform and night duty allowance paid as composite every month.

Working conditions are important for motivating health workers to perform their tasks. Satisfactory working conditions comprise a clean and safe environment, innovative management, availability of medical equipment and supplies. Besides, it is essential that the staff is not overwhelmed with work. They need to take vacation regularly when required. However, some of the health workers are demotivated by the run down infrastructure, equipment and working conditions and heavy workloads.

Development of the nursing profession is an essential goal of nursing education. One way to reach the goal is by clarifying professional status, a status which for the most part is transferred through tacit knowledge.

The goals of any nursing education do not include the entire body of tacit knowledge. The development requires recognition of professional status.

1.5.4 Challenges in Nursing Practice

In the Zambian context, nurses are faced with several challenges as they provide health services to their clients. The medical field is one of the fastest growing industries all over the world and along with it, is the increased demand for **doctors**, **nurses** and other medical personnel who make up the medical team.

There are a number of factors that represent the major ingredients of the challenges facing the nursing profession today and they include: Technological advancement, health care reform, increasing workload, shortage of nurses, shortage of infrastructure increased and increasing professional demand.

Advancement in the technology is the greatest challenge facing the nursing profession with the increasing growth in information technology influencing the health care delivery system in many areas including processing speed and capacity, the development of interactive user interfaces, image storage, transfer and

telecommunications technology, and the increased affordability of personal computers.

Another area of challenge facing the nursing profession today has to do with the population increase and migration which has affected health care priorities as well as nursing practice.

The challenge of the long life span on the nursing profession has to do with a demand for higher academic knowledge and mental sharpness to effectively handle the new crop of patient with its new complexity. People are now living longer than before and non communicable diseases have become common and challenging to treat.

One of the biggest challenges for the **nurse practitioner** is the requirement for a very progressive and flexible approach in the provision of services to their clients. The shortage of doctors has also increased the nurses' demand for services. Almost half of the work of the physicians is to be taken on by nurse practitioners. Hence the need and ability for the nurse to interact well with others within the medical team so as to handle the work efficiently, with a leadership quality.

The nurse has had experiences on consumer demands as she/ he provides services on a daily basis. Consumers are better educated and have become more knowledgeable about health and illness than in the past. The ethical and moral issues raised by poverty and neglect have made people to become more aware about the needs of minority groups and the poor that are in most cases not able to pay for their health services. Consumers are therefore becoming more interested and knowledgeable about health promotion as well as disease prevention, with increased acceptance and demand for alternative and complementary health options.

The public's concepts of health and nursing have also changed. It is believed that health is a right of all people, not just a privilege of the rich.

The burden of disease in Zambia is high, and is largely influenced by the high prevalence and impact of communicable diseases, particularly malaria, HIV and AIDS, Tuberculosis (TB) and Sexually Transmitted Infections (STIs). The country is also faced with a high burden of Maternal, Neonatal and Child Health (MNCH) problems, and a growing problem of Non-Communicable Diseases (NCDs) including mental health, cancers, sickle cell anaemia, diabetes mellitus, hypertension and heart diseases, chronic respiratory disease, blindness and eye refractive defects and oral health problems. Currently, the top 10 causes of morbidity and mortality in Zambia include malaria, respiratory infections (non-pneumonia), diarrhoea (non-blood), trauma (accidents, injuries, wounds and burns), eye infections, skin infections, respiratory infections (pneumonia), ear, nose and throat infections, intestinal worms and anaemia.

The country is also faced with the high burden of the HIV&AIDS epidemic, which has significantly impacted on the morbidity and mortality levels across the country.

1.6 Summary

In summary, we have looked at how the nursing profession emerged and discussed the historical development of nursing from the primitive era to the modern era. We

also discussed the importance of professional growth and emphasized the need to keep abreast with the changing trends in nursing practice. Furthermore we discussed factors that influence the professional nurse in executing his/her duties.

Self Assessment: 2

Indicate true (T) or false (F) in the following statements.

1. ----------The four pillars of nursing include nursing practice, education, treatment and trends.

In circle the most appropriate answer

2. Which of the following is a factor that impact on the nursing profession?

    (a) Drugs
    (b) Health
    (c) Consumer demands
    (d) Money

3. All of the following are challenges in nursing practice EXCEPT:

    a) Increased work load
    b) Ill health
    c) Shortage of nurses
    d) Poor infrastructure

ANSWERS 1. False 2. C 3. B

1.7 Reference

Smith C.N. (2008), What are the five pillars of Nursing? Ehow, http://www.ehow.com/list-6849606-five-pillars-nursing-html

National Health Strategic Plan2011-2015 (2011) Ministry of Health, Lusaka

(http://www.ehow.com/about_5364906_history-nursing.html
(http://dictionary.reference.com/browse/profession
http://www.merriam-webster.com/dictionary/professionalism).
Ancho ELA (2000) ***Fundamentals of Nursing***, Spring House, Pa: Spring house Corporation.
Craven R and Hirnle CJ (***1992) Fundamentals of Nursing: Human Health and Function***, Philadelphia; Lippincott Publishers
ECSACON (2001) ***Nursing and Midwifery Professional Regulatory Framework***:
Arusha:eHow.comhttp://www.ehow.com/about_5364906_history;nursing.html#ixzz2Krxa4wGL
GNC (1998) ***Professional Code of Conduct***, Lusaka GNC
GNC (2201) ***Professional Nursing & Midwifery Regulatory Frame work:*** Lusaka
GNC (1997) ***The Nurses and Midwives Act No. 31***, of 1997 Lusaka GNC
Kozier B et al (1995) **Fundamentals of Nursing Concepts Process and Practice**: Calir: Addison Wesley
MoH (2009) ***Integrated Guidelines for Frontline health workers***, Government printers, Lusaka, Zambia.
Piera R. (2001) ***Nursing Dynamic Department of Advanced Nursing Science*** Pretoria, SA
Potter P.A & Griffin AP (2001) ***Fundamentals of Nursing*** St. Louis; Morsby Company
Searle C (2000) ***Professional Nursing***, Johannesburg Heinemann
Makasa E. (2014) Medical Journal of Zambia, Volume 35, No 3.

UNIT 2: POLICIES, LEGISLATION AND REGULATIONS IN NURSING PRACTICE

2.1 Unit Introduction

Welcome to Unit 2 which will focus on policies, legislation and regulation governing nursing practice. Now that we have defined some of the important terms in nursing and understand the origins of the nursing profession we can now look at the policies, legislation and regulation for nursing practice. This refers to issues over which nurses can be subjected to lawsuit and criminal prosecution with regards to their work. It is important that nurses know their rights, that of patient and their families in order to understand judicial processes. The privileges of the nurse, conduct, legal issues, organizations that protect the interest of the nursing profession and rights of clients are highlighted in order to ensure that in the course of practice, the nurse does not deviate from expectations.

2.2 Unit Objectives

At the end of the unit, the learner should be able to:

1. Define the terms " law" and "the constitution"
2. Explain the Zambian Constitution
3. Describe the Nurses and Midwives Act
4. State the main parts of the Health and Allied Professions Act
5. Explain the Public Health Act
6. State the Disability Act
7. State the Child Protection Act
8. Outline the Professional code of Conduct
9. Explain the International Code of Ethic and Practice
10. Describe the Professional Regulatory Framework
11. Describe the Health Policies
12. Explain the Regulatory Organisations

2.3 Definitions of Key Terms

Hello learner, in this subunit we will define some terms related to policies, legislation and regulations for nursing practice. Before we do that, let us do the following activity.

Activity 3

What is law? Write your answer in your note book.

Good! Now compare you answer as you read this section

2.3.1 Law is the system of rules which a particular country or community recognizes as regulating the actions of its members and which it may enforce by the imposition of penalties (GRZ 2012). Law is the whole system or set of rules made by the government of a town, state, country, etc.

2.3.2 Constitution is The fundamental law, written or unwritten, that establishes the character of a government by defining the basic principles to which a society must conform; by describing the organization of the government and regulation, distribution, and limitations on the functions of different government departments; and by prescribing the extent and manner of the exercise of its sovereign powers (GRZ, 2012)**.** A legislative charter by which a government or group derives its authority to act. This is the supreme law of the country. It is a body of fundamental principles or established procedures according to which a state or other organization is acknowledged to be governed.

Other definitions

2.3.3 A policy is a broad guideline or framework that describes how the organisation should carry out operations to meet its goals and objectives. It is the basis for decision making.

2.3.4 Legislation is the act or process of making the laws governing a country or an organisation.

2.4 Introduction to the Zambian Constitution

Having defined the terms related to policy, legislation and regulations for nursing practice, we shall now introduce you to the Zambian Constitution. The Zambian constitution is the supreme law of the land. Therefore, it binds every citizen or person of the Republic of Zambia. If any other law is inconsistent with this constitution that other law is rendered void to the extent of the inconsistency. The constitution has fourteen (14) parts as follows:

PART I

This talks about the declaration of the Republic, the sovereignty of the people of Zambia, the constitution as the supreme law and English as the official language of our country.

It also talks about the Public seal, National anthem, National flag, National emblem and the National motto that they shall be such as may be prescribed by or under the Act of Parliament.

PART II

This part talks about citizenship. A citizen of Zambia here is every person who immediately before the commencement of the constitution was a citizen of Zambia

and shall continue to be such. It also talks about persons who are entitled to apply to be registered as citizens. Under this part, Parliament may make provisions for the acquisition of citizenship by persons who are not eligible to become citizens of Zambia. This part also establishes the Citizenship Board and talks about how a person can cease to be a citizen of Zambia.

PART III

Part III of the Zambian constitution focuses on:

a) Protection of the fundamental rights and freedoms of the individual. The fundamental rights under this part include:

b) Life, liberty, security of the person and the protection of the law;

c) Freedom of conscience, expression. Assembly, movement and association;

d) Protection of young persons from exploitation;

e) Protection for the privacy of his home and other property and from deprivation of property without compensation;

This part further talks about protection of right to life; that a person shall not be deprived of life intentionally except in execution of the sentence of a court in respect of a criminal offence under the law in force in Zambia of which he/she has been convicted.

Furthermore, it says a person shall not deprive unborn child of life by termination of pregnancy except in accordance with the conditions laid down by an Act of Parliament for that purpose. This article furthermore says, a person shall not be regarded as having been deprived of his life in contravention of this Article if he/she dies as a result of the use of force to such extent as is reasonably justifiable in the circumstances of the case-

a) For the defence of any person from violence or for the defence of property;

b) In order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

c) For the purpose of suppressing a riot, insurrection, mutiny or if he/she dies as a result of lawful act of war;

d) In order to prevent the commission by that person of a criminal offence.

The other issues this Article focuses on are the:

- Protection of right to personal property,
- protection from slavery and forced labour,
- protection from inhuman treatment,

- protection from deprivation of property,
- protection from privacy of home and other
- property, provision to secure protection of law,
- protection of freedom of conscience, protection of freedom of expression
- Protection of freedom of assembly and association,
- Protection of freedom of movement,
- Protection from discrimination on the ground of race etc,
- Protection of young persons from exploitation,
- Derogation from fundamental rights and detention

PART IV

This Article talks about the Executive. The cabinet consists of the president, vice president and ministers. The function of the cabinet is to formulate the policy of government and to advise the president. The article also gives provision for the Secretary to the Cabinet who is Head of the Public Service and is responsible to the president

- For securing the general efficiency of the Public Service; have charge of Cabinet Office, arranging business for,
- Keeping the minutes of the cabinet and conveying decisions made in Cabinet to the appropriate authorities;
- Have other functions as prescribed by an Act of Parliament or as the president may direct.

PART V

This part talks about the Legislature whose power is vested in the Parliament, which consist of the President and the National Assembly. This article further says, the legislative power of the National Assembly shall be exercised by Bills passed by the National Assembly and assented to by the President. Where a Bill is presented to the president for assent, he shall either assent or withhold his assent. Where the president withholds the Bill, he may return the Bill to National Assembly Requesting it to reconsider the Bill on any specified provision, and if the request is considered he shall assent the Bill within 21 days of its presentation. Where the president withholds his assent to a Bill, the Bill shall not again be presented for assent. Where a Bill has been duly passed is assented to it becomes law the president shall thereupon cause it to be published in the Gazette as a law. This article further says alteration of the Constitution is made through Parliament. The Bill for alteration of the Constitution should pass through first, second and third readings. The Bill should be supported by

on second and third reading by votes of not less than two thirds of all members of the assembly.

PART VI

This article is about the Judicature. The Judicature of the Republic of Zambia consist of:

- The Supreme Court of Zambia;
- The High Court of Zambia;
- The Industrial Relations Court;
- The Subordinate Courts;
- The Local Courts; and
- Such lower courts as may be prescribed by an act of Parliament.

PART VII

This is about the Defence and National Security. The functions of the Zambia Defence Force are to:

- Preserve and defend the sovereignty and territorial integrity of Zambia;
- Co-operate with the civilian authority in emergency situations and in cases of natural disaster;
- Foster harmony and understanding between the Zambia Defence Force and civilians; and
- Engage in productive activities for the development of Zambia.

The article also provide for the Zambia Police Service/Force. Functions of the Zambia Police Service include:

- To protect life and property;
- To preserve law and order;
- To detect and prevent crime;
- To co-operate with the civilian authority and other security organs established under this constitution and with the population generally.

The article provides for the formation of the Zambia Prison Service as well as the Zambia Security Intelligence Service. All the organs described under this article are regulated by Parliament.

PART VIII

This part is about the Local Government System which consists of democratically elected councils on the basis of universal adult suffrage. The functions of the Local Government are prescribed by an act of Parliament.

PART IX

This part is about the Directive Principle of State Policy and the Duties of a Citizen. The directive principles of state policy set out in this Part guide the Executive, the Legislature and the Judiciary in:

- Development of national policies;
- Implementation of national policies;
- Making and enactment of laws; and
- Application of the Constitution and any other law.

The following are the Directive Principles of State Policy:

- The state shall be based on democratic principles;
- The state shall endeavour to create an economic environment which shall encourage individual initiative and self reliance among the people and promote private investment;
- The state shall endeavour to create conditions under which all citizens shall be able to secure adequate means of livelihood and opportunity to obtain employment;
- The state shall endeavour to provide clean and safe water, adequate medical and health facilities and decent shelter for all persons, and take measures to constantly improve such facilities and amenities;
- The state shall endeavour to provide equal and adequate educational opportunities in all fields and at all levels for all;
- The state shall endeavour to provide to all persons with disabilities, the aged and other disadvantaged persons such social benefits and amenities as are suitable to their needs and are just and equitable;
- The state shall take measures to promote the practice, enjoyment and development by any person of that person’s culture, tradition, custom or language insofar as these are not inconsistent with this constitution;
- The state shall strive to provide a clean and healthy environment for all;
- The state shall promote sustenance, development and public awareness of the need to manage the land, air and water resources in a balanced and suitable manner for the present and future generation; and
- The state shall recognise the right of every person to fair Labour practices and safe and healthy working conditions.

The duties of every Zambian citizen include:

- To be patriotic and loyal to Zambia and to promote its wellbeing;
- To contribute to the well-being of the community where that citizen lives, including the observance of health controls;
- Foster national unity and live in harmony with others;
- To promote democracy and the rule of law;
- To vote in national and local government elections;
- To provide defence and military service when called upon;
- Carry out with discipline and honesty legal public functions;
- To pay taxes and duties legally due and owing to the state; and
- To assist in the enforcement of the law at all times.

PART X

It is about finances; the taxation, imposition of taxation and expenditures which is only done or altered by an Act of Parliament.

PART XI

This is about the establishment of service commissions. Under this article there is an establishment of the Judicial Service Commission.

PART XII

Human Rights Commission

PART XIII

Chiefs and House of Chiefs

PART XIV

Miscellaneous provisions

SELF ASSESSMENT: 3

1. The legislation that governs an organisation or country is known as

a) constitution

b) law

c) policy

2. Which part of the Zambian Constitution provides for the Directive Principle of State Policy and Duties of a citizen?

a) Part VI

b) Part IX

c) Part IV

ANSWERS 1. A 2. B

2.5 The Nurses and Midwives Act

The Zambian Constitution provides for the Nurses and midwives Act. Let us now look at the various aspects of this Act,

2.5.1 Historical Development of the Act

Well learner, in the previous topic we looked at the Zambian Constitution. Now we shall introduce you to a very important Act; which is the Nurses and Midwives Act. We will begin by describing the historical development of this Act.

Prior to the establishment of the General Nursing Council, professional matters of nurses including education and training were dealt with by the Medical Council of Zambia which had been established earlier in 1965 through the legislation of the Medical and Allied Professions Act. The Doctors and Nurses were registered under the same act. The nurses were not happy with this development because it was a profession on its own; therefore they wanted to be registered separately.

At this time, the Zambian Nurses Association which had been in existence since 1951 began to agitate for the establishment of a Council for nurses. Through the initiative of the Zambia Nurses Association, representations were made to parliament and the bill went through Parliament in December 1970 to become the Nurses and Midwives Act No. 55 of 1970.

Hence the General Nursing Council was born under the then Zambia National Association through Act of Parliament No. 55 of 1970 as a regulatory body for nursing and midwifery in Zambia. According to the Act, it was enacted in order “to further and better provision for the registration, enrolment, control and training of nurses and midwives; to provide for the purposes relating to the practice of nursing

and midwifery; to establish the General Nursing Council of Zambia; and to provide for matters incidental to or connected with the foregoing."

In 1997, the new Nurses and Midwives Act No. 31 of 1997 was enacted by Parliament of Zambia. The act was to revise the law regulating the professional conduct of nurses and midwives; to repeal and replace the Nurses and Midwives Act of 1970; and to provide for matters connected with or incidental to the foregoing. The new Act has broadened the scope of nursing and midwifery practice and provided for private practice.

2.5.2 Components of the Act

The Nurses and Midwives Act has nine very important components, namely:

PART I: Preliminary Section

This talks about the title of the Act, which is the: Nurses and Midwives Act No. 31 of 1997; an Act to revise the law regulating the professional conduct of Nurses and Midwives in Zambia. It also has the operational definitions of the terms used in the act.

Part II: The General Nursing Council of Zambia

This part stipulates the functions of the General Nursing Council of Zambia and those of the Registra and other staffs.

Part III: Registration of Nurses and Midwives

This explains the procedures for registration and removal of Nurses and Midwives from the General Nursing Council Registration.

Part IV: Education and training of nurses and midwives

This part provides for the registration of Nursing Schools, certification of the same and regulations relating to education and training.

Part V: Professional Practice of Nurses and Midwives

This part stipulates the Nursing and Midwifery scope of practice, for instance, a nurse or specialist should provide preventive, therapeutic, palliative, rehabilitative care and treatment of illnesses to patients. This include to assess, diagnose the disease and provide relevant therapeutic interventions for example carry out physical examination, insert and remove devices, carry out vacuum extraction, intravenous infusion procedures, prescribe relevant drugs, counseling of patients and to provide information, communication and education. It also talks about regulations relating to nursing practice.

Part VI: Registration of Nursing Homes and Agencies

This part provides for registration of nursing homes and agencies and procedures on how the General Nursing Council can refuse to register these homes. It also talks about procedures on how the General Nursing Council can de-register the Nursing Homes.

Part VII: Professional Conduct of Nurses and Midwives

This part stipulates procedures on how a suspected erring nurse or an erring nurse or midwife may be disciplined or restored into the register of the General Nursing Council of Zambia.

Part VIII: Inspection

This part provides for the procedures for inspecting institutions by the General Nursing Council of Zambia and stipulates the powers of the inspector.

Part IX: Miscellaneous

This part explains on the savings of the General Nursing Council of Zambia, the transition provisions and the general penalties. It outlines other regulations and the repeal of Act No 55 of 1970.

2.5.3 Implications of the Act

Dear learner, the introduction of the Nurses and Midwives Act means that the professional nurse or midwife will provide health care as stipulated by the scope of practice under Part V of the Act. This same Act may be used in the court of law if the nurse/midwife is sued concerning his/her practice. This now entails that the professional nurse/midwife should ensure that he/she is competent in the procedures he/she carries out on patients in order to avoid litigations.

SELF ASSESSMENT: 4

1. Prior to the establishment of the General Nursing Council of Zambia, professional matters of nurses including education and training were dealt by

a) Zambia Nurses Association (ZNA)

b)Nurses and Midwives Act

c) Medical Council of Zambia

2. Which component of the Nurses and Midwives Act deals with the scope of practice?

a) Part VI

b) Part V

c) Part IV
ANSWERS 1. C 2. B

Well learner, we hope you have enjoyed our discussion on the Nurses and Midwives Act. In the next subunits, we shall further introduce you to Acts and policies which include the Health and Allied Professions Act, Public Health Act, Disability Act and many more.

2.6 Health and Allied Professions Act

This is an Act enacted to continue the existence of the Medical Council of Zambia and rename it as the **Health Professions Council of Zambia**; provide for the registration of health practitioners and regulate their professional conduct; provide for the licensing of health facilities and the accreditation of health care services provided by health facilities; provide for the recognition and approval of and provide for matters connected with or incidental to the foregoing.(Blachall's Laws of Zambia, 2013).

2.7 Public Health Act

This Act provides for matters affecting public health in Zambia. This includes prevention and suppression of infectious diseases including diseases communicable from animal to man, sanitation, protection of food, supply of water, protection from mosquitoes and pollution in general.
The Minister is granted certain regulation-making powers in respect of infectious diseases. Importation of animals may be restricted. The Act also prohibits the sale of unwholesome food and grants in general regulation-making powers to the Minister especially for the control of quality and hygiene of food. Water shall be kept in such a manner so as to avoid stagnant water. Local authorities shall take all possible measure for the prevention of the pollution of water and to purify any polluted water supply. The Minister may make, on the recommendation of the Central Board of Health, certain orders for the protection of milk.

2.8 Disability Act

This Act was enacted to continue the existence of the Zambia Agency for Persons with Disabilities and define its functions and powers; promote the participation of persons with disabilities with equal opportunities in the civil, political, economic, social and cultural spheres; provide for mainstreaming of disability issues as an integral part of national policies and strategies of sustainable development; incorporate a gender perspective in the promotion of the full enjoyment of human rights and fundamental freedoms by persons with disabilities; ensure accessibility by persons with disabilities to the physical, social, economic and cultural environment, and to health, education, information, communication and technology; provide for the regulation and registration of institutions that provide services to persons with disabilities and organizations of, and for, persons with disabilities; continue the existence of the National Trust Fund for Persons with Disabilities; provide for the domestication of the Convention on the Rights of Persons with Disabilities and its Optional Protocol and other international instruments on persons with disabilities to

which Zambia is party, in order to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities and to promote respect for their inherent dignity; repeal and replace the Persons with Disabilities Act, 1996; and provide for matters connected with, or incidental to, the foregoing (Zambia Lii, 2012).

Self Assessment Test: 5

CHOOSE THE MOST APPROPRIATE ANSWER

1. The new Nurses and midwives Act NO31 was enacted by parliament in

a) 1998
b) 1997
c) 1996

2. Which act provides for registration of health practitioners and regulate their professional conduct

a) Disability Act
b) Public health Act
c) Health and allied professions Act

Answer: 1b, 2c

2.9 Child Protection Act

This Act is not yet in place. However, the government of the Republic of Zambia through the Ministry of Community Development Mother and Child Health embarked on a law reform process to comprehensively review various pieces of child related legislation in order to harmonize them and to bring them in line with the general principles of the United Nations Convention on the rights of the child (UNCRC) (CHIN, 2015). The civil rights and freedoms of the child that are being looked at include:

- Birth registration for every child
- Child corporal punishment
- Torture and ill-treatment of the child
- Violence, including abuse, neglect and maltreatment of the child
- Basic health and welfare for children and those of children with disabilities.

SELF ASSESSMENT: 6

Indicate whether True (T) or False (F) for the following statements 1. Health Professions Council of Zambia was formally known as the Medical Council of Zambia 2. Public Health Act provide for matters affecting maternal health in Zambia 3. The Disability Act incorporate a gender perspective in the promotion of the full enjoyment of human rights and fundamental freedoms by persons with disabilities 4. The rights of children may include birth registration for every child
ANSWERS 1. T 2. F 3. T 4. T

2.10 Professional Code of Conduct

The Professional Code of Conduct is a set of principles which guides nurses and midwives in maintaining quality standards of nursing and midwifery education and practice. These principles are prescribed by General Nursing Council of Zambia (GNC) which is a statutory body enacted by an Act of Parliament; the Nurses and Midwives Act No. 31 of 1997.

2.10.1 Definition of Professional Code of Conduct

It is a set of principles, which guides nurses and midwives in maintaining quality standards of Nursing and midwifery education and practice.

2.10.2 Purpose

The purpose of these principles is to direct nurses and midwives including stake holders in upholding their professionalism in the general conduct and practice.

2.10.3 Objectives of the Code of Conduct

To uphold the professional values, integrity and ethical standards for Nurses and Midwives in Zambia.

To enhance Nurses' and Midwives' commitment to their professional, ethical, legal, personal and moral obligation to their clients

To promote Nurse' and Midwives' compliance to the professional code of conduct

2.10 .4 Broad Guidelines

The following are broad guideline on the code for Nurses and Midwives;

a) Serving the interest of the society
b) Justifying public trust and confidence;
c) Upholding and enhancing the good standing and reputation of the profession.

2.10.5 Administration of Code of Conduct

The Professional code of conduct is administered by the General Nursing Council of Zambia and all stakeholders.

2.10.6 Application of the Code of Conduct

A. Practitioner

i. It is the responsibility of the individual practitioner to acquire a copy of the professional code of conduct from the General Nursing Council Zambia.
ii. It is the responsibility of the individual practitioner to insure that she reads and understands the obligations placed upon her through the code of conduct

B. Employers

i. Each employer is responsible to insure that the professional code of conduct is made available to all nurses and midwives.
ii. Each employer is responsible to ensure that professional code of conduct is understood by all nurses and midwives including the stakeholders.
iii. It is the employer to provide an enabling environment for nurses and midwives to uphold the professional code of conduct.
iv. It is the responsibility of each employer to ensure that they have in place a mechanism for implementing, monitoring and evaluating the professional code of conduct

C. Consumers

i. It is the responsibility of the practitioner to ensure that the consumer has the right to care.
ii. The rights of the consumer shall be respected in the delivery of care through the professional code of conduct.
iii.

2.10.7 Breach of the Professional Code of Conduct and Grievance Procedure.

Breach of the professional code of conduct will warrant disciplinary action being taken against the offender as outlined in the Disciplinary Code –Appendix II

2.10.8 Grievance

Any individual practitioner who has any grievance as regarding the professional code of conduct can, after following the laid down procedures of the institution report to the GNC professional conduct committee.

2.10.9 Code of Conduct

As nurses and midwives, you are personally accountable for your practice, and in your exercise of professional accountability, you must:

1 Always perform in such a manner as to promote and protect the interests, safety and well-being of clients.
2 Ensure that no action or omission on your part or within your sphere of responsibility is harmful to the interest, condition and safety of clients.
3 Regularly maintain and update your professional knowledge and competence through education, research and self-motivated learning.
4 Acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform the, in a safe and skilled manner.

5 Work in an open and co-operative manner with clients and their families, foster their independence, recognize and respect their involvement in the planning and delivery of care.
6 Uphold the principles of leadership, accountability, partnership and sustainability in the delivery of health care recognizing and respecting the contributions of other members of the health care team.
7 Recognize and respect the uniqueness and dignity of each client and respond to their need for care, irrespective of their ethnic origin, political affiliation, religious beliefs gender, traditional beliefs, values and practices, personal attributes, and the nature of their health problem or any relevant procedures which may be contrary to your professional practice.
8 Report to an appropriate person or authority, at the earliest possible time any objections by the client, to any relevant procedures which may be contrary to your professional practice.
9 Avoid abuse of your privileged relationship with clients and of their privileged access allowed to them, their property, residence or work place.
10 Protect all confidential information concerning the clients obtained in the course of your professional practice and make disclosures only with consent whereby the order of the court, GNC, or where you can justify disclosure in the wide public interest.
11 Report to an appropriate authority or person, having regard to the physical, psychological and social effect on client any circumstances in the environment of care which could jeopardize standard of practice and quality of care.
12 Report to an appropriate person or authority were it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice and care
13 Practice within your qualifications competence, knowledge, and experience and be personally accountable for your actions you should not neglect client (s) for your actions you should not neglect clients (s) for any reason.
14 Support professional colleagues in context of your knowledge, experience and sphere of responsibility to develop their professional competence and assist others in the health care team to contribute safely, to the provision of quality care to a level appropriate to their roles.
15 Refuse any gift, favour or hospitality from clients currently in your care which might be interpreted as bribe, nepotism or seeking to extent influence to obtain preferential consideration.
16 Ensure that your professional status is not used to promote commercial products.
17 Declare any financial or other interests in relevant organizations providing such goods and services and ensure that your professional judgment is not influenced by any commercial consideration.
18 Ensure that research ethics are upheld at all times
19 Uphold the standards of Nursing and Midwifery practice by maximizing utilization of available resources.

Self Assessment Test: 7

Indicate true for a correct statement and false for a wrong statement

1. Code of conduct is a set of principles, which guides nurses and midwives in maintaining quality standards of Nursing and midwifery education and practice -------

2. Nurses and midwives, are not personally accountable for their practice ----------

3. Nurses are allowed to accept any gift, favour or hospitality from clients currently in their care which might be interpreted as bribe, nepotism or seeking to extent influence to obtain preferential consideration ----------.

4. Ensure that your professional status is not used to promote commercial products ------

Answers: 1-T, 2-F, 3-F, 4-T

2.11 International Ethical Code of Practice

Welcome to the discussion on the ethical code of practice for nurses and midwives that considers the maintenance of standards of practice by both nurses and midwives. Previously we did discuss the professional code of conduct for nurses and midwives that looked at how the nurse conducts her/him as the care is being provided to clients. The International Code of Ethics is stipulated by the International Council of Nurses (ICN) and the International Council of Midwives (ICM).

2.11.1 International Council of Nurses (ICN)

(a) Definition:
It is an international association for nurses which aim at contributing to elevating and maintaining highest standards of nursing around the world. ICN is the oldest international association of professional nurses. It was founded in 1899 by Mrs Bedford Fenwick assisted by nursing leaders from many countries. Its constitution was adopted in 1900. Active membership was offered to self-governing national nurses association and nurses in every country were encouraged to form a nurses association. Membership consists of national associations rather than individuals and this is done at a fee.

(b)Objectives of ICN

The objectives of ICN are:

1 To promote professional excellence in nursing education, practice, research, management and leadership.
2 Advance the promotion of information by way of news, magazines, brochures etc.

2.11.2 Code for Nurses as Stipulated by ICN

The fundamental responsibility of the nurse is four folds.

- To promote health
- To prevent illness
- To restore health
- To alleviate suffering

The need for nursing is universal. Inherent in nursing is respect for life, dignity and rights of man. It is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status. Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups.

2.11.3 Nurses and People

The nurse provides care by promoting an environment in which values, customs and spiritual beliefs of the individual are respected. She holds information in confidence.

2.11.4 Nurses and Practice: The nurse carries personal responsibility for nursing practice and for maintaining competence by continual learning.

2.11.5 Nurses and Society: The nurse shares with other citizens the responsibility for initiating and supporting action to meet the health and social needs of the public.

2.11.6 Nurses and Co-workers

The nurse sustains a cooperative relationship with co-workers in nursing and other fields.

2.11.7 Nurses and the Profession: The nurse plays the major role in determining and implementing desirable standards of nursing practice and nursing education.

2.11.8 International Confederation of Midwives –ICM

Definition

The aim of the international confederation of midwives (ICM) is to improve the standard of care provided to women, babies and families throughout the world through the development of education and appropriate utilization of the professional

midwife in keeping with its aim of women's health and focus on the midwife.ICM sets forth the following code to guide the education, practice and research of the midwife. This code acknowledges women as persons, seeks justice for all people and equity in access to health care and is based on mutual relationships of respect, trust and the dignity of all members of society.

The international Code of Ethics for Midwives

1. **Midwifery relationships:**
   a) Midwives respect a woman's informed right of choice and promote the woman's acceptance of responsibility for the outcomes of her choices.
   b) Midwives support and sustain each other in their professional roles and actively nature their own and other's sense of self-worth.
   c) Midwives work with other health professionals consulting and referring as necessary when women's need for care exceeds the competencies of the midwife.
2. **Practice of midwifery**
   a) Midwives provide care for women and child bearing families with respect for cultural diversity
   b) Midwives use their professional knowledge to ensure safe birthing practices in all environments and cultures.
   c) Midwives respond to the psychological, physical emotional and spiritual needs of women seeking health care, whatever their circumstances.
3. **The professional responsibilities of midwives**
   a) Midwives hold in confidence client information in order to protect the right to privacy and use judgement in sharing this information.
   b) Midwives participate in the development and implementation of health policies that promote the health of all women and child bearing families.

Advancement of midwifery knowledge and practice

a) Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women as persons.
b) Midwives develop and share midwifery knowledge through a variety of processes such as peer review and research.
c) Midwives participate in the formal education of midwifery students and midwives.

2.12 Professional Regulation Framework

Welcome to this topic of Professional regulation which is a means by which order, consistency and control are brought to a professional and its practice for the purpose of ensuring quality care (INC, 1992). The regulatory frame identifies who and what is to be regulated.

2.12.1 Definitions

1. Regulatory frame work is a frame work that presents the cornerstones and principles of quality professional nursing and midwifery education and practice.
2. Regulation is controlling something by means of rules.
3. Frame work is a set of beliefs ideas or rules that is used as the basis for making for making judgements, decisions etc.
4. Cornerstone: The most important part of something that the rest depends on.
5. Regulatory bodies: These are bodies which are established under the Act of parliament to control and regulate the education and practices of their professions as they deliver health services to the society which include individuals, families and communities.
They include the country's constitution and the legal systems, specific nursing and midwifery professional organizations which are constituted in the relevant nursing and midwifery Acts and other relevant statutes.
6. Scope of nursing and midwifery practice: The scope of practice defines the parameters within which the nurse and the midwife practice. It also identifies the clients as individuals, families, groups and communities who have health care needs and demands to which the nurse or midwife must respond.

2.12.2 Scope of Nursing and Midwifery Practice

We have defined some of the terms related to Regulatory Framework. Now let us discuss the scope of practice of nursing and midwifery. We will begin by defining scope of nursing.

2.12.3 Definition of scope of nursing

The scope of nursing refers to the extent or limits to which a nurse can practice. The practice of nursing is governed by laws that define a scope of practice, generally mandated by the legislature of the country or area within which the nurse practices. Nurses are held legally responsible and accountable for their practice. The standard of care is that of the "prudent nurse."

Activity 4

In your note book write the definition of scope of Nursing

2.12.4 Nursing worldwide

Throughout the world nurses are known to be caring individuals that people look for as someone to advocate for the sick and provide empathy towards the needy.

2.12.5 Nursing specialties

Nursing is the most diverse of all healthcare professions. Nurses practice in a wide range of settings but generally nursing is divided depending on the needs of the person being nursed.

2.12.6 The major divisions of Nursing are as follows:-

The nursing of people with mental health problems – Psychiatric andMental Health Nursing

The nursing of people with learning or developmental disability – Learning Disability Nursing

The nursing of children – Paediatric Nursing

The nursing of older adults – Geriatric Nursing

The nursing of people in their own homes is called Home Health Nursing (US), District Nursing and Health visiting (UK).

There are also specialist areas such as cardiac nursing, orthopaedic nursing, palliative care, peri-operative nursing, obstetrical nursing, and oncology nursing

Nurses work in a large variety of specialties where they work independently and as part of a team to assess, plan, implement and evaluate care.

2.12.7 Standards of Nursing and Midwifery Practice

Standards may be defined as follows:

a) A standard is a model of established practice that is commonly accepted as correct.

b) A desired or achievable level of performance against actual performance which can be evaluated for the purpose of enhancing the quality of care of clients.

c) Standards may be defined as “a benchmark of achievement which is based on a desired level of excellence”.

2.12.8 Standards of practice (standards of care): These are guidelines used to determine what a nurse should or should not do. Standards of care measure the degree of excellence in nursing care and describe a competent level of nursing care.

2.12.9 Importance of Standards of Nursing and Midwifery Practice

Nursing Practice Standards have been developed to:

a) Regulate, guide and direct nursing practice

b) Promote professional nursing practice

c) Facilitate evaluation of nursing practice

d) Enable the patient/client to judge the adequacy of nursing care

e) Provide guidelines to nurse researchers in identifying and exploring relationships between nursing practice and patient care outcomes.

f) provide guidelines for nurse administrators to support and facilitate safe, competent and ethical nursing practice within their agencies

g) Provide guidelines for nurse educators in setting objectives of educational programs

h) Provide a framework for developing specialty nursing standards

i) Facilitate articulation of the role of nursing within the health-care team

j) Provide direction for the standards of practice, competencies and consent as reflected in the standards of education.

k) Using the scope of practice, the nurse or midwife meets the needs of the client by providing preventive, promotive, rehabilitative and curative services.

l) It calls for understanding of the determinants of health and the causation and treatment of illness as well as the environmental, social and political context of health care and of the health care system.

Standards of nursing and midwifery practice are authoritative statements by which the profession describe the responsibilities of its practitioners and their accountability. The east, central and southern Africa College of nursing (ECSACON), presents standard for professional practice based on 3 major categories of nursing and midwifery roles
These are: –

1. Provider and collaborator role
2. Professional role
3. Advocacy role

2.12.10 Provider and collaborator role

Nurses and midwives assess clients plan and implement care and evaluate the effectiveness of that care. Standards are as follows:

a) Provision of management of care bases practice on scientific approaches of assessment, planning, implementing and evaluation in the context of PHC throughout the life cycle.

b) Responds efficiently and effectively to emergency and disaster situations to save life and prevent disability.

c) Conducts research and utilizes research findings to improve client care.

d) Manages and minimizes utilisation of resources, to improve quality of health care and services.

Professional role: Here nurses and midwives demonstrate responsibility and accountability for professional practice.
Standards:

a) Demonstrates a specialised body of knowledge and skills in the provision of care to optimize client's health status in the ECSA region.

b) Functions within the ECSACON professional self-regulatory frame work and recognised relevant legislation to maintain safe practice.

c) Designs and participates in the education of the client and other members of the health team mad stakeholders to improve health care.

d) Upholds and fosters the professional code of ethics and helps others to observe the code and project a positive image of the profession.

Advocacy role: Nurses and Midwives advocate on behalf of their clients, the health care system and their profession.

Standards:

a) Advocating for clients rights and continued developments of education, practice research and provision and management of comprehensive quality health care in the ESCA region.

b) Advocating for and meaningful, actively and effectively participating in health policy developments to improve health services.

c) Advocating for recognition of clients rights and their participation in assessing, planning, implementing and evaluating care aimed at improving own health status.

d) Advocating for clients' recognition of their own rights and responsibilities in health.

2.12.12 Standards of Nursing and Midwifery Education

These refer to the acceptable levels for nurse education in the country.

The purpose of educational standards for nursing and midwifery are to:

a) Provide for safe practice and quality care for clients.

b) Evaluate nursing education progress

c) Ensure that nursing education acquires standards for professional practice and the required competencies for entry level required for registration and licensure.

Process standards

Curriculum instruction: The curriculum should ;

a) Reflects the health care issues, challenges and needs of clients and the challenges of the profession.
b) Reflects the needs of students
c) Describes the philosophy and values, the conceptual frame work, full program of studies, courses in nursing and physical social sciences and related disciplines, the organisational structure of the curriculum, goals and objectives and graduate outcomes.

Outcome standards

Graduates Performance

Graduates of the education program meet professional practice requirements.

1. They ensure safety of the client through providing quality care within the scope of practice of nursing and midwifery as prescribed by the regulatory authority.
2. They meet criteria for registration/licensure in order to qualify for entry into practice.
3. They meet the current standards for professional practice and core competencies as documented, through employer, client, peers and self-evaluation of performance in the practice setting.

Structure standards

Teaching learning resources and environment: The physical facilities are sufficient to meet the curriculum and program needs and objectives.

Faculty and clinical supervisors

The number and qualifications of faculty and clinical supervisors are sufficient to meet curriculum and programme requirements.

Support staff.

The management and organisation of the education programme is effective and is sufficient to meet programme requirements.

The Licensed Practical Nurse/Midwifes

1. Shall complete a formal education program approved by the appropriate nursing authority in a state.
2. Shall successfully pass the National Council Qualifying (Licensure) Examination
3. Shall participate in initial orientation within the employing institution.

Continuing Educations

1. Shall be responsible for maintaining the highest possible level of professional competence at all times.
2. Shall periodically reassess career goals and select continuing education activities which will help to achieve these goals.
3. Shall take advantage of continuing education and certification opportunities which will lead to personal growth and professional development.
4. Shall seek and participate in continuing education activities which are approved for credit by appropriate organizations.

2.12.13 Competences

The amazing nature of humans is their diversity to change to circumstances. Being effective at work as an individual is related to how personal qualities and characteristics of the individual interact with the requirements of the work environment. Understanding oneself, as well as others, can greatly add to the personal effectiveness and the effectiveness of others.

Competencies guide nurse educators and practitioners in designing curricula that position graduates for practice in a dynamic health care arena: practice that is informed by a body of knowledge and that ensures that all members of the public receive safe and quality care.

Self Assessment Test: 8

MATCHING **Column 1**	**Match the specialities of nursing in column 1 with their functions in column 2** **Column 2**
1. Paediatric Nursing 2. Geriatric Nursing 3. Oncology Nursing 4. Psychiatric Nursing	a. Nursing patients with mental health problems b. Nursing children c. Nursing of older adults d. Nursing patients with cancer.
Answer: 1-b, 2-c, 3-d, 4-a	

2.13 Policies and Health
2.13. 1 Gender Policy

Gender policy encourages the empowerment of females by according them equal opportunities to services as men. It has acknowledged the fact that women traditionally were placed lower than men hence the ratio of men working to women working is high.

Programs Advancing Girl Education (PAGE) have improved the chances for women having gainful employment

Gender does not mean:

- Focusing on women's position only. In some instances men may be disadvantaged rather than women
- Fighting for equality between men and women
- Socially exaggerating the biological differences between men and women
- Blaming the opposite sex for inequality
- That only women should be gender advocates. Men also need to be involved

Gender means:

- That to government both men and women have roles in the spheres of health services delivery and public life from community to government level
- Recognition that gender roles are socially constructed and can therefore be changed
- Seeking to understand the root causes of inequalities and addressing those root causes.
- Emphasizing the establishment of structures or programs that reduce women's workload and release them from culturally defined limitations that prevent them from participating in development activities.
- Addressing the inter-relationship between gender roles and accepting that both men and women should be gender advocates
- Appreciating that men and women are different as a result of their biological and physiological make up and that these differences often may become synonymous with inequalities and discrimination and so become unjust.

Gender violence: Includes emotional and physical abuse mainly against women.

Domestic violence is a pattern of behaviour that generally starts with tension and intimidation in the couple's relationship and progresses to physical assault with injury to the woman and sometimes the children.

It is characterized by periods of time when the tension builds up then released through violence.

It is a common cause of mental ill health and often results in serious harm or death of the afflicted

It is the most common type of abuse seen in the health care setting.

Sexual harassment:

Sexual harassment is defined as any unwanted or unwelcome behaviour of a sexual nature that is offensive to the subject of the harassment and causes that person to feel threatened, humiliated or embarrassed. It is a type of gender violence

Risk factors:

a) Increased use of alcohol or illicit drugs
b) Gender inequalities- subordinate position of women
c) Cultural values that glamorize violence
d) Unemployment
e) Poverty and
f) Homelessness

Prevention of gender violence:

The following are some of the ways in which we can prevent gender-based violence:

a) Collecting information and define causes of the problem
b) Identifying vulnerable groups and develop prevention measures
c) Developing and test interventions to promote protective conditions and
d) Minimizing vulnerability in different settings

2.13.2 National Health Policy

The National Health Policy outlines a statement by the Zambian Government to set clear directions for the development of the Health Sector in Zambia. The policy is anchored in the Vision 2030 and shall be implemented through successive National Development Plans and National Health Strategic Plans.

It sets out policy measures that shall guide strategies and programmes in the health sector. The policy also takes into consideration various Regional and International Instruments, Protocols and Commitments which will ensure that Zambia's health programmes are integrated with the regional and global health system.

Vision
A Nation of Healthy and Productive people

Objectives

i. To promote hygiene, universal access to safe water, acceptable sanitation and food safety in order to reduce the incidence of environmentally related diseases.
ii. To significantly improve the nutritional status of Zambian population particularly for children, adolescents and women in child bearing age.
iii. To provide efficient and effective health education and promotion to empower individuals, families and communities with appropriate knowledge to develop and practice healthy lifestyles.
iv. To achieve increased coverage of occupational health and safety services in all sectors in order to contribute to the reduction of occupational health and safety hazards at places of work.
v. To ensure equity of access to provide quality, cost-effective and affordable MNCH services in order to reduce maternal, newborn and child morbidity and mortality.
vi. To halt and reduce the spread of HIV and AIDS by increasing access to quality HIV and AIDS and STIs interventions for prevention, treatment and care.
vii. To scale-up interventions aimed at combating and controlling malaria including prevention, treatment and care.
viii. To halt and reduce the spread of TB by increasing access to quality TB interventions for prevention, treatment and care.
ix. To halt and reduce the spread of leprosy by increasing access to quality leprosy interventions for prevention, treatment and care.
x. To scale-up interventions aimed at combating and controlling neglected tropical diseases including prevention, treatment and care.

xi. To scale-up interventions aimed at combating and controlling other communicable diseases, including prevention, treatment and care
xii. To improve public health surveillance and control of epidemics, so as to reduce morbidity and mortality associated with epidemics.
xiii. To improve the health landscape of the nation through implementation of Global Health initiatives.
xiv. To prevent, or delay the onset of Non-Communicable diseases and their related complications in order to enhance quality of life of the population
xv. Mental health services are often inaccessible, and are not integrated with primary health care services. There is a need to improve knowledge and treatment of mental disorders.

Issues addressed by the policy

The National Health Policy takes into consideration emerging issues at both the national and international levels such as communicable and non communicable diseases, health systems strengthening, gender equality, globalization, and climate change. The policy takes into account the disjointed policy environment in the health sector. The policy provides an overarching National Health Policy Framework that amalgamates existing policies in the health sector.

In addition the policy provides strategic direction to future initiatives, programmes and policies in the health sector. Through this policy, it is hoped that Zambia will reach the objective of the 'health for all' principle as adopted by the World Health Organization, with priority given to the provision of free primary health care services to the Zambian citizens.

2.13.3 Occupational Health and Safety

Dear learner it is important to note that the Occupational Health and Safety Bill of 2010 was established to be called the Occupational Health and Safety Institute and provide for the welfare, health and safety of persons at places of work(not clear). The bill also provides for the establishment of health and safety committees at workplaces and for the health, safety and welfare of persons at work; provides for the duties of manufacturers, importers and suppliers of articles, devices, items and substances for use at work; provide for the protection of persons, other than persons at work, against risks to health or safety arising from, or in connection with, the activities of persons at work; and provide for matters connected with, or incidental to, the foregoing.

Functions:

The function of the bill are to:

1. provide for the establishment of health and safety committees at work places and for the health, safety and welfare of persons at work;
2. provide for the duties of manufacturers, importers and suppliers of articles, devices, items and substances for use at work;
3. provide for the protection of persons, other than persons at work, against risks to health or safety arising from, or in connection with, the activities of persons at work; and
4. Provide for matters connected with, or incidental to, the foregoing.

Interpretations:

- “occupation” means any employment, business, calling, pursuit,
- vocation or profession;
- “occupational hygiene” means the physical conditions, agents,
- materials or substances present in a working or community
- environment, which may cause sickness, impaired health
- and well being, or significant discomfort and in efficiency,
- among employees or among other persons;
- “occupational disease or injury” means such disease or injury
- as the Minister may prescribe, by statutory instrument;
- “occupational health and safety service” means a service
- organised for the purpose of —

  (a) protecting employees against any health or safety hazard which may arise out of their work or the conditions in which the work is carried on;

  (b) contributing towards the employees’ physical and mental adjustment, to the employees’ adaptation to their work and to their assignment to work for which they are suited; and

  (c) contributing to the establishment and maintenance,of the highest possible degree of physical and mental wellbeing of the employees;

Components of the bill

a) the occupational health and safety institute
b) health and safety committees
c) health and safety workplaces
d) enforcement provisions
e) enforcement provisions
f) general provision

The functions of the Institute are to—

(a) Develop and implement programs to provide incentives for employers to implement measures to eliminate or reduce risks to health or safety or to improve occupational hygiene, occupational health and safety;

(b) Investigate and detect occupational diseases and injuries at workplaces;

(c) Conduct medical examinations for occupational health and safety purposes catering for all industries including agriculture and construction;

(d) Provide an occupational laboratory service;

(e) Promote studies and carry out investigations and research on occupational health and safety;

(f) Prepare and maintain statistics on employee’s morbidity and mortality;

(g) Conduct and encourage awareness educational programmes relating to the promotion of occupational health and safety; and

(h) Carry out such other functions as are necessary or incidental to the performance of its functions under this ACT

Composition of the Occupational Health and Safety Board members shall comprise of the following part-time members to be appointed by the Minister:

(a) A representative of the Ministry responsible for agriculture;
(b) A representative of the Ministry responsible for health;
(c) A representative of the Ministry responsible for labour;
(d) A representative of the Ministry responsible for livestock;
(e) A representative of the Ministry responsible for mines;
(f) A representative of the Attorney-General;
(g) A representative of the Federation of Employers;
(h) A representative of a trade union;
(i) The Director, as *ex-officio* member; and
(j) Two other persons.

HEALTH and SAFETY at WORKPLACES For the purposes of this Part, in determining what is, or was, at any particular time, reasonably practicable in relation to ensuring health and safety at a workplace, regard shall be had to the following matters:

(a) The likelihood of the hazard or risk concerned occurring;
(b) The degree of harm that would result if the hazard or risk occurred;
(c) What the person concerned knows, or ought reasonable to know, about the hazard or risk and any ways of eliminating or reducing the hazard or risk;
(d) The availability and suitability of ways to eliminate or reduce the hazard or risk; and
(e) The cost of eliminating or reducing the hazard or risk.

Duties of an employer

Notwithstanding any other written law, an employer shall—

(a) Ensure, so far as is reasonably practicable, the health, safety and welfare of the employees by the employer at a workplace; and
(b) Place and maintain an employee in an occupational environment adapted to the employee's physical, physiological and psychological ability.
2. Without prejudice to the generality of subsection (1), an employer shall:
(a) Provide plant and systems of work that are, so far as is reasonably practicable, safe and without any risks to human health and maintain them in that condition;
(b) ensure, so far as is reasonably practicable, that articles, devices, items and substances provided for the use of the employees at a workplace are used, handled, stored and transported in a manner that is safe and without any risk to the health and safety of the employees at the workplace;
(c) Provide such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety of the employees at their workplace;
(d) so far as is reasonably practicable, maintain a workplace under the employer's control, in a condition that is safe and without any risk to the health and safety of employees at their workplace;
(e) so far as is reasonably practicable, provide and maintain the means of access to, or exit from, a workplace that are safe and without any risk to the health and safety of the employees using it;
(f) provide and maintain a working environment for the employees that is, so far as is reasonably practicable, safe and without any risks to their health and safety, and

which is adequate as regards facilities and arrangements for their welfare at the workplace;

(g) Inform and consult a health and safety representative

(i) Where an authorised officer visits the workplace, and gives the health and safety representative an opportunity to meet the authorised officer;

(ii) On the circumstances and future prevention of any injury or illness;

(iii) On the circumstances of any injury for which a claim has been submitted to the Workers 'Compensation Fund Control Board; or

(iv) With a view to making and maintaining arrangements to enable the employer and the employees to cooperate effectively in promoting and developing measures to ensure the health and safety of the employees at the workplace, and checking the effectiveness of those measures;

(h) provide at the employer's expense all appropriate protective clothing equipment to be used in the workplace by employees, who in the course of employment, are likely to be exposed to the risk of bodily injuries, and adequate instructions in the use of such protective clothing or equipment; and

(i) do for, or provide to, the employees, free of charge, anything which by law is required to be provided to those employees by the employer.

A person who contravenes subsection (1) or (2) commits an offence and is liable, upon conviction, to a fine not exceeding five hundred thousand penalty units or to imprisonment for a period not exceeding five years, or to both.

Duties of employees

An employee shall, at a workplace—

(a) Take reasonable care for the employee's own health and safety and that of other persons who may be affected by the employee's acts or omissions at the workplace;

(b) Not operate any machine or engage in a process which is unsafe or is an imminent risk to the employee's own health or safety and that of others; and

(c) cooperate with the employer or any other person in relation to any duty imposed on the employer or that other person, so far as is necessary to enable that duty or

requirement to be performed or complied with.

(2) Where an employee has reasonable grounds to believe that any item, device, article, plant or substance, condition or aspect of the workplace is, or may be, dangerous to the employees 'occupational health or safety at or near the workplace, the employee shall immediately inform the employer, the committee or health and safety representative.

Activity 5
In your note book write at least two duties of an employer and those of an employee Answers: duties of an employer 1. ensure so far as is reasonably practicable, the health, safety and welfare of the employees by the employer at the place of work 2. provide and maintain a working environment for the employees that is safe and without any risk to their health and safety. Duties of an employee

1. take reasonable care for the employee's own health and safety and that of other persons who may be affected by the employee's acts or omissions at the place of work.
2. Not to operate any machine or engage in the process which is unsafe or is an imminent risk to the employee's pwn health or safty and that of others.

2.13.4 Poverty Reduction Strategy Paper

Poverty Reduction Strategy Papers (PRSPs) are prepared by member countries in broad consultation with stakeholders and development partners, including the staffs of the World Bank and the International Monitory Fund (IMF). Updated every three years with annual progress reports, they describe the country's macroeconomic, structural, and social policies in support of growth and poverty reduction, as well as associated external financing needs and major sources of financing.

The resurgence of planning to tackle the challenges of wealth creation and poverty reduction is both timely and imperative. The re-emergence of planning following nearly two decades of the preoccupation with stabilisation and adjustment, signals the realisation of several realities that the Government shares with bilateral and multilateral bodies as well as with civil society. Principal among these is the recognition that in spite of the reasonable level of growth during the years of structural reforms, poverty remains pervasive. What is even more disconcerting is the realisation that the depth of poverty and its severity have been fast worsening as the majority of Zambians continue to subsist on the equivalent of less than $1 a day. National statistics show that the poverty level in the country in 2004 averaged 68 percent while rural regions' average is much higher.
Under such conditions, poverty is slowly compromising the sustainability of all that the country has achieved since independence. Adverse human welfare indices such as reduced access to a nutritionally adequate food basket, child and adult malnutrition, insufficient access to education and health facilities, and the resultant reduction in life expectancy all point to the urgency of effectively addressing the national developmental challenge.

Zambia is currently in the lowest category of human development as defined by the United Nations Development Programme (UNDP). In this regard, the challenge of reducing poverty is perceived by the Government not as an option but as an imperative for under such high poverty conditions, the social and political stability that is so pivotal for the revival of the country's growth and prosperity becomes vulnerable to real and potential societal tensions. One of the important lessons learnt from the 1990s was the realization that even in a liberalized economy, development planning is necessary for guiding priority setting and resource allocation. The absence of planning tends to force us to concentrate on
short- term needs representing narrow sectional interests thus denying the country the opportunity to attain a broad based socio-economic development.

The national long-term planning instrument entitled Vision 2030, prepared in consultation with line ministries, provinces, and districts, the donor community and civil society, sets Zambia's the long-term vision. The Vision 2030 reflects the collective understanding, aspirations and determination of the Zambian people to be a '*prosperous middle-income country'.* The Vision sets the horizon for developing the medium-term plans and provides the 'gravitational pull' to achieve long-term objectives. It outlines in broad terms, plausible courses of action to be taken towards the achievement of the country's long-term objectives and targets. It broadly reflects what Zambians aspire to be by 2030 and the options they feel will realistically get them there.

The Vision will be operationalised through five year medium term planning instruments, which are to contain specific policies, programmes and projects, predominantly targeted towards wealth creation and poverty reduction. The first of these plans is the Fifth National Development Plan (FNDP), which will be implemented from 2006 to 2010. The planning process of the FNDP integrated views from the Provincial and District Development Plans approved by the respective provincial and district level organs. The FNDP's goals are multi-pronged:
Firstly, the Government recognises that wealth creation through sustained economic growth constitutes the most important element in poverty reduction and, consequently, a very high premium is being placed on growth-stimulating interventions.

Secondly, the Government recognises that redistributive policies do matter for reducing poverty and that *growth* and *equity* are not necessarily in conflict. The Government maintains that there is no intrinsic trade-off between long run aggregate efficiency and overall equity, hence its resolve to approach poverty reduction through the 'broad-based growth' approach. It is in this context that the Government, together with civil society, has placed priority attention on those sectors that both maximise growth stimulation as well as on those, such as agriculture, education and health, that best address the plight of the poor;

Thirdly, the Government maintains that the needed linkages between growth and poverty reduction can be developed in a sustainable way, but only through an approach that allows everyone to share the benefits of growth. Although, under the right circumstances, sustained growth does often result in poverty reduction, rising inequality adversely affects this and it is in this regard that the role of social protection is considered an important FNDP component. Notwithstanding this, empowering the poor to earn a decent living income is perceived to be a much more effective approach in addressing their plight than the often unsustainable subsidy programmes that tend to destroy the very financial and human
Resource bases that are expected to facilitate positive growth through productive investment; and,

Fourthly, long periods of neglect in infrastructure maintenance due, in part, to the curtailment of development budgets in the interest of fiscal balance, have resulted in the country's characteristic deterioration of its transport networks. It is in this regard that, as one of its priorities in this Plan, the major transport arteries that connect the countryside to the market are focused upon to ensure basic minimum connectivity for moving poor people's income-yielding commodities over long distances. Under the

banner of *Broad-Based Wealth and Job Creation through Citizenry Participation and Technological Advancement* as its theme, the Plan aims to target in the next five years both wealth creation and poverty reduction. In putting together this Plan, the Government enlisted the involvement of all the major stakeholders, including civil society, cooperating partners, and the private sector. District and provincial plans were developed through a consultative process that was facilitated by the Ministry of Finance and National Planning. The consultation process has integrated views of 21 Sector Advisory Groups (SAGs) and included the preparation of 106 district development plans that were approved by the respective district level organs.

Indeed, the summary of the Government's strategies and programmes at provincial level are drawn from the provincial and district development plans. The comparative advantage of each province and linkages within the sectors are clearly stated in the strategic focus of each province with the key programmes that will be undertaken during the FNDP. The bottom-up and top-down consultation approach during the preparation of the FNDP and subsequent national development plans will be fully established and strengthened through programmes such as fiscal decentralization which is part of the overall decentralization policy process.

The objective of the fiscal decentralization programme is to come up with a fiscal framework that will spell out how resources will be shared and distributed to the district levels. After a thorough process of refinements, these lower-level plans were considered and approved by the Provincial and District Development Coordinating Committees. At the central level, Sector Advisory Groups (SAGs), chaired by the respective Permanent Secretaries, were given revised Terms of Reference to enable them play a strategic role in the development of the FNDP.

Members of SAGs include Government officials, representatives of cooperating partners, and representatives of civil society organisations. Consultants were also hired to support the work of the SAGs. A series of meetings were held to identify the FNDP priorities and the Ministry of Finance and National Planning, through its Planning and Economic Management Department (PEMD), assumed the lead role as facilitator of the process that has resulted in the production of this Plan. PEMD was also assisted by a team of consultants in finalising this Plan. A Steering Committee of Permanent Secretaries, chaired by the Secretary to the Cabinet, superintended the entire FNDP planning process. After the draft Plan was released, a national stakeholders' workshop was held which discussed the Plan and its implications. Based on the draft and the input from the stakeholders' conference, this Plan was then approved by the Cabinet and published.

2.13.5 HIV and AIDS Policy

This is a written document that acknowledges the effects of HIV and other related illnesses on the smooth operation of a company. Since HIV/AIDS has been recognised as a workplace health concern, more and more companies in Zambia are formulating HIV/AIDS Workplace Policies that address the many issues surrounding HIV/AIDS. Although each and every workplace around the country has its own way of responding to the AIDS pandemic, a well-written HIV/AIDS Workplace Policy contains key factors that are internationally accepted.

(a) Contents of an HIV/AIDS Workplace Policy

For any written document to be regarded as binding, it must be accepted by all parties involved. In this case, for any HIV/AIDS Workplace Policy to be deemed as binding, its structure, content, principles, objectives and aims must be agreed upon and endorsed by employers, employees and workers representatives, such as Trade Unions.

A proper HIV/AIDS Workplace Policy must be built on a foundation that includes the right to accurate information, employment benefits, and freedom of association, equality and human dignity.

Furthermore, HIV/AIDS Workplace Policy can be used as a tool for addressing the stigma and discrimination associated with HIV or AIDS. Therefore, it should always include a section on how stigma can be reduced.

Additional elements such as guidelines on disciplinary measures for co-workers who discriminate against people living with HIV "can be included depending on the workplace and the parties involved," says Chungu Kampamba, a Lusaka-based AIDS Educator and employee living with HIV.

(b)Checklist of the HIV/AIDS Workplace Policy

Mywage in Zambia has compiled a simple checklist to help you understand your HIV/AIDS Workplace Policy. This involves:

- **Non-discrimination**

No employer, employees or workers' representatives should discriminate against employees with HIV. They have equal rights to human dignity and must therefore not be discriminated against.

- **Confidentiality**

No employee must be subjected to disclosure of their HIV status at any point. Any employer who discloses the HIV status of his or her workers has breached confidentiality and may face any agreed action that might include termination of employment.

- **Voluntary HIV Testing**

Employers will under no circumstances subject their employees to mandatory or involuntary HIV testing. Routine HIV testing can only be conducted if it is part of the agreed HIV/AIDS Workplace Policy. For example, workers in the hospitality, food or beverage industry may be required to undergo routine medical check-ups that may include HIV testing due to the nature of their jobs. Even in this instance, HIV testing should be voluntary.

- **Safe Working Environment**

Every employer must ensure that employees operate in a safe working environment with minimal possibilities of contracting HIV at their places of work. It is common procedure for employers to ensure that they provide a safe and healthy working environment. No employee should contract HIV as a result of a poor or unsafe working environment.

- **Awareness and Sensitisation**

As a way of mitigating the spread of HIV in places of work, employers in collaboration with employees and workers' representatives must ensure that they conduct periodic awareness programmes. Employers must ensure that they provide accurate information on the dangers of HIV, the benefits of abstinence, being faithful to one partner and consistent condom use (or ABC for short).

- **Access to Treatment**

Employees that are diagnosed with HIV can be productive given proper, support, care and treatment. It is therefore the duty of an employer to ensure that workers that have been tested HIV positive are given the right treatment and care. For example, an employer can help secure life-prolonging drugs for its infected employees for a period of about 12 months after which they can decide on the next course of action.

2.12.6 Decentralisation Policy

Zambia implemented an ambitious process of health sector decentralization in the mid-1990s. The decentralization was characterized by both the "delegation" of day-to-day management responsibilities from the Ministry of Health to a semiautonomous Central Board of Health (CBOH) and the "de-concentration" to the Ministry offices at the district level (District Health Management Teams (DHMTs)) and their local health boards (District Health Boards (DHBs)). The Zambian system was not "devolved" to municipal or district governments.

Decentralization allowed the local districts to make decisions regarding the allocation of resources, user fees levels, and expenditures. The general guidelines for allocation of resources were not respected in the district offices, where allocations were consistently much higher. However some districts—large urban districts and those without district hospitals—were not using their resources to pay for the anticipated level of spending in hospitals. It was therefore, suggested that the CBOH develop more explicit guidelines for contracting and more carefully monitoring and enforcing the contracting of hospital services in these districts. CBOH was also mandated to develop a more appropriate guideline for expenditures in district offices and enforce it more rigorously.

Wealthier and urban districts were more successful in raising revenue through user fees, although the proportion of total expenditures that came from user fees was low. Over time, it is likely that user fees in these communities will be more important revenue sources. Therefore, user fee income should be carefully monitored, and as disparities in total expenditures grow, poorer rural districts should be compensated accordingly in the grants formula.

The decision making process at the local level was expected to involve District Boards and neighbourhood and facility committees. In most cases these were not involved. It was therefore, recommended that the boards and committees be reauthorized and that the roles, responsibilities, and selection processes be more clearly defined and consistently enforced by the CBOH. There was little communication between district boards and the neighbourhood and facility committees, which reduced the potential effectiveness of these committees in the priority setting process. It was also recommended that district boards have some measure of accountability or at least that the boards be required to communicate with these committees. Although the districts appeared to follow the planning process involving the initial action plans, critical decision points occurred when the initial budgets were cut by the central authorities as government revenues failed to reach planned levels, and this happened consistently. Neither boards nor committees had much, if any, involvement in making decisions regarding allocations after cuts, and the DHMT tended to simply use percentage guidelines rather than set rational priorities for determining allocations after cuts.

Performance

Indicators of performance, such as the utilization of health services, immunization coverage, and family planning activities, could not be compared from before decentralization to the period after decentralization. The period of 1995-1998 indicators for which data were available did not show significant changes in trends. Although immunization coverage appeared to decline and family planning activities generally rose, these trends could not be linked to decentralization. Overall, the study found no clear evidence that decentralization has weakened the Zambian health system. Indeed, in the face of economic decline and the rise in HIV/AIDS, the system appears to have maintained itself with stable utilization rates (except for immunizations) and increases in reproductive health activities. Decentralization has in some sense probably improved efficiency since the activity levels have been maintained in the face of recent declines in funding.

The fact that decentralization cannot be clearly linked to improvements or deterioration may be due to data limitations. There were suggestions to improve the effectiveness and processes of decentralization

2.13.7 Reproductive Health Policy

The challenge of addressing people's overall reproductive health needs, together with the recognition of the shortcomings of existing health programmes has led to the incorporation of maternal/child health, family planning and STD/HIV/AIDS into the broader concept of reproductive health. This acknowledgement is important in the sense that there is need to adopt a comprehensive approach to the delivery of health care, especially for such related incidences as family planning, maternal and neo-natal mortality and morbidity. Reproductive ill health results from complications of pregnancy, reproductive tract infections, cancers, STIs, HIV/AIDS, infertility and violence against women.

Definition of Reproductive Health

The International Conference on Population and Development defined reproductive health as not just the absence of disease; rather, it refers to a spectrum of conditions, events and processes that occur throughout one's life. These range from healthy sexual development, physical comfort and closeness and the joys of safe childbearing, disease and even death. Consequently, reproductive health offers opportunities to improve not only the health of childbearing women, and generally the female population, but also provides space for involvement of men in all aspects of reproductive health. In addition, reproductive health has multidimensional and cross-cutting aspects and, therefore, requires collaboration with other sectors. In a broader sense, reproductive health also raises issues of human rights, equity and discrimination that must be addressed through participatory and inclusive processes that involve communities, families and individuals.

Safe Motherhood

Safe motherhood addresses service delivery for improvement of the health of the mother and the newborn baby. It means ensuring affordable quality care for the mother and the newborn as close to the family as possible. Safe motherhood services have been provided in the past and continue to be provided but there has not been any significant impact on health indicators of the mother and the newborn. This is largely due to the fact that the quality of safe motherhood services has been poor. The poor quality of safe motherhood services is, in turn, explained by the inadequate supply of infrastructure, equipment, referral services, drugs, limited human skills, gaps in the content of service provided, including lack of policy to guide and inform stakeholders. This in effect affects the proper management of certain disease conditions associated with pregnancy this in turn affect the proper management of complications of pregnancy as a well as certain disease conditions such as anaemia , diabaetes cardiac disease, renal .Other contributory factors to poor safe motherhood include:

a) Young maternal age at first pregnancy;
b) Inadequate family planning services and information;
c) Lack of knowledge of danger signs and complications;
d) Poor economic status and conditions;
e) Poor nutritional status of women;
f) Unaffordable transport to health facilities; and
g) Harmful traditional practices during labour and delivery.
h) Non availability of a law to make maternal deaths notifiale
i) Non-availability of organized data on the population of Zambians for easy capturing of events of reproductive implication in the communities.
j) To include causes of maternal deaths and lack of data and lack of maternal death reviews

Community Safe Motherhood

In an effort to promote safe motherhood at community level and to broaden the range of safe motherhood providers, the Ministry of Health in 1972 introduced the training programme of Traditional Birth Attendants (TBAs). The training programme

is a community-based service that is provided by trained community members. A substantial number of TBAs have since been trained mainly through community initiatives. However, for various reasons, only a fraction of trained TBAs are utilized due to inadequate supplies, inadequate motivation and poor community involvement in the selection process. Recent analyses have come to the conclusion that the impact of training TBAs on maternal mortality is low. An emphasis on large-scale TBA training efforts could also be counterproductive, by holding back the training of the necessary numbers of medium level provides, particularly midwives.
Currently, several NGOs have training programmes for Safe Mother Action Group Members who are volunteers but trained to provide safe motherhood services at community level.

Antenatal Care

Zambia is among countries in the Southern African Sub- Saharan region with a high percentage (94%) of Ante-Natal Care (ANC) ZDHS 2007. Most Zambian women rely on professionally trained safe motherhood service providers such as doctors, clinical officers, nurses and midwives, for ANC. Previous studies have, in fact, demonstrated that on average 93.4% per cent of all pregnant women had received at least one Ante-Natal check-up from a Doctor, trained Nurse, Midwife or Clinical Officer. However, there are concerns over the median number of months at first ANC visit which is estimated at 5.3 months. The median compromises the quality of ANC women receive as it creates missed opportunities for critical ANC interventions such as timely testing and treatment of couples for STIs and screening and/or treatment of women with anaemia.

The other concern is the inadequate quality of the ANC package as only 24% of pregnant women have urine samples collected for investigation, while only 44% of pregnant women's blood is taken for syphilis screening. A significant percentage 29.4% of pregnant women do not receive micro-nutrients and 13.5 % do not have their blood pressure checked. Equally of concern is the inadequate education among mothers with regard to birth preparedness and danger signs during pregnancy and delivery.

Intrapartum Care

Zambia is recording a high number of neonates dying from birth asphyxia sepsis and prematurity. According to ZDHS, 2007 another concern is that the majority of new-born babies (53.8 per cent) are not weighed at birth. This is largely explained by the low level of institutional deliveries and the increasing rate of deliveries that are assisted by trained Traditional Birth Attendants (TBAs).

Having deliveries assisted by skilled attendants is critical in reducing maternal and new-born mortality. According to the Zambia Demographic Health Survey (ZDHS 2007), despite the high rate of ANC coverage, the majority (46.5%) of deliveries are taking place at home with the assistance of either TBAs or relatives and friends with no midwifery skills. Women whose deliveries are assisted by unskilled attendants are at a higher risk of dying in the event of complications. Several factors contribute to the choice of place of delivery. These include distance to the nearest health facility, staff attitudes, traditional beliefs and practices, inadequate and/or inappropriate infrastructure, inadequate drugs and medical supplies and reluctance to be delivered by a male health provider.

Post **natal care**

Presently calculated at 22.7 percent, the rate of post-natal care attendance in Zambia is relatively low. In fact, the majority of women (77.2%) who deliver at home do not receive post-natal care. This has implications on women who develop complications at childbirth with most of the deaths occurring within the first 24 hours to one week postpartum mainly due to haemorrhage and infection. Post-natal care affords the mother and the new-born baby an opportunity to be examined for any complications, receive vitamin A and information on danger signs and recommended preventive action including counselling in Family planning Nutrition and infant feeding. After delivery a woman is expected to get post–natal care after 6hrs, 6 days and 6 weeks.

Before discharging the woman from the hospital after delivery, explain the risk of an unwanted pregnancy and the need for contraception. Urge the client to find family planning services near her home, *or* before discharging the woman from the hospital, help her to initiate a contraceptive method of her choice, *or* schedule a follow-up appointment in two weeks to discuss family planning and initiate a method, *or* give the woman a referral appointment at a family planning clinic near her home.

Emergency Obstetric Care

Access to emergency obstetric care when a woman develops pregnancy and childbirth related complications are critical for a woman's survival as it significantly contributes towards reduction of MMR. Caesarean Section (C/S) rate provides a proxy for women's access to care for pregnancy and childbirth related complications (both basic and comprehensive). In Zambia access to basic and comprehensive obstetric care is poor as reflected by the low C/S rate which is estimated at 2.1% (DHS 2001-2) as compared to 15% as stipulated by WHO. Consequently, Zambia is among the countries in the Sub Saharan region with high maternal mortality rate, which is estimated at 729/100,000 live births.

Neonatal Health

Majority (53.8%) of the newborns are not weighed at birth. This could be a consequence of lack of scales, negligence or low institutional deliveries and those assisted by trained Traditional Birth Attendants (tTBAs). However, majority (85.8%) of the children are said to be average or large at birth (ZDHS 2001-2),

Mother to Child Transmission of HIV

Mother-to-Child Transmission (MTCT) of HIV is by far the largest source of infection of children below five years of age. Experience so far demonstrates that 90 per cent of all new-born babies born to HIV-positive mothers acquire the virus before birth, during birth or through breast feeding. On average, the HIV prevalence rate among women of reproductive age is 18 per cent making the risk of HIV infection a looming threat to expectant mothers and their children. The present estimate is that of the 400,000 babies born annually in Zambia, the HIV virus will infect 25,000 of them. This translates to 70 new HIV infections in babies per day. Fortunately, the high ANC coverage rate provides a window of opportunity for the prevention of mother-to-child transmission of the HIV.

Prevention of Mother-to-Child Transmission (PMTCT) has been piloted in several districts in the country and CBoH is in the process of working out logistics on how scaling up to all districts might be undertaken. Lessons learnt from the pilot programme indicate that PMTCT has the potential of improving and strengthening the provision of safe motherhood services that have so far been found wanting. PMTCT is, however, constrained by inadequate trained safe motherhood providers and the high turnover of suitably trained and experienced manpower. Equally of concern is the inadequacy of universal precautions for health professionals and protective safeguards against exposure to HIV prophylaxis. Experience so far demonstrates that men are not adequately informed about PMTCT largely on account of male-unfriendly ANC services. Other limitations to PMTCT programmes include non inclusion of HIV-negative mothers, poor quality of counselling services, stigma, non availability of care and support for the family and inadequacy of family planning services.

Family Planning

Modern methods of Family planning in Zambia were initially introduced as early as the 1960s. However, family planning utilisation is still very low. For instance, despite the high percentage of women who have heard about family planning services, contraceptive prevalence continues to be one of the lowest compared to other countries in the Southern African sub-region. According to the findings of the 2001/02 ZDHS, 99 per cent of currently married women and men in Zambia know at least one method of contraception, while 97 per cent and 98 per cent of sexually active women and men, respectively, are aware of one contraceptive method or the other. However, despite this knowledge, only 34 per cent of married women in Zambia are currently using contraceptive methods. Out of this figure, 23 per cent are using modern methods while the remaining 11 per cent are using traditional methods. Reasons for the low utilisation of family planning include traditional misconceptions and myths, distance to health facilities, method mix available at the health facilities, and inadequate trained personnel in family planning service provision.

Utilisation of modern family planning services is more prevalent among urban women (46 per cent) than rural women (28 per cent). In addition, the fertility rate in rural areas at 6.9 is higher than the national fertility rate that currently stands at 5.9 per cent. A significant parameter is that contraceptive use tends to increase with increasing levels of education with the result that better educated women are more likely to use modern methods than women with less education.

There is currently a gap between actual provision of family planning services and demand. Some women who, for instance, would like to delay the next pregnancy by a number of years (spacing) or want to altogether stop child bearing (limiting) are not using any contraceptive method. Current family planning use for modern methods is at 23 per cent while unmet need is at 27 per cent. Unmet need is the percentage of women who would have liked to space or limit but did not use modern family planning methods. It is currently estimated that spacing is at 24 months but evidence has shown that longer spacing of three to five years has maximum impact on reduction of maternal and neonatal morbidity and mortality.

The prevalence of HIV in women is 18% while in men it is 13 % with an average prevalence of 16% in the 15 to 49 age group. The HIV and AIDS epidemic poses major challenges for family planning services in Zambia and the use of non-barrier family planning methods in the context of high HIV and other STI infections is a continuing challenge.

The use of a condom is largely preferred since it is a well-known fact that almost all family planning methods do not prevent Sexually Transmitted Infections (STIs). Integration of HIV information into family planning counselling is, however, a challenge that needs to be addressed by reproductive health service providers at all levels. At community level, another challenge is how to provide family planning services as close to the family as possible. In fact, for many years family planning services have only been provided at health facilities. Nevertheless, with the low utilisation of family planning services in rural areas (28 percent), Community-Based Distributors (CBD) are increasingly being used as an option.

Interestingly men are more exposed to family planning messages on both radio (57 percent) and television (33 percent) than their female counterparts (DHS 2001-2002). Despite their exposure, their involvement in family planning is still insignificant, while their views on family sizes usually predominate over those of women. Experience demonstrates that men generally prefer larger families than women. Paradoxically, most often, it is women who look after children. Long distances to family planning centres also contribute to the low utilisation of family planning services.

Maternal Nutrition

The poor nutrition status of women in Zambia has been worsened by the high poverty levels currently calculated at close to 80 per cent, HIV and AIDS. Malnutrition in mothers is associated with low birth weight, risk of child mental retardation and stunting, including an increased risk of complications during delivery and breast-feeding. Indicators of maternal nutrition include height, body mass index (BMI), haemoglobin level and the birth weight of the newborn baby. According to the 2002 Demographic and Health Survey (DHS), the average height of mothers in Zambia is 158 centimetres, which is above the critical cut-off point of 145 centimetres. The median BMI for Zambian mothers is, however, below the cut-off point of 18.5. Poor maternal nutrition is particularly acute for the majority of pregnant women in rural areas.

Adolescent Sexuality and Health

Adolescent sexuality is becoming an increasing concern in Zambia. This is partially because of rapid urbanisation and modernisation that are, invariably, giving rise to new pattern of sexual behaviour. Concerns include pre-marital sex, which often leads to early pregnancy, induced abortions and sexually transmitted and HIV infections. The early pregnancies have implications on the mother and the child in that the mother is likely to leave school and be prone to complications at the time of delivery because of the immature pelvic development. In addition because of the limited education the mother tends not to understand her sexuality and have no skills of taking care of the baby. This is likely to endanger the life of the baby. Literature has shown that a mother needs to have at least higher secondary education to be able to meaningfully take care of the baby. On their part, adolescents usually report

lack of information and understanding of their own sexuality and negative attitude of health workers when they try to access services. In Zambia, marriages occur relatively early with 70 per cent of young women getting married by the age of 20 years.

Teenage fertility is one of the major concerns in Zambia and is compounded by the fact that contraceptive prevalence in this age group is extremely low. On average, by the age of 20, between 60 and 70 per cent of Zambian women have either given birth to or are pregnant with their first child. Negative consequences include, *inter alia*, unsafe abortions and related complications. Young women in urban areas on average marry at least one year later than their counterparts in rural settings. The median age at first marriage is, however, higher among young women with at least some secondary education than among those without any.

Apart from high-risk pregnancies, the large numbers of adolescents who initiate sexual activity at an early age are at high risk of contracting STIs and/or HIV/AIDS. The population survey on HIV sero-prevalence of 1996, for instance, indicated an infection rate of 8.2 per cent among girls aged 15-19 years in rural areas and 14.3 per cent among urban girls in the same age group. Unfortunately, despite their vulnerability to sexually transmitted and HIV infections, adolescents remain largely excluded from and under-served by the current reproductive health service delivery system. Adolescents also remain mostly excluded from guidance on sexuality and relationships within their own home environments. Some of the reasons include lack of appropriate training for health providers and cultural attitudes regarding sexuality.

Sexually Transmitted Infections and HIV and AIDS

Sexually Transmitted Infections (STIs) are a contributory factor in HIV transmission and have contributed to the high incidence of the HIV/AIDS pandemic in Zambia. The current estimate is that 16 per cent of men and women in the 15-49 age group are HIV-positive. Women face particularly high risks of contracting the HIV virus on account of certain cultural beliefs that emphasise female subservience to men. The relatively high prevalence of sexually transmitted and HIV infections continue to pose a challenge to reproductive health programmes and activities, including the provision of quality health care in the country.

STIs can cause acute morbidity and complications and might contribute to maternal and foetal mortality, including adverse pregnancy outcomes such as ectopic pregnancies, spontaneous or involuntary abortions and infertility. The World Health Organisation (WHO), for example, estimates that in Zambia 18 per cent of early foetal deaths and 43 per cent of late foetus deaths are due to Maternal Syphilis. It further estimates that 30 per cent of perinatal mortality is associated with Syphilis. Prematurity is another problem that is often associated with STIs. Ophthalmia Neonatorum, Congenital Syphilis and Chlamydial Neonatal Pneumonia also remain frequent causes of infant morbidity and mortality.

In Zambia, health information messages are usually disseminated using mass media. Unfortunately, 51 per cent of women and 40 per cent of men do not have any access to any form of electronic or print media. The situation is particularly acute in rural areas. Despite the fact that about 90 per cent of women and men know one or more symptoms of STIs, 32 per cent of women and 30 per cent of men do not seek

any treatment. On average, 21 per cent of women and 32 per cent of men do not inform their partners that they have an STI, while almost 30 per cent of women and 32 per cent of men took no action to protect their partners from contracting an STI.

Health care providers in Zambia have adopted the syndromic approach to the management of STIs. However, experience demonstrates that the approach is usually appropriate for addressing syndromes associated with urethral discharge and genital ulcer. Disadvantages of the approach include "…the inevitable overtreatment, since it is necessary to provide antimicrobial coverage against all of the major etiologies of a particular syndrome" (King K. Holmes et. al., Sexually Transmitted Diseases (3rd Edition), 1999: 1384). The other concern is that the approach has a relatively high sensitivity at the expense of specificity and requires treatment involving more than one antimicrobial drug. In the Zambian situation, this is compounded by the fact that very few health providers have received formal training in STI case management. According to the Central Board of Health (CBoH), for instance, only 37 per cent of health providers have received training in STI case management. Other limitations include shortages of drugs and supplies in some health facilities and the non-inclusion of most STI essential drugs in the Essential Drug Kit. This is particularly true for rural health facilities with the result that there are increasing cases of inappropriate and incorrect prescriptions that sometimes lead to drug resistance.

Abortions

Unsafe and poorly performed abortions are some of the major causes of maternal mortality in Zambia. In 1993, for instance, the Ministry of Health indicated that over 16,000 maternal hospital admissions nationally were due to abortions performed in the community by non professionals. It also indicated that 15 per cent of all maternal deaths were occurring among patients with abortion cases. Despite the availability of family planning services, many young women and teenagers fail to prevent pregnancies. The Ministry of Health also estimated that about 23 per cent of incomplete abortions were among women younger than 20 years, while 25 per cent of maternal deaths due to induced abortions were in girls younger than 18 years. This might well reflect the lack of information and difficulties experienced in accessing family planning services and inability to negotiate safe sex with their partners. Cultural attitudes that value maternity also play a role. Inadequate access to safe abortion services is one of the major reasons why so many women suffer from abortion complications. In some cases women end up dying. Apart from being contributing factors to maternal mortality, unsafe abortions at times also result in pelvic infection that might result in chronic pelvic pain or infertility.

In order to enable access to safe abortions, the government in 1972 adopted the Termination of Pregnancy Act that allows for termination of pregnancy under specific conditions. However, in practice, the Act has not managed to enhance access to abortion services that are, in any case, not widely available and easily accessible because of the requirement that there should be three doctors one being a psychiatric doctor and the lack of equitable distribution of doctors and facilities. Progress has, however, been made in the provision of Post Abortion Care (PAC). PAC comprises three elements of treatment. These are emergency care (e.g. treatment of bleeding, removal of retained products of conception), provision of

counselling and family planning services on discharge of the patient and linkages to other reproductive health services. So far, all the country's nine provinces have been oriented in PAC and training sites have been established in provincial hospitals.

Government recognises the prevalence of abortion and that it is a public health problem and not just a moral dilemma. It has therefore promoted access to and use of modern methods of family planning, including for youth who are the main culprits of abortions, secondly recognising the role that gender to enable abortion to take place under safe conditions lays on abortions government has prioritised gender as key to safe motherhood

Infertility

Rates of infertility in Zambia are not known. Nevertheless, gauging from the prevalence of STIs alone, it is estimated that both primary and secondary infertility rates are high. Impaired fertility, variously described as infertility or sub-fertility, may be due to a relative or absolute inability to conceive or repeated pregnancy wastage. It affects both men and women in approximately equal proportions and causes considerable personal suffering and disruption of family life. Incidentally, like in many other societies, in Zambia the inability to conceive and bear a healthy child is considered to be the fault of the female partner rather than a problem of the couple. Infertility can largely be prevented through reduction of reproductive tract infections. Given the costly nature of treatment of infertility, it is cost-effective to focus on prevention and creation of awareness through the provision of counselling services and adequate infrastructure at each health facility level.

Other Reproductive Health Issues

Vesicle fistula i.e. vesicle vagina fistula (VVF) and rectal vaginal fistula (AVF) are the other complications that may result from complicated childbirth. Currently the skilled to handle fistula are limited to bigger usually tertiary hospitals. This tends to work against the rural mothers. This leaves a lot of mothers incapacitated and deprived of the enjoyment of sex as a gift from god. These mothers have to leave a miserable life if unable to access services of a skilled gynaecologist. Cervical cancer is one of the major causes of death among women. Certain STIs, particularly the human papilloma virus, increase the risk of cervical cancer. The cancer is, nevertheless, potentially curable if detected early and treated adequately. Inadequate facilities for periodic cytological screening (Pap smear) to detect early pre-invasive cancer (especially in clinics and rural health centres), however, do not allow early detection of cervical cancer.

Breast cancer is similar to cervical cancer in terms of its impact on women. The risk factors associated with breast cancer are poorly understood. Usually, breast cancer is associated with a family's pre-disposition such as breast cancer pre-menopausal in a mother or sister. Age at menarche, age at first and last pregnancy and age at menopause are also associated with increased risk but may not easily be modified through public health interventions. There is further, little possibility for primary preventive strategies to reduce either incidence or mortality from breast cancer. Ordinarily, the organisation and implementation of a mass screening programme would have been ideal for early diagnosis of breast cancer. However, such

undertaking is currently beyond available national resources. Currently, apart from surgical treatment for cancers of the breast and the cervix, Zambia has no facilities for radiotherapy treatment although construction of radiotherapy treatment facilities in Lusaka has commenced.

Menopause, the permanent cessation of menstruation, generally occurs between the ages of 45-55. In some women, menstruation stops abruptly, while others many months of irregular bleeding precede the final menstrual period. Specific diseases associated with hormonal changes accompanying menopause include circulatory diseases and osteoporosis. In addition to irregular bleeding patterns and eventual cessation of menses, pre-menopausal and menopausal women at times experience vasomotor symptoms (hot flushes, night sweat), urogenital problems and psychological symptoms. In Zambia, not all women, though, experience or report all these symptoms.

Declining oestrogen levels which lead to urogenital atrophy (decreased vaginal and bladder muscle tone), a thinner vaginal epithelium and vaginal dryness, making intercourse painful is another post menopausal problem. Other cases that are usually reported by post-menopausal women include difficulties in passing urine, urgency of urination and incontinence (leaking urine). In isolated cases, pelvic floor muscles that have been damaged from repeated pregnancies further compound the problem of urinary incontinence. Certain health risks such as cardiovascular disease and osteoporosis increase after menopause.

Post-menopausal women have higher cholesterol levels (including total cholesterol, very-low-density lipoprotein cholesterol and low-density lipoprotein cholesterol) than pre-menopausal women. Menopause also triggers a process of reduction in bone mass that can result in pain, disability and increased risk of fractures (particularly hip and spine fractures in women aged 60-80). The link between osteoporosis and menopause is related to decreasing ovarian hormone levels, particularly estrogen. Repeated pregnancies and obstetric trauma can lead to genital prolapse, a painful debilitating condition. Genital prolapse can involve the vaginal wall or uterus descending below their normal positions. It also can involve protrusion of part of the bladder or rectum into the vagina.

As women age, various factors make them more susceptible to urinary tract infections, including decreased bladder tone, incomplete voiding, genital prolapse and, in some cases, reduced immune function. Prolapse also can compound reproductive tract infections such as vaginitis, cervicitis and pelvic inflammatory diseases. Another condition other than breast cancer but which has not so far been addressed in Zambia is prostate cancer. This cancer usually affects elderly men and its cure rate has not been that successful. In order to enhance the cure rate, the MoH is considering initiating a screening programme for men.

Vulnerable and socially excluded Groups

This category includes the differently-abled, street kids, mentally retarded people, orphans and vulnerable children (OVCs), elderly people, prisoners and refugees.

Given the social status of this group and the nature of existing reproductive health arrangements that do not target its members, reproductive health services hardly reach those in need of them. The situation is compounded by the fact that some health providers may also lack skills in addressing their reproductive health problems.

Reproductive Health and Rural Communities

Women in rural areas of Zambia, as indicated elsewhere in this document, have a higher fertility rate than their urban counterparts. Again, as already noted, the total fertility rate is influenced by the level of education; women with no education have a higher fertility, while those with at least some secondary education have a lower rate. Women in rural areas are, on the other hand, less likely to use contraceptive than those in urban areas. This is partially on account of certain traditional beliefs that associate modern contraceptive methods with negative side effects. Consequently, much of the unmet reproductive health service gaps in Zambia result from women's fear of the health side effects associated with contraceptive methods such as pills and injectables.

So far, the Ministry of Community Development Mother and Child Health has been working to reduce health risks of mothers and children through increasing the proportion of health facility-based deliveries. Unfortunately, over half of births still occur at home with little chances of accessing post-natal care. According to the ZDHS 2007, more than half (51 percent) of the women did not receive any postnatal care; however, 39 percent received a postnatal check-up within two days of delivery. Nine percent of the women had a check-up 3 to 41 days after delivery. This is especially in the case for rural areas where health facilities are, in some cases, distant to reach and money for transport is scarce. Conversely, urban women are three times more likely to deliver in a health facility. There are currently several programmes working with various communities around the country with a view to improving the reproductive health status of women.

These include programmes run by non-governmental organisations (NGOs), community-Based Organisations (CBOs) and Neighbourhood Health Committees (NHCs). NHCs play particularly important roles in building people-level consensus on community health priorities and enjoy a singular strength that resides in the election of its leadership by the local people. Other initiatives involve the training by District Health Management Teams (DHMTs) and some NGOs of Traditional Birth Attendants (TBAs), Community Based Distributors (CBDs) and Community Health Workers (CHWs) in basic reproductive health service delivery. These also serve as links between communities and health centres.

Gender and Reproductive Health

In Zambia, men and women's access to health services, including reproductive health services, is constricted by several traditional beliefs and norms. They are largely excluded from decision-making processes and have inadequate access to

reproductive health related information. Consequently, instances of forced sex, early marriages and sex with older men are common especially among rural and uneducated women. These put them at risk of unsafe pregnancies and contracting STIs and HIV/AIDS. There are also cases of violence against women during and after pregnancy. In some cases, this has resulted in maternal mortality or miscarriage due to injury and/or trauma.

The need for women to be empowered has for a long time been a matter of policy concern for the Zambian Government. One of the major policy aspirations is to increase women participation in making decisions that affect their lives. In pursuance of this cardinal objective and to mainstream gender in the management of national affairs, the Government in March 2000 published the National Gender Policy document. The Policy provides government framework for eliminating male discrimination and empowerment of women. Unfortunately, to date men still continue to dominate in making decisions affecting lives of women as evidenced in both rural and urban communities and public affairs being strongly entrenched in culture.

Health Delivery System and Human resources

In 1992, the Zambian Government embarked on a radical health reform process with a view to building structures that would allow the provision of equity of access to cost effective quality health care as close to the family as possible. Some progress has since been made in areas such as control of malaria and child health. Nevertheless, a lot of challenges remain to be overcome. These include institutional and human resource constraints.

Currently, there are 206 and 880 health centres in urban and rural areas, respectively. Urban health centres have an average catchment population of between 30,000 and 50,000 around a 30-kilometre radius. In rural areas, the catchment is in the neighbourhood of 10,000 within the same radius. Rural health centres face particularly serious difficulties with regard to staffing, drug logistics and supplies with the result that the majority are unable to provide a basic package of primary health services, let alone a 24- hour service. In some areas, this situation also applies to a number of hospitals that operate on the back of depleted and demotivated staff complements, inadequate and poorly maintained equipment and insufficient supply of drugs.

The national health delivery system also suffers from an uneven and inadequate supply and distribution of health personnel. Some rural health centres, for instance, have no nurses or midwives. Currently, registration figures indicate that there are 7,051 Enrolled Nurses, 2,901 Registered Nurses, approximately 3,500 Nurse-midwives, 531 Physicians and 12,093 Clinical Officers. Unfortunately, it is not clear how many are in practice, let alone where some of those who are practicing are located. Referral systems, on their part, are weak. This is especially true in rural areas where health centres are more likely to be inadequately staffed or where staff cannot deliver certain health services due to either inadequate training or insufficient availability of drugs and medical supplies. Telephone communication between rural health centres and hospitals is in some cases virtually non-existent.

These limitations are compounded by the low level of dissemination of information regarding reproductive health services among the majority of health workers. This is

despite the general acknowledgement of the critical role that information, education and communication (IEC) play in reproductive health service delivery. Documentation of IEC programmes and activities is equally weak, erratic and dispersed across the system. The use of reproductive health information is, however, a *sine qua non* for planning national, provincial and district health service delivery programmes. The Central Statistical Office (CSO), the MoH and the CBoH have for years been collecting and collating health data and information on reproductive health as a way of enhancing planning, monitoring and evaluation. These include Demographic and Health Surveys (DHS) of the CSO and Sentinel Surveillance of HIV infection and prevalence by the MoH. There is, unfortunately, no institutional forum for sharing results and best practices among health providers.

Some health providers have not undergone any upgrading of their skills for years on end. In addition, there are no agreed and standardised protocols or guidelines on management of reproductive health problems at all levels of the national health delivery system. Another weakness is that supervision has not adequately been developed and built into the health care delivery system. The majority of health providers, for example, do not receive routine supportive supervision from the centre. This has been made worse by the fact that some DHMTs, that are supposed to provide the supportive supervision, do not have adequate staff and transport logistics for regular field supervisory visits.

2.13.8 Child Protection Policy

This policy is the child rights-centred protection policy, in which the safety of children and vulnerable adults is at all times paramount. The Premises display and adhere to the following notices

Child Protection Notice: In keeping with the Policy of Safeguarding Children, Serenity Harm Reduction Programme Zambia request that a parent / guardian or the person acting in locus parentis:

• accompany a child on the premises

•supervise the child / children while they are on premises.

Serenity Harm Reduction Programme Zambia (SHARPZ) Child Protection Policy Statement: states that Each child shall be cherished and affirmed as a gift from God with an inherent right to dignity of life and bodily integrity which shall be respected, nurtured and protected by all. Everyone has an obligation to ensure that the fundamental rights of children are respected.

Self Assessment Test :9

Write short notes in your note book on these policies
1. Child protection policy **2.** Reproduction health policy **3.** HIV/AIDS policy **4.** Poverty reduction strategy paper **5.** Decentralization policy

2.14 Regulatory Organizations

2.14.1 The General Nursing Council of Zambia (GNC)

Definition

Hello learner, today we are looking at the General Nursing Council of Zambia (GNC) which is a Statutory Body, established in 1970 under the Nurses and Midwives Act No.55 of 1970 which was repealed and replaced by the Nurses and Midwives Act No. 31 of 1997. This Act redefined the functions of the Council and expanded the scope of practice for Nurses and Midwives. The Act also provides for the establishment of private practice.

The main responsibilities of the GNC are to provide policy on:

1. Education and training of nurses and midwives.
2. Professional conduct of nurses and midwives
3. Professional conduct matters pertaining to nursing and midwives.
4. Accreditation (official approval given by an organisation stating that somebody, something has achieved a required standard).

Membership

The Council has a membership of 13 people who are appointed by the Minister of Health. These appointed Council members serve for a period of 3 years.

GNC Mission Statement

The GNC is a statutory body responsible for ensuring that members of the public receive the best possible health care. The GNC sets, monitors and evaluates performance standards for nursing/midwifery education, clinical practice, management and research.
The nurses and midwives shall be empowered to provide quality nursing and midwifery care through attainment and maintenance of professional excellence.

Functions

The Council functions mainly through standing committees namely; Education, Examination, Disciplinary and Executive. Adhoc committees are constituted when a need arises e.g. financial sustainability. Each is given responsibilities by the council and submits regular reports on its activities at each council meeting.

Education and Training

- Review of nursing and midwifery curricula.
- Institute diplomas and certificates of competence.
- Determines suitability of an institution to carry out training.

- Makes rules regarding the requirement to be fulfilled by persons to undergo training.
- Inspection of training institution and hospitals.

Registration and Enrolment

- Maintains register and rolls for nurses and midwives.
- Enrolled nurse who convert shall change from roll to a register.
- The council may however refuse to register a person, but shall give reasons for refusal in writing.

Uniforms and budges

On the Council's recommendation the Ministry of Health may make requisitions specifying distinctive uniforms to be worn by nurses/midwives.

Discipline

The act makes provisions for establishment of a disciplinary committee appointed by the minister. The members held office for 12 months but in the new Act the appointed member holds office for 3 years.

Powers of disciplinary committee

If after an inquiry a nurse is found guilty of infamous conduct in any professional respect, one or more of the following penalties may be imposed.

- direct deletion of his or her name from registrar or roll
- Censure him/her (i.e. strong criticism)
- Caution him and postpone for a period not exceeding one year any further action against him on one or more conditions as to his conduct during that period.
- Order him to pay to council the cost stipulated

Restoration of Names to Register/Roll

When application for restoration has been made the committee may direct restoration of the name;

- Before the expiry of 6 months from the date of deletion or
- With a period of 6 months from the consideration by the disciplinary committee of a previous application in that behalf.

Appeals

When the council directs deletion of the name from the register or roll or rejects the restoration of a name, the aggrieved (feeling that you have been treated unfairly) person will be informed in writing by the registrar and given 90 days in which to appeal to high court.

Definition of Nurses and Midwives Act:

The Nurses and Midwives Act No. 31 of 1997 is the law that regulates the professional conduct of nurses and midwives in the country.

It stipulates the GNC functions as follows:

1. Register nurses and midwives
2. Register all nursing training colleges
3. Register all nursing homes and agencies
4. Regulate professional conduct of nurses and midwives
5. Regulate nursing and midwifery education
6. Regulate nursing homes and agencies
7. Advise the Minister on matters relating to nurses and midwives.

The ACT also prescribes the scope of practice for both nurses and midwives as:
A nurse or specialist shall provide preventive, therapeutic, palliative, rehabilitative care and treatment of illnesses normally carried out in nursing and midwifery practice and in a nursing home.

These include;

- Assess, diagnose and provide relevant therapeutic interventions
- Carry out physical examinations
- Insert and remove devices
- Carry out vacuum extractions
- Carry out intravenous infusion procedures
- Prescribe relevant drugs and other pharmaceutical preparations from a list defined by the National Drug Formulary Committee
- Provide counselling to patients relating to illness
- Provide information, care and procedures relevant to nursing and midwifery practice necessary to prevent disease, disability or any illness or to protect life.

The Ministry may in consultation with the council make rules to regulate the scope of nursing and midwifery.

Activity: 6
In your not book write five functions of the General Nursing Council. Good now you can proceed to the next topic.

2.14.2 Health Profession council of Zambia

Dear learner, in the previous topic we looked at the General Nursing Council as one of the regulatory bodies. We will now introduce you to the other regulatory body which is the Health Professions Council of Zambia.

The Health Professions Council of Zambia, a regulatory body within the health sector, came to be on 14th May, 2010 when the Commencement Order was signed. The existence of the Health Professions Council of Zambia is governed by the Health Professions Act No.24 of 2009 of the Laws of Zambia. The Health Professions Act of 2009 of the Laws of Zambia continues the existence of the Medical Council of Zambia and renames it as the Health Professions Council of Zambia.

Medical and Allied Professions Act

This is an act to establish the medical council of Zambia to provide for the regulation of the medical dental, pharmaceutical and allied professions and to provide for matters incidental to or connected with the fore going. It was enacted on 16thJuly1966.Before GNC was formed even nurses were registered under this act.

Medical workers who register under this Act

- Medical Practitioner
- Dental surgeons
- Pharmacists
- Health inspectors
- Opticians
- Physiotherapists
- Occupational therapists
- Dental technicians
- Radiographers
- medical laboratory assistants
- medical laboratory technicians
- medical assistants
- Dental technicians
- Dental auxiliaries
- health assistants
- x-ray assistants
- pharmacy technicians

2.14.3 PHARMACEUTICAL REGULATORY AUTHORITY (PRA)/ ZAMBIA MEDICINES REGULATORY AUTHORITY (ZMRA)

Hello learner, we are now going to introduce you to the last regulatory body in this unit, the Pharmaceutical Regulatory Authority (PRA).

The Authority was established to ensure that medicines and allied substances being made available to the Zambian public conform to the required standards of quality, safety and efficacy throughout the chain of manufacture, importation, exportation, storage, distribution, supply, sale and use.

The Pharmaceutical Regulatory Authority (PRA) is mandated to regulate and control medicines and related substances being made available to the Zambian public. This is done through among other things registration of medicines and licensing of establishments involved in the manufacture, importation, wholesale dealing and supply and sell of medicines and related substances.

Self assessment test: 10

DO THIS MCQ EXERCISE

6. GNC has ---------- members:

   a) 12

   B) 15,

   C) 13

7. The appointed council members serve for a period of ----------

   A)2Years

   B) 3years

   C) 4years

8. The following are standing committees of GNC EXCEPT :

   - Education committee
   - Examination committee
   - Displinary committee
   - Finance committee

Answers 1-c, 2-b, 3-d

2.15 Summary

Dear learner, we have now come to the end of our discussion in unit 2 where we looked at the law and contititution of Zambia, the nurses and midwives Act the Professional Code of Conduct where we looked at principles which guide nurses and midwives in maintaining quality standards of nursing and midwifery education and practice were discussed. The National Reproductive Health was also looked as nurses need to adopt a comprehensive approach to the delivery of health care, especially for such related incidences as family planning, maternal and neo-natal mortality and morbidity. We also discussed the some of the policies which relate to health like the gender policy, national health policy, decentralization policy, HIV and AIDS Policy, reproductive health policy, and child protection policy. Finally we looked at the Regulatory Authorities of Zambia as statutory bodies enacted by an Act of Parliament mandated to ensuring that members of the public receive the best possible health care services in the country.

2.16 References

1. General Nursing Council (notes on Professional Practice)
2. 5th National Development Plan 2006-2010, (2007) GRZ/IMF, Lusaka
3. National Reproductive Health Policy (2005) MoH, Lusaka.
4. Zambia Demographic and Health Survey (2007) CSO/MICRO/MoH, Lusaka
5. Daly, J (2005) Nursing Leadership, 2nd edition, Churchill Livingstone, Marrickville.

Unit 3: PROFESSIONALISM

3.1 Unit Introduction

Welcome learner to the discussion we are going to have on professionalism. Previously we looked at unit 2 that discussed the policies, legislation and regulation for nursing practice within the nursing profession. Now we are looking at professionalism as it refers to the conduct, aims, or qualities that characterize a professional person.

3.2 Unit Objectives

At the end of the Unit, the student should be able to:

1 Define Professionalism and Profession
2 Describe the characteristics of a Profession
3 Describe Professional Responsibilities
4 Explain Ethical Aspects of Nursing Practice
5 Explain Legal Aspects of Nursing Practice
6 Explain the Rights of the Nurse
7 Explain the Rights of the Client
8 Describe Professional Organizations and Interest groups

3.3 Definition of terms

Professionalism refers to the conduct, aims, or qualities that characterize or mark a profession or a professional person. It also refers to the competencies and professional conducts acquired through training and education which ensures that an individual is able to perform according to ethical standards recognized by the professional association or council.

Profession

- A profession is "a vocation *requiring* knowledge of some department of learning or science."
- An occupation that requires extensive training and the study and mastery of specialized knowledge.
- An occupation that requires advanced knowledge and skills that grow out of society needs for special services.
- A disciplined group of individuals who adhere to themselves and are accepted by the public as possessing special knowledge and skills in a widely recognized, organized body of learning derived from education and training at a higher level and these skills are in the interest of others.

- The conduct, aims, or qualities that characterize or mark a profession or a professional person.

Professional: is one by virtue of intellectual capacity, education and moral outlook is capable of the exercise intellectual and moral judgment at a high level of responsibility or one specialized in a particular field or occupation, affiliated to mother body and upholding its code of conduct

Self assessment: 10 matching Column 1	**Match the definition in column 1 with those in column 2**
1. Professionalism	a) An occupation that requires extensive training, study and mastery of specialized knowledge
2. Profession	b) one specialized in a particular field or occupation, affiliated to a mother body and upholding it's code of conduct
3. Professional	c) the conduct, aims or qualities that characterize a profession or a professional person.
Answers: 1-c, 2-a, 3b	

3.4 Characteristics of a Profession

I hope you enjoyed our discussion on definitions. We shall now introduce you to the topic on the characteristics of a profession. The list of characteristics that follows is extensive, but does not claim to include every characteristic that has ever been attributed to professions, nor do all of these features apply to every profession:

1. **Skill based on theoretical knowledge**: Professionals are assumed to have extensive theoretical knowledge and to possess skills based on that knowledge that they are able to apply in practice.
2. **Professional association**: Professions usually have professional bodies organized by their members, which are intended to enhance the status of their members and have carefully controlled entrance requirements.
3. **Extensive period of education**: The most prestigious professions usually require at least three years at university.
4. **Testing of competence**: Before being admitted to membership of a professional body, there is a requirement to pass prescribed examinations that are based on mainly theoretical knowledge.
5. **Institutional training**: In addition to examinations, there is usually a requirement for a long period of institutionalized training where aspiring professionals acquire specified practical experience in some sort of trainee role before being recognized as a full member of a professional body. Continuous upgrading of skills through professional development is also mandatory these days.

6. **Licensed practitioners**: Professions seek to establish a register or membership so that only those individuals so licensed are recognized as bona fide.
7. **Work autonomy**: Professionals tend to retain control over their work, even when they are employed outside the profession in commercial or public organizations. They have also gained control over their own theoretical knowledge.
8. **Code of professional conduct or ethics**: Professional bodies usually have codes of conduct or ethics for their members and disciplinary procedures for those who infringe the rules.
9. **Exclusion, monopoly and legal recognition**: Professions tend to exclude those who have not met their requirements and joined the appropriate professional body. This is often termed *professional closure,* and seeks to bar entry for the unqualified and to sanction or expel incompetent members.
10. **Mobility**: The skill knowledge and authority of professionals belongs to the professionals as individuals, not the organizations for which they work. Professionals are therefore relatively mobile in employment opportunities as they can move to other employers and take their talents with them. Standardization of professional training and procedures enhances this mobility.

3.5 Professional Responsibilities

Hello learner! We just looked at the characteristics of a profession in the last topic, now we shall discuss professional responsibilities as they relate to the following:

3.5.1 Accountability

Accountability within the nursing profession is growing, particularly as nurses take on new roles and responsibilities, often finding themselves working on their own without a mentor and or supervisor. In the last decade there has been an enormous increase in litigation against hospitals over the type of nursing care provided to individuals coming to the hospitals seeking care. It is therefore essential for all nurses to be aware that **accountability means taking responsibility for your own actions and decisions**. The nurse balances accountability to the client, the profession, the employer and society. For example, a nurse may know that a client who will be discharged soon remains confused about how to administer Insulin. No one else can answer for you and it is no defense to say you were acting on someone's orders. A nurse must be able to justify decisions and judgments you make.

Accountability has long been a complex issue for nurses, particularly since the introduction of the nursing process, an initiative that has both clarified and recast the nature of nursing and nurses' accountability. Significantly, the nursing process has been credited with transforming nursing from simple carrying out of tasks to a process of decision-making informed by specialised knowledge and skill, whilst also allowing the evaluation of individual practitioners. Accountability can mean both to be 'accounted on' (in the sense of being dependable) and 'being able to be counted' (that is, being ready to speak out against injustice or bad practice). Accountability is

often teamed with “open”, for example, as in the phrase “open and accountable”, suggesting that accountability is associated with visibility or transparency.

To be accountable denotes an acceptance of the obligation to disclose and the possible consequences of disclosure (Duff, 1995). Disclosure involves making decisions explicit so that others can evaluate them, and such disclosure may be discretionary in the timing and extent of disclosure and may depend on the situation and the other people involved. These “other people” may include patients/consumers, colleagues, regulatory bodies or employing organizations, to whom accountability is owed, irrespective of disclosure.

Professional accountability applies to everyone involved in health care (Moore, 2011).
Accountability is a legal obligation in health care delivery and also an ethical and moral responsibility. Assuming responsibility for one’s own nursing practice is the most important achievement for the nursing profession. A professional nurse has the responsibility to practice within his/her scope of care, calling upon his/her knowledge and skills to make decisions in the best interest of the client.

Professional accountability is concerned with weighing up the interests of clients in complex situations, using professional knowledge, judgment and skills to make decision and enabling you to account for the decision made (UKCC, 1996).

3.5.1.1Types of Accountability

1. PROCESS ACCOUNTABILITY
   This type concerns the use of proper procedures; for example, demonstrating that locally derived standards and those set out by government are adhered to.
2. FISCAL ACCOUNTABILITY
   Concerns financial probity and ability to trace and adequately explain expenditure.
3. PROGRAMME ACCOUNTABILITY
   This one concerns the activities undertaken and their quality.
4. PRIORITY ACCOUNTABILITY
   This type involves the relevance or appropriateness of chosen activities.

In addition to the accountability found within institutions (financial and public accountability), the individual operates through four dimensions of accountability

A. SOCIAL ACCOUNTABILITY, which sets norms for acceptable behaviour within a society, relying on the individual offering or being asked to provide accounts that explain their actions in an attempt to shape the way others will perceive these.

B. ETHICAL ACCOUNTABILITY, relating to the moral obligation to be answerable. This is derived from the relationship of implicit-trust between

client and the practitioner. This dimension of accountability stresses values and principles identified with various ethical approaches as follows:

i. Duty based: focusing on the duty of health care professionals to be accountable.
ii. Consequences-based: focusing not on the explanation or the individual but the consequences of an account.
iii. Virtue-based: focusing on the integrity of the accountable individual with implicit faith in that person's knowledge of what is the right explanation to give.
IV. Principle-based: assuming that truth and honest are the fundamental principles on which to base an account
v. Emotive: possibly focusing on the fear surrounding accountability.

C. LEGAL ACCOUNTABILITY: this accountability is enshrined by the law through acts of parliament, case law, tribunals and inquiries.
D. PROFFESSIONAL ACCOUNTABILITY: its associated with individuals recognizing that they are members of a profession and therefore accepting the status, rights and responsibilities of a given profession. In the course of practice you have to make judgments in a wide variety of circumstances.
E. Each profession is accountable to its statutory body, such as General Nursing Council of Zambia.

Accountability is dependent on certain preconditions: that the nurse has ability (appropriate knowledge, skills and values) as well as appropriate responsibility and authority.

1. Upward accountability (looking up the line and doing what the managers and administrators require).
2. Lateral accountability (accountability as self-regulation, in which practitioners are accountable to, and judged by criteria set by their peers).
3. Downward or public accountability (where the national health services staff are accountable to patients).
4. The interest of the patient or client are paramount
5. Professional accountability must be exercised in such a manner as to ensure that the primary interest of patients is respected and must not be overridden by those of the professions or practitioners.
6. The exercise of accountability requires the practitioner to seek to achieve and maintain high standards.
7. Advocacy on behalf of patients or clients is an essential feature of the exercise of accountability by the professional practitioner
8. The role of other persons in the delivery of health care to patients or clients must be recognized and respected, provided that the first principle above is honoured.

3.5.2 Advocacy

Advocacy is fundamental to nursing as in most cases the Nurse will be seen advocating for his/her client. The health care system is complex and many clients are too ill to deal with it on their own.

3.5.2.1Definition

The American Nurses Association (ANA) includes advocacy in its definition of nursing as “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations”. **Advocacy is usually employed by someone powerful on behalf of someone who has no power**. Advocacy is the act of pleading for or supporting the course of action on behalf of a person, a group, or community. Advocacy may also be defined as any action that speaks in favour of, recommends, argues for a cause, supports or defends, or pleads on behalf of others. Advocacy is speaking out on issues of that you care about; that is, offering your opinion and suggestions for how to improve something to the people who are in control.

3.5.2.2An Advocate

An advocate is one who expresses and defends the cause of another. A client advocate is one who advocate for clients’ rights. The overall goal for the client advocate is to protect client’s rights. An action to achieve this goal is to consider the type of information to be used, supportive techniques to be used, and mediating factors.

1. The advocate informs clients about their rights and provides them with the information they need to make informed decisions
2. An advocate supports clients in their decisions, giving them full or at least mutual responsibility in decision making when they are capable to do that. The advocate must be careful to remain objective and not convey approval or disapproval of client’s choices. Advocacy requires accepting and respecting the client’s right to decide, even if the nurse believes the decision to be is wrong
3. In mediating, the advocate directly intervenes on client’s behalf, often by influencing others.

3.5.2.3 Patient Advocacy

Rules and regulations designed to help a complex hospital run efficiently can get in the way of a clients' treatment, and an impersonal health care system frequently infringes on the patient’s rights. Nurses who occupy patient advocate positions know how to cut through the levels of bureaucracy and red tape and will stand up for the patient’s rights, advocating his or her best interests at all times.

They must value patient self-determination, that is, patient independence and decision making. In this role, nurses sometimes help patients bend the rules when it is in the patient’s interests and doing so will harm no one else. Patient advocates are nurses who realise that policies are important and govern most situations well but occasionally can, and should, be broken. For example, special care units often have strict visiting hours. Family members may be allowed in to see the patient for only 10 minutes each hour. If the patient recovery will be faster if the family is present, the

nurse serving as a patient advocate will allow the family members more generous visitation than policy provides. It's important that every nurse advocates for patients daily.

3.5.2.4 Professional and Public Advocacy

Advocacy is needed for nursing profession as well as for the public. Gains that the nursing profession makes in developing and improving health policy at institutional and government levels help to achieve better health care for the public. Nurses who function as advocates are in a better position to affect change.

To act as an advocate in this arena, the nurse needs an understanding of the ethical issues in nursing and health care as well as knowledge of the laws and regulations that affect nursing practice and health of society.
To be an effective advocate involves:

1. Being assertive
2. Recognizing that the rights and values of clients and families must take precedence when they conflict with those of health care providers.
3. Being aware that conflicts may arise over issues that require consultation, confrontation or negotiation between the nurse and the physician.
4. Working with unfamiliar community agencies and lay practitioners.
5. Knowing that advocacy may require political action – communicating a client's health care needs to government and other officials who have that authority to do something about these needs.

3.5.3 Governance

The concept of "governance" is not new and it is as old as human civilization.

3.5.3.1 Definition

Governance is **the process of decision-making and the process by which decisions are implemented (or not implemented)**. It relates to decisions that define *expectations*, grant power, or verify performance. It consists of either a separate process or part of management or leadership processes.

The term "governance" covers both:

a) The activity or process of governing
b) Those people charged with the duty of governing and
c) The manner, method and system by which a particular society is governed.

The importance of governance can be better appreciated by considering its responsibilities. Governance is expected to establish overriding principles and objectives, maintain and adapt infrastructure and instruments, develop policy and regulatory frameworks, plans, norms and regulations and connects government with civil society on issues of governance.

Governance also assists in organizing and coordinating collective action, llegitimizes and balances stakeholders' interaction, harmonize individual, sectoral and societal perspectives, maintain productive socio-ecological systems and social order and enforce decisions and regulations.

Maintain coherence across jurisdictional, space and time scales, define the conditions for allocation of power, resources and benefits. Interact with other governance systems and maintain the capacity to learn and change.

3.5.3.2Good Governance

Good governance has 8 major characteristics outline as follows:
It is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law. It assures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in society are heard in decision-making. It is also responsive to the present and future needs of society.

Participation

Participation by both men and women is a key cornerstone of good governance. Participation could be either direct or through legitimate intermediate institutions or representatives. It is important to point out that representative democracy does not necessarily mean that the concerns of the most vulnerable in society would be taken into consideration in decision making.

Participation needs to be informed and organized. This means freedom of association and expression on the one hand and an organized civil society on the other hand.

Rule of Law

Good governance requires fair legal frameworks that are enforced impartially.
It also requires full protection of human rights, particularly those of minorities.
Impartial enforcement of laws requires an independent judiciary and an impartial and incorruptible police force.

Transparency

Transparency means that decisions taken and their enforcement are done in a manner that follows rules and regulations. It also means that information is freely available and directly accessible to those who will be affected by such decisions and their enforcement. It also means that enough information is provided and that it is provided in easily understandable forms and media.

Responsiveness

Good governance requires that institutions and processes try to serve all stakeholders within a reasonable timeframe.

Consensus Oriented

There are several actors and as many view points in a given society. Good governance requires mediation of the different interests in society to reach a broad consensus in society on what is in the best interest of the whole community and how this can be achieved.

It also requires a broad and long-term perspective on what is needed for sustainable human development and how to achieve the goals of such development.
This can only result from an understanding of the historical, cultural and social contexts of a given society or community

Equity and Inclusiveness

A society's well being depends on ensuring that all its members feel that they have a stake in it and do not feel excluded from the mainstream of society.
This requires all groups, but particularly the most vulnerable, have opportunities to improve or maintain their well being.

Effectiveness and Efficiency

Good governance means that processes and institutions produce results that meet the needs of society while making the best use of resources at their disposal.
The concept of efficiency in the context of good governance also covers the sustainable use of natural resources and the protection of the environment.

Accountability

Accountability is a key requirement of good governance. Not only governmental institutions but also the private sector and civil society organizations must be accountable to the public and to their institutional stakeholders. Who is accountable to whom varies depending on whether decisions or actions taken are internal or external to an organization or institution.

In general an organization or an institution is accountable to those who will be affected by its decisions or actions. Accountability cannot be enforced without transparency and the rule of law.

3.5.4 Leadership

In nursing autocratic leadership no longer brings staff together to share a common vision. Nursing leaders need to build and develop others to realise their greatest potential and achievement. Grossman and Valiga (2000) argue that leaders need to focus on people, have a long-range perspective, develop innovative ideas and be able to generate a power base from knowledge and credibility to motivate others.

3.5.4.1 Definition of Leadership

There are many definitions of leadership. The Collins English dictionary defines leadership as “the leader(s) of a party or group.” Yet true leadership is much more than that. A leader can be the CEO (Chief Executive Officer) of an organization, or a first year employee who leads his or her team to success behind the scenes. A leader might lead through official authority and power, yet just as often great leaders lead through inspiration, persuasion and personal connections. Leadership may also be defined as the ability to lead or guide others like students and practicing nurses or leadership may be the art of leading others to deliberately create a result that would not have happened otherwise.

It is not just the creation of results that makes good leadership. Good leaders are able to deliberately create challenging results by enlisting the help of others. Some characteristics that make a good leader are as follows:

(a)Self-Awareness:

You have an intimate knowledge of your inner emotional state. You know your strengths and your weaknesses. You know when you are working in flow and you know when you are over worked. You know yourself, including your capabilities and your limitations, which allow you to push yourself to your maximum potential.

(b)Self-Direction:

You are able to direct yourself effectively and powerfully. You know how to get things done, how to organize tasks and how to avoid procrastination. You know how to generate energy for projects, to calm yourself when angered. You can make decisions quickly when necessary, but can also slow to consider all the options on the table.

(c)Visionary:

You are working towards a goal that’s greater than yourself. It could be something small, like the success of the team, or a larger vision like world peace. Working towards a vision is far more inspiring than working towards personal gain.

(d)Ability to Motivate:

Leaders do not lead by telling people what they *have* to do. Instead, leaders cause people to *want* to help them. A key part of this is cultivating your own desire to help others. When others sense that you want to help them, they in turn want to help you.

(e)Social Awareness:

Understanding social networks and key influencers in that social network is another key part of leadership. Who in the organization has the most clout, both officially and unofficially? Who moves the hearts of the group?

SELF ASSESSMENT TEST: 11
dear learner write weather the following are charecteristics of a profession or not (

true or false)

1. Lincesed practitioner ----------
2. Short period of education ----------
3. Skill based on practical knowledge ----------
4. Code of professional conduct ----------

Answers 1-T, 2-F, 3-F, 4-T

3.6 Ethical Aspects of Nursing Practice

Having discussed professional responsibilities, we shall introduce you to ethical aspects of nursing practice. Before we go into the details of the discussion, let us define some terms.

3.6.1 Definitions

3.6.1.1 Ethics is the term that encompasses a variety of approaches to the understanding and examination of moral living.

3.6.1.2 Morality is the distinction and content of right and wrong.

3.6.1.3 Common morality is considered as a consensus, widely shared and stable, about socially approved human behaviour and values.

3.6.2 Ethics

We have already defined ethics; now let us look at the core concepts of ethics.

3.6.2.1Core concepts of ethics:

- The fundamental responsibility of the nurse/midwife is to conserve life, promote health and alleviate suffering.
- The nurse must provide nursing care in accordance with human need and with respect for dignity of man with no regard for race, creed, nationality, social/political/economic standing
- The nurse must not use his/her knowledge to the detriment of the society
- The nurse must keep in confidence all confidential information about his/her patients.
- The nurse must be a law abiding citizen
- The nurse has the duty to uphold the efforts of his/her profession
- The nurse must continue to develop the professional competence and assist others do the same.
- The nurse must help to establish and maintain professional standards in nursing.
- The nurse must be concerned with all legislation affecting the health care of human beings.
- The nurse does not advertise.

- The nurse has the responsibility to teach others and prevent unskilled and unauthorized persons from performing tasks of danger to patients

3.6.3 Ethical Dilemmas of Caring

3.6.3.1 Dilemma: This is a predicament; a conflict to what one believes in.

- The nurse does not participate in unethical practices.
- Nurses are faced with the challenges of cloning or test tube babies; in as much as the profession demands those patients' obligations be first priority; nurses are guided by their morals.
- Cases of termination of pregnancy bring in the weighing of benefits to whom and risks to whom.
- Patient religious beliefs have to be upheld despite personal convictions.
- Mercy killing or euthanasia is an issue still being debated
- The provision of total care to a criminal is not an easy task for nurses.
- Many at times nurses have to care for family members despite being an issue of ethics.
- Experiments on patients being unethical are sometimes inevitable when conducting trials of drugs.

3.6.4 Values and attitudes

Dear learner, nursing is essentially a work of intimacy. The tasks of nursing require the nurse to be in close contact with clients, physically and emotionally. Nursing involves the negotiation of values whether the values are those of the client, the physician, the employer or other groups. To negotiate values, it is important to have to clarify about one' own values: what they are, where they came from, and how they stand in relationship to others' values and to society's values.

A value is a personal belief about the worthy of a given idea, attitude, custom or objects that sets standard that influence behaviour. The values that an individual holds reflect cultural and social influences relationships and personal needs. Values vary among people and develop and change over time. Understanding one's own value system and assessing the value system of others helps to facilitate decision making while ensuring respect client autonomy.

3.6.5 Etiquette

3.6.5.1 Etiquette – This means code of good manners or rules of common courtesy.

This includes nursing and hospital etiquette which is respect or courtesy between members of nursing staff, other staff, patients and visitors. Some of these may vary slightly from one hospital to another, but generally they are the same in all hospitals.

1. A nurse should stand in the presence of a superior, unless permission is given to sit.
2. When receiving instructions from a doctor or ward in-charge, the nurse should

stand, looking at the speaker, listening well and answering e.g. "Yes sir/Madam". If there is any doubt or question, he/she should ask the speaker to repeat at this time, not later.

3. If you are asked a question you should answer immediately in a clear, distinct voice. You should be facing the one who asked the question. Your head should be up and your hands away from the mouth.
4. If for some reason you cannot carry out the order, notify the ward in-charge immediately.
5. A nurse should be thankful for all the help and teaching he/she receives. When spoken to about a mistake, he/she should not grumble or talk back but should be thankful for this too and learn from mistakes. A good attitude towards her work and co-workers is even more important than good marks in examinations.
6. When accompanying a doctor or ward in-charge, be as helpful and respectful as possible - bring screens, turn down bedclothes, etc. as required and stand on the opposite side of the bed from the doctor.
7. Each nurse should remember that he/she is a host in the hospital. Patients should be received in a kindly manner and made to feel at home. Be courteous to patients' relatives and visitors.
8. A nurse should not run except in an extreme emergency.
9. A nurse should not visit while on duty. If he/she has friends or relatives in hospital whom he/she wishes to visit, he/she should do so when he/she is off duty.
10. A nurse should leave the ward only when his/her work requires it.
11. A nurse should never leave the ward or department where he/she is working without telling the one in-charge where he/she is going.
12. A nurse should come on duty punctually so that those whom he/she relieves may go off duty punctually.
13. A nurse should allow a more senior person to pass through doorway first.
14. When answering a telephone he/she should speak clearly, telling his/her name and the ward from where he/she is answering.
15. A nurse should not sit on a patient's bed to prevent cross infection.

Self Assessment Test/ scenario: 12

Ethical dilemmas occur when a nurse has a conflict between her beliefs and what she is expected to do during her practice.

Briefly explain a situation when a nurse can experience an ethical dilemma.

3.7 Legal Aspects of Nursing Practice

This refers to issues over which nurses can be subjected to lawsuit and criminal prosecution pertaining to their work. It is important that nurses know their rights, that of patient and their families in order to understand judicial processes. Below are the circumstances under which a nurse can be sued:

1. **Standards of care**: this is the degree of care ordinarily exercised by nurses of similar training and experience. The nurse must do what other reasonable careful nurses would do under the circumstances. Failure to provide standard of care the nurse is liable to a lawsuit.

1. **Malpractice**: this is negligence or carelessness on the part of the professional personnel. The nurse who fails to meet the standards of care might be charged with malpractice if her/his care results in harm or injury to the client.
2. **Negligence**: this is a broad category covering many wrongs: violation of client's rights, causing distress or mental anguish, failure to carry out medical orders or carrying them out incorrectly, carelessness, failure to meet standards of care etc.
3. **Liability:** liability is a legal responsibility a nurse may be held liable in cases of negligence or of failure to meet the standard of care.
4. **Tort:** any kind of civil wrong i.e.

    - Battery and assault – battery is the intentional touching of another person without consent; assault is the suggestion or threat of battery e.g. performing a treatment or surgical procedure without consent.
    - False imprisonment – it is a charge that a person has been held (in prison or hospital) without sufficient cause.
    - Invasion of privacy – a wrong in which information given in confidence is released without the knowledge or consent of the client i.e. mishandling of patient's records or revealing information about patient's illness.

3.7.1 Legal Obligations to Nursing

3.7.1.1 Practicing Nurse

Safe nursing practice includes an understanding of the legal boundaries within which both students and practicing nurses must function. As with all aspects of nursing today, an understanding of the implications of the law supports critical thinking on the nurse's part. Nurses must understand the law to be able to protect them from liability and to protect their client's rights. Currently the public is more aware about their rights to health care. As health care evolves in our society, nurses must understand that the legal implications for health care practice also evolves. Nurses' familiarity with the laws enhances their ability to be clients advocates as well. Professional nurses must understand the legal limits influencing their daily practice. This coupled with good judgement and sound decision making ensures safe and appropriate nursing care

3.7.1.2Students

Nursing students are responsible for their own actions and liable for their own acts of negligence committed during the course of clinical experiences. When they perform duties that are within the scope of professional nursing, such as administering an injection, they are legally held to the same standard of skill and competence as registered professional nurses.

If a student harms a client as a direct result of his or her actions or lack of action, the student, instructor, hospital or health care facility and educational institution generally share the liability for the incorrect action. Nursing students should never be assigned to perform tasks for which they are unprepared, and instructors should carefully supervise them as they learn new skills. Although nursing students are not employees of the hospital, the institution has a responsibility to monitor the acts of nursing students.

Nursing students are expected to perform as professional nurses would in providing safe clinical care. Students in clinical situations must be assigned activity within their capabilities and given reasonable guidance and supervision. Nursing instructors are responsible for assigning students to the care of clients and for providing reasonable supervision. Failure to provide reasonable supervision or assignment of a client to a student who is not prepared and competent can be a basis for liability.

To fulfill responsibilities to clients and to minimize chances for liability, nursing students need to:

1. Make sure they are prepared to carry out the necessary care for assigned clients
2. Ask for additional help or supervision in situations for which they feel inadequately prepared.
3. Comply with the policies of the organization in which they obtain their clinical experience.
4. Comply with policies and definitions of responsibility supplied by the school of nursing.

3.7.2 Potential Liabilities in Nursing

Despite the efforts of dedicated professionals, sometimes mistakes are made and unfortunately, patients are injured. It is essential for nurses to carry professional liability insurance to protect their assets and income in case they are required to pay monetary compensation to an injured patient.

3.7.3 Legal Protection

The nursing profession has many complexes and intertwined relationships with the law that are important to identify and understand. The legal aspect of nursing is an area that is both extremely important and constantly changing. It is essential to maintain a working knowledge of the law as it relates to professional nursing practice. Nurses who do not understand and stay abreast with the regulations that govern nursing practice may find themselves involved in disciplinary measures, fines, or litigation. The purpose of the law is to:

i. Ensure order
ii. Protect the individual person
iii. Resolve disputes
iv. Promote the general welfare

3.7.3.1 Definition of Law

Law is defined as the sum total of man-made rules and regulations by which society is governed in a formal and binding manner.

The practice parameters of disciplines such as nursing, medicine and law are established by state legislation. The practitioners of these disciplines cannot legally practice without a license. The purpose of licensing certain professions is to protect the public safety and welfare. The statute that defines and controls nursing practice is called the **Nurse's and Midwives Act No. 31 of 1997 and the Professional Code of Conduct.**

ACTIVITY: 7	**MATCHING**
Match the items in column 1 to those in column 2	
COLUMN 1) MORALITY 2) DILEMMA 3) ETIQUETEE Answers: 1-b, 2-c, 3-a	COLUMN 2 a) Code of good manners or rules of courtesy b) distinction and content of right and wrong c) the predicament, conflict to what one belives in

3.8 Rights of a Nurse

The rights of a nurse are what the nurse is entitled to by virtue of his/her being a nurse. It goes with the job and must be awarded to him/her or he/she may demand it. The following are the rights/privileges of nurses:

- Right to reasonable wages for work

- Right to be paid for working extra hours
- Right to information on patients condition which may pose a danger to the nurse
- Right to be respected and awarded for good deeds
- Right to review patient records and intervene
- Right to consult other colleagues or physicians
- Right to reasonable accommodation
- Right to adequate rest from work
- Right to proceed on local occasional, vacation and compassionate leave
- Right to advance in studies
- Right to seek care from preferred physician
- Right to assessment and promotion
- Right to protective clothing
- Right to belong to any political party but not display partisan politics at work or bring ideologies to work but support the party of the day.

Privileges are what the employers or institutions provide on local arrangement but could be withdrawn at any time without giving any notice . It is usually an incentive. These include:

- Accommodation
- Transport
- Bonus
- Lunch
- Tea break
- Uniform

3.8.1 Nurses As providers of Health Care

Nurses are workers whose main responsibility is to provide safe and effective care within constantly evolving health care systems. Nurses collaborate with one another, as well as doctors, aides, technicians, and others, to provide holistic care to patients. Although advocating for patient safety is a nurse's role, it is also necessary for the patient to be an active participant in their safety. Patient safety is a collaborative goal that requires concerted efforts from the patient and all members of the health care team. It is also a means to foster communication between the patient and the nurse including other health care members to better patient’s health.

3.8.2 Political Neutrality in Care Provision as an employee

Persons working in the public service (civil servants) are required to behave in a politically neutral manner (apolitical) in the course of their duties. This enables public servants to provide consistent services (including policy development) for the government of the day.

What this means for Public servants

This means, essentially, that public servants must keep their jobs out of their political affiliation and their politics out of their jobs. At all times there must be a proper balance between respect for public servants' freedoms of expression and

association, and the public interest in having a politically neutral and effective public service.

As an employee: The nurse should be given an appropriate salary/wage

Appropriate education for practice: The nurse (public servant) should be allowed to go for workshop and training

International labour Organisation Regulations

3.8.3 Requirements to Practice

Nurses and midwives are required to practice only after their prescribed training as per Nurses and Midwives Act No. 31 of 1997. Standards of nursing and midwifery practice are authoritative statements by which the profession describe the responsibilities of its practitioners and their accountability towards their practice. Here nurses and midwives demonstrate responsibility and accountability for professional practice.

According to the Nurses and midwives Act No. 31 of 1997 a nurse or midwife shall provide preventive, therapeutic, palliative and rehabilitative care and treatment of illnesses normally carried out in nursing and midwifery practice and a nursing home. A nurse or midwife shall in administering nursing care-

a) Assess, diagnose and provide the relevant therapeutic interventions;
b) Carry out physical examinations;
c) Insert and remove devices;
d) Carry out resuscitation and intubation;
e) Carry out vacuum extraction;
f) Carry out intravenous infusion procedures;
g) Prescribe relevant drugs and other pharmaceutical preparations from a list defined by the National Drug Formulary Committee constituted under the Pharmacy and Poisons Act;
h) Provide counselling to patients relating to any illness; and
i) Provide such other information, care and procedures relevant to nursing and midwifery practice necessary to prevent disease, disability or any illness or to protect life.

3.8.4 Appropriate Education for Practice

Nurses and Midwives must attain certain requirements for them to be able to practice as nurses and midwives. This refers to the acceptable levels for nurse education as prescribed in the Nurses and Midwives Act No. 31 of 1997 which states that nurses shall be registered after undergoing an approved program of training for a period of 3 years or more. After the prescribed training the Council shall issue a certificate to a nurse or midwife and shall also keep a register of nurses and midwives registered under the Act. Furthermore educational standards for nursing and midwifery are to:

- Provide for safe practice and quality care for clients.
- Evaluate nursing education progress

- Ensure that nursing education acquires standards for professional practice and the required competencies for entry level required for registration and licensure.

3.8.5 Employment Act Cap 268

This is an Act that stipulates the procedures involved in the employment processes. It is subdivided into several parts. You can read more on this Act in Leadership and Management where it is discussed in details.

Self Assessment Test: 13

1.List any five rights of a nurse 2. list five privileges of a nurse 3. list five rights of a patient

3.8.6 ILO convention on life and work of Nursing Personnel

Well learner it is important to understand that the global shortage of nursing personnel is not a new phenomenon. The words above were written the 1970's when concern about the insufficient supply and the ineffective deployment of nursing personnel worldwide led the International Labour Organization (ILO) and the World Health Organization (WHO) to jointly develop standards for adequate nursing personnel policies and working conditions. In 1977, these efforts resulted in the adoption of the ILO Nursing Personnel Convention. Today, the effective management of human resources for health has recently re-entered the policy agenda after a period of neglect. The challenge to implement international development programmes such as the UN Millennium Development Goals, as well as the WHO/UNAIDS "3 by 5 Initiatives" have highlighted the crisis in health personnel, especially in developing countries. Worldwide, addressing the human resources for health crisis will constitute one of the prominent health policy issues for the years to come. Within this context, nursing personnel need to be recognized both nationally and internationally for their important contribution to the overall objective of "health for all".

ILO became the first specialized agency of the United Nations in 1946. The tripartite structure of the ILO, whose organs involve employers' and workers' representative along with government representatives, is unique in the UN system. It currently it has 178 member countries.

The major goal of the ILO is to promote opportunities for women and men to obtain decent and productive work in conditions of freedom, equity, security and human dignity. The ILO mandate emphasizes setting and adopting international labour standards to serve as guidelines for national authorities in putting policies into action, backed by a system to supervise their application. Examples include such hallmarks such as the 8-hour day, maternity protection, minimum age, and workplace safety conventions. All international labour standards reflect

tripartite agreements. ILO standards take the form of international labour Conventions and Recommendations.

3.9 Clients Rights

The following are the rights for the clients:

- To be treated with respect and dignity.
- To privacy and confidentiality.
- Freedom of choice
- To involve an advocate of their choice.
- To information that is accessible, accurate, timely & understandable. (The right to adequate information regarding all aspects of services provided or treatment available, in order to make informed choices regarding their health care. The information should be easily understood and in an appropriate language).
- To be consulted about needs and preferences, and be involved in decision-making.
- To express grievances and have them dealt with fairly.
- To have cultural needs respected.
- To have one's needs met in a professional and ethical manner.
- To give or hold consent to services and/or programs. (The right to consent to, or to refuse treatment, or to refuse to participate in educational or research programs, including treatment by students).
- To withdraw from the service at any time.
- To regular reviews of service provision to ensure care remains appropriate.
- To receive an efficient and effective service, delivered in a timely manner.
- The right to quality and respectful health care regardless of gender, race, social status or sexual preference, taking into account such things as cultural background, health status or special needs.
- The right to request transfer to another staff member.
- The right to participate in decision making about their care, in line with a mutually agreed action plan.

3.9.1 Confidentiality

My dear learner it is vital to understand that clients have rights and privileges for protection and privacy without diminishing their access to quality health care. Medical records may not be copied or forwarded without clients consent. Health care information, including laboratory result, diagnosis, and prognosis, is not shared with

others without specific client consent. The practice includes preventing other family members or friends of the client from acquiring health care information.

The commitment to confidentiality is particularly challenged as medical records become computerised. Preservation of confidentiality is often in competition with the need to facilitate access to information. In such cases health care systems may want to use access cords.

Confidentiality is both a legal and an ethical concern in nursing practice. Confidentiality is the protection of private information gathered about a patient during the provision of health care services. The code of ethics for nurses states, 'that the nurse has a duty to maintain confidentiality of all patient information---.' Only information pertinent to a patient's treatment and welfare is disclosed, and only to those directly involved with the patient's care.

The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature. The Nurses code of conduct acknowledges exceptions to the obligation of confidentiality. These include discussing the care of patients with others involved in their direct care, quality assurance activities, legally mandated disclosure or public health authorities, and information required by third-party players. The code also recognizes the need to disclose information without the patient's consent when the safety of innocent parties is in question.

3.9.2 Right to Health

All individuals in Zambia have the right to health irrespective of their ethnic origin, political affiliation, religious beliefs, gender, traditional beliefs, values and practices and personal attributes. Individual citizens have the right to get health care whenever it is needed regardless of their ability to pay from any government institution.

3.9.3 Right to Refuse Care

As nursing care is being provided to clients from the time of admission to discharge, the client has the right to the care being provided during this time. It is the responsibility of the nurse to ensure that the client's rights are respected. As care is being provided clients are consulted on every procedure to be carried out and consent provided by the client and his/her family members or significant others. It is especially important to understand client's cultural beliefs when explaining advance directives.

3.9.4 Right to Dignity

The GNC Professional Code of Conduct recognises and respects the uniqueness and dignity for each client and responds to their need for the care, irrespective of their ethnic origin, political affiliation, religious beliefs, gender, traditional beliefs, values and practices, personal attributes and the nature of their health problem or any other factors. The fundamental principle that underlies all nursing practice is the respect for the inherent worth, dignity, and human rights of every individual.

The nurse respects the worth, dignity and rights of all human beings irrespective of the nature of the health problem. The worth of the person is not affected by diseases, disability, functional status, or proximity to death. This respect extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering, and the provision of supportive care to those who are dying. The measures nurses take to care for the client enable the client to live with as much physical, emotional, social, and spiritual well-being as possible. Nursing care aims to maximise the values that the client has treasured in life and extends supportive care to the family and significant others.

3.9.5 Informed Consent

An informed consent is a person's agreement to allow something to happen, such as surgery or an invasive diagnostic procedure, based on a full disclosure of risks, benefits, alternatives and consequences of refusal. Surgery cannot be legally or ethically performed until a client understands the need for a procedure, the steps involved, risks, expected results and alternative treatment.

An informed consent is given with full knowledge of the risks involved, probable consequences, and the alternatives. In medical treatment requiring invasive (and possibly life threatening) procedures, a doctor or healthcare provider must disclose sufficient information to the patient for him or her (or his or her guardian to give an informed consent.

Informed consent is a full authorization by the patient for care, treatment and procedures and must include information about risks, benefits, side effects, costs and alternatives (Chitty, 2005)

Informed consent is an agreement by a client to accept a course of treatment or a procedure, after complete information, including the risks of treatment and facts relating to it, has been provided by a health provider (Kozier, 2000)

In the case of patients who are minors, or who are under the effects of drugs or alcohol (including pre-operative medications), or who have other medical deficits, it is questionable that competency to consent exists. There are two types of consent: express and implied.

The following factors are required for informed consent:

1. A brief, complete explanation of the procedure or treatment must be given;
2. Names and qualifications of the persons performing and assisting in the procedure should be provided;
3. A description of the serious harm, including death which may occur as a result of the procedure, as well as anticipated pain or discomfort should be provided;
4. An explanation of alternative therapies to the proposed procedure /treatment should be provided, as well as risks of doing nothing

5. The client needs to be informed of his/her right to refuse the procedure or treatment without discontinuing other supportive care; and
6. The client may refuse the procedure/treatment even after the procedure has begun. (Perry and Potter 2005).

Therapeutic interventions

This may involve either a medical procedure or surgical procedure involving an incision with instruments; performed to repair damage or arrest disease in a living body. These therapeutic interventions affect not only the client but the family unit as a whole. The nurse therefore must prepare both the client and the family for these procedures. Identification of clients and family's knowledge, expectations, and perceptions allows the nurse to plan teaching and to provide individualised emotional support measures.

Each client brings fears to the therapeutic interventions due to past hospital experiences, warnings from friends and family or lack of knowledge. The nurse will find out the clients understanding for the planned procedure and its implications. The nurse faces an ethical dilemma when a client is misinformed or is an aware of the reason for the intervention. The nurse should confer with other medical personnel if the client has an inaccurate perception or knowledge of the procedure before the client is sent for the procedure. In case of surgical procedures, the nurse also determines whether the surgeon explained routine preoperative and post operative procedures. When the client is well prepared and knows what to expect, the nurse reinforces the clients' knowledge and maintains accuracy and consistency.

Post mortem

When a client dies the nurse provides post mortem care, hence it is important for the nurse to care for the clients body with dignity and sensitivity and in a manner consistent with the clients religious and cultural beliefs. After death and during post mortem the body undergoes many physical changes. For that reason care must be provided as soon as possible to prevent tissue damage or disfigurement of the body parts.

The doctor will request for permission to undertake the post mortem, but it is the nurse's job to answer questions and support the family choices. Nurses should understand the value that a post mortem or autopsy will have by improving knowledge in the field of medicine. Clients' and families' cultural beliefs become very important in post mortem care. Maintaining the integrity of rituals and mourning practices gives families a sense of acceptance of the client's death and an inner peace. The ethical decisions that surround a client's death are based on the values of a culture.

It is important for the nurse to be familiar with institutional policies and procedures that are established for post mortem care. It is also important to note that when a client dies the shift of concern moves to the living family and that the family may

need pastoral care. Documentation of all the events surrounding the client's death is important to avoid misunderstandings and litigation.

Research Process

Health care is continuously changing in the way that nurses organise and deliver nursing to clients; hence nursing knowledge must continuously grow and expand to keep nursing care approaches relevant, current and appropriate. One important source for new knowledge is research. Research provided a solid foundation on which nurses base their practice. The scientific knowledge base for professional nursing practice is developed through scholarly inquiry of the research literature, use of existing research findings, and the actual conduct of the research.

Nursing research is a way to identify new knowledge, improve professional education and practice and use the resources effectively (Perry and Potter 2005). A process consists of a purpose, a series of actions and a goal. The purpose gives direction to the process and a series of actions is organised into steps to achieve the identified goal. A process is continuous and can be revised and re-implemented to reach an end point or goal.

The research process consists of an orderly series of phases or steps that allow the researcher to move from asking the research question to finding the answer. Usually the answer to the initial research question suggests new questions and areas of further study. The phases and steps of the research process are as follows:

1. Identify the research problem
2. Review literature
3. Develop theoretical framework
4. Formulate variable
    a. Select the research design
5. Identify sample and setting
6. Select data collection methods
7. Evaluate instrument quality
    a. Conduct the study
8. Get approval to use human subjects
9. Recruit subjects
10. Collect data
    a. Analyse the data
11. Describe the sample
12. Answer the research questions
13. Interpret the results
    a. Use the study results
14. Recommend further research
15. State implications for nursing
16. Disseminate the findings

Self Assessment Test: 14

True/ false: indicate whether the statement is true or false

1) The patient's medical records can be copied and forwarded without the patient's consent ----------
2) Individual citizens have the right to get health care whenever it is needed regardless of their ability to pay from any government institution ----------
3) Client's cultural beliefs are not important as we provide our Nursing care ----------
4) There is NO need to explain to the patients on the procedure or treatment that they are receiving ----------

Answers: 1-F, 2-T, 3-F, 4-F

3.10 Professional Organizations and Interest Groups

Welcome to this topic of Professional organisations which are institutions that are created to deal with issues of concern to those practicing in the nursing profession. In Zambia, the Zambia Union of Nurses Organisation (ZUNO**)** is a professional organization and a trade union for all categories of nurses and midwives registered or enrolled with the General Nursing Council of Zambia. Some interests groups are functioning whilst others are not. The interest groups that are functioning are the Midwifery Association of Zambia, the Theatre

3.10.1 Roles and Functions

The Zambia Union of Nurses Organisation protects and promotes the interests of nurses and midwives through effective representation and capacity building. In so doing, ZUNO will promote the highest level of professionalism and integrity in the delivery of health care services to the community. It also promotes activities of nursing interest groups and participates in capacity building programmes **(see below for further functions of ZUNO).**

3.10.2 Professional Associations

Hello learner, we are now going to introduce you to various professional organisations. These include:

3.10.2.1 Zambia Union of Nurses Organisation (ZUNO)

The ZUNO is a professional organization and a trade union for all categories of nurses and midwives registered or enrolled with the General Nursing Council of Zambia, regardless of where they may be employed, including students, associate and honorary members.

Vision

The vision of ZUNO is to have an empowered nurse who is motivated and able to continuously uphold professional excellence.

Mission

Zambia Union of Nurses Organisation is committed to being a vibrant, self-sustaining, Professional and Socio-Economic Welfare Organisation that will protect and promote the interests of nurses and midwives through effective representation and capacity building. In so doing, ZUNO will promote the highest level of professionalism and integrity in the delivery of health care services to the community.

Core values

1.Holistic representation
2. Professionalism
3. Empowerment
4. Partnership
5. Visionary and innovative leadership
6. Commitment, transparency and accountability

Objectives of ZUNO

1. To recruit and unite nurses into one single Organisation in order to enable them share their professional, social and economic welfare.

2. To advocate for better socio-economic welfare for nurses through collective bargaining with employers, by securing improved wages and better conditions of service.

3. To ensure job security of members, to advance their employment prospects and to serve their individual and collective interests.

4. To initiate and organize training programmes which adequately prepare the ZUNO and nursing leadership and members in the practice of various negotiating skills, for resolving employment concerns i.e. grievance procedures, collective bargaining, arbitration and conciliation.

5. To network with other trade unions, trade union federations, labour institutions and professional bodies for the benefit of members.

6. To maintain the professional set standards and ensure that the conduct of nurses and midwives is in conformity with laid down ethics.

7. To raise the status and image of nurses and midwives through the provision of continuing education and to maintain their integrity, respect and to generally promote and safeguard their professional knowledge and interests.

8. To provide legal advice or assistance to ZUNO members as deemed necessary.

9. To regulate collective relations between employees and employers or between employees and organisations of employers, or between employees and employers.

10. To serve as the authoritative voice for nurses, midwives and the nursing profession as a whole in Zambia.

Functions of Zuno

The following are the functions of ZUNO

1. To promote high professional ideals among members by taking steps necessary from time to time to further their knowledge, education and experience.

2. To collectively bargain and negotiate for improved salaries and conditions of service for nurses and midwives.

3. To initiate the formation of ZUNO Branches in places where Nurses are working.

4. To assist members in promoting and improving health services for the public.

5. To advocate for nurse involvement in health and social policy formulation so as to influence health outcomes.

6. To provide professional advice to government and other stake holders on both policy and non-policy matters affecting Nursing and public health as a whole.

7. To print, publish and circulate any journal, newsletter or similar documents providing information for Nurses and midwives on professional or other matters and as a media for free exchange of opinion.

8. To raise funds, borrow or invest money in any such way as will expedite the interests of ZUNO.

9. To acquire, whether by purchase or outright or other disposition, land and building for the general purposes of ZUNO.

10. To raise funds by subscription of its members and functions or methods as seen suitable and accept donations and other contributions of all kinds for the benefit of ZUNO.

11. To establish and maintain liaison/or cooperate with other national and international organisations and to represent ZUNO at National and International forum.

12. To assist Nurse Retirees or Retrenchees secure possible entrepreneur means of participating in the informal sector development for continued social and economic survival.

13. To assist nurse retirees and retrenchees in every possible way that can facilitate easy access to their terminal benefits, once proved that one is discriminated or unfairly treated.

14. To help promote, establish or carry on or assist in the provision of social support services for the benefit of members, their widows, widowers, orphaned children and legally adopted dependants.

15. To promote the welfare of nursing students and equip them to take their rightful

places in the profession, and contribute to the development of the health of the nation.

16. To promote activities of nursing interest groups and participate in capacity building programmes.

17. To carry out all such other lawful actions as may be incidental or conducive to the attainment of the objectives of ZUNO.

3.10.2.2 East, Central, and Southern Africa College of Nursing (ECSACON).

In 1974, the East, Central and Southern Africa College of Nursing (ECSACON) was formed. It was inaugurated in 1990 in Malawi. The aim was to promote and sustain excellence in the nursing education, nursing practice, nursing education, nursing administration and nursing research.

It has 14 member countries and these are Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. It speaks authoritatively for the nursing profession. The also programme aims to strengthen human capacity development in the health sector in the Region. The programme objectives are to:-

Coordinate and strengthen capacities of member states to train and manage human resources for health and advocate for and develop policies that promote HRH development and capacity building for improved health services delivery.

Contribute towards improving quality of care through professional regulate, standards development and harmonization of training and education programmes and basic competencies.

Enhance information dissemination, networking and promote sharing of best practices and evidence based policies and programmes.

It consists of the Council of National Representatives (CNR) – President, Vice President, Treasurer, and four chairpersons of the four regional constituent Faculties, the National Council Representatives from the member states and four ex-official members who include:

- The immediate past president of the college
- The Executive Director of the college
- The Coordinator, Human Resource and Capacity Building
- The Senior Program officer
- The National Nurses Associations

Vision of Ecsacon

The vision of ECSACON is to be the centre for excellence for nursing and Midwifery in the ECSA region.

Mission of Ecsacon

The Mission of ECSA is to improve the quality of health of the communities in the ECSA region through strengthening of the contribution of the frontline Health workers(nurses and midwives) towards delivery of quality health care services.

Means of achieving the Mission

In an effort to achieve the mission, ECSACON has embarked on;

Promoting and strengthening professional excellence through development of programmes that will strengthen nursing and midwifery education, practice, management, leadership and research for the improvement and delivery of quality health care to ECSA communities.

Committed to regional collaboration, cooperation and networking with member states and other organizations with similar interests, and to advocate for enabling policies.

Official Language

The official working language of ECSACON is English.

The Philosophy of ECSACON

ECSACON believes in the;

- Capability of individuals to attain the highest Education
- Dignity, equality, individuality and wholeness of the person
- Welfare of the nurse/midwife as a professional, an individual, a member of the family and community.
- Promotion and maintenance of quality nursing and midwifery education research, practice, management and leadership.
- Right of people to adequate and competent health care and quality nursing/midwifery care regardless of race, creed, ethnic background, socio-economic status, political conviction, gender and colour.
- Right of individuals, families and communities to be involved in management of their care.
- Complexity of the needs of a person which cannot be met by a single profession.
- Interdependence of various disciplines and subscribes to the team approach in the care of the client/patient.
- Wealth of ideas and experiences within the Member States in this Region which can be effectively shared through a unified forum in order to improve the delivery of Health Care Services.
- Strengthening the implementation of Primary Health Care as a means of achieving the goal of “Health For All” for the Member States.

Functions of the College

The function of the College are to:

- strengthen systems for delivery of services.
- establish quality improvement systems and promotion of better practice models.
- advocate for policy changes and development that would facilitate delivery of quality care.
- improve and strengthen information management systems, communication, build partnerships /alliances through collaboration and networking with other stakeholders across the member states and internationally who have similar interests.
- empower the constituents of ECSACON through motivation, building their capacities, skills development in leadership and management and resource mobilization for sustainability of the organizations.
- mobilize adequate resources
- promote, organize and conduct post graduate education and training in nursing/midwifery.
- promote the highest level of skills, attitudes and efficiency in nursing and midwifery practice.

Powers of the College

The powers of the College shall be to;

- review regularly and ensure proper functioning of the Constitution.
- produce bye-laws for the constitution and formulate policies and rules for the effective functioning of the College.
- establish standing and adhoc committees as may be deemed necessary from time to time.
- develop mechanisms for recognizing each Member State's Nursing and Midwifery professional qualifications in relation to the minimum criteria spelt out by the College in areas of scope of practice, professional practice standards, core competencies and core curriculum content and educational standards.
- assist Member States in formulation, implementation and evaluation of Nursing/Midwifery Programmes in response to the community needs.
- build capacity in areas of Nursing and Midwifery education, practice, research, management and leadership.
- assist in the development of relevant Nursing and Midwifery legislations to govern education and practice and of the professional conduct/behaviour.

Organization Structure

The Quadrennial General Assembly:

The quadrennial General Assembly is attended by all members of the College and is chaired by the President of the College

This forum is hosted in member states following the alphabetical order or at such places and times as the Council of National Representative (CNR) may determine.

The Council of National Representatives (CNR):

The CNR is chaired by the President of the College and is the executive arm of the College

Composition of the CNR

The President of the College

The Vice-President of the College

A nurse/midwife country representative who also services as the country's Contact Person.

Four chairpersons of the four regional Constituent Faculties.

Four ex-officio members who include:

The immediate past President of the College

The Executive Director of the College

The Coordinator, Human Resource and Capacity Building

The Senior Programme Officer

The National Nurses Associations (NNAs)

National Nurses Associations (NNAs)

At country level, NNAs verify professional credibility of individual members who apply to become members of any of the four constituent faculties.

The National Nursing Councils (NNCs)

The NNCs are the professional bodies in each member state.

The NNCs are the regulatory bodies from each member state and are second level stakeholders of the College.

Constituent Faculties

There are four Constituent Faculties namely Faculties of Education, Clinical Practice, Leadership and Management and Research.

The Four Constituent Faculties are made up of individual nurses and midwives from ECSA member states and are headed by Faculty Chairpersons.

These are headed by Faculty Chairpersons and form the main functional framework of the College

The Faculties are the driving force of ECSACON activities at both regional and national levels.

Individual Members

These are qualified nurses and midwives who are registered and licensed to practice by regulatory bodies in their respective countries.

Individual members make up the General Assembly of the College.

Functional Structures of Ecsacon

Ministries of Health

These are the main stakeholders and also the focal points for all Regional and National ECSACON activities.

ECSACON Secretariat is in Arusha

The ECSACON Secretariat is responsible for the day to day running of the College

National chapters

Constitute ECSACON branches at country level

A National ECSACON Chapter functions through an elected National Committee which discharges the functions of ECSACON at country level

3.10.2.3 Midwives Association of Zambia (MAZ)

The Midwifery Association of Zambia is an organisation which started in August 2010 and was registered in 2011. The association was launched by the 1st Lady in November 2011 and has its secretariat on plot 97 Chilimbulu road, Chilenje, Lusaka. The mission of the association is to promote the provision of quality and evidence based midwifery practices at community level for women, children and men at all levels of health care. The association has a National Executive Committee comprising of seventeen (17) members as follows:

- President
- Vice president
- Treasurer

- Vice treasurer
- Secretary

Vice secretary

- 4 committee members
- 1 student midwife
- 1 community representative
- 5 ex-officials

It also has the constitution and operational guidelines in place.

The midwifery association of Zambia has the following **objectives:**

1. Promote improvement of lives for women, children and men through the provision of quality midwifery and other reproductive health services;
2. Promote the identity of midwives and midwifery professional practice through effective communication by means of influencing policy legislation and public image building;
3. Promote best midwifery practices through research in maternal, neonatal and child health services;
4. Provide leadership and direction in maintaining professionalism at all levels of care;

Create and maintain strategic relationship with stakeholders and the community;

5. Uphold the national and international recognized midwifery competencies and role sphere of practice; and
6. Promote education of midwives and facilitate continuous professional development by providing varied educational opportunities.

3.10.2.4 Africa Midwives Research Network (AMREN)

The African Midwives Research Network (AMRN) was initiated in Tanzania in 1992 by midwives from Tanzania, Zimbabwe, Zambia, Mozambique, and Sweden at a SAREC (Swedish Agency for Research Cooperation in Developing Countries) sponsored Regional Reproductive Health Workshop. To-date, through Sida support and by collaboration with Karolinska Institute, Division of of Reproductive and Perinatal Health care, the Network has active participation from Tanzania, Zimbabwe, Zambia, Mozambique, Uganda, Kenya and Eritrea. Other countries that have been involved through the Millennium Health Research Award by the Rockefeller Foundation are Ethiopia, Egypt, Djibout, Nigeria, Swaziland, Malawi and Botswana. This network group coordinates the midwives challenges and improvement/changes in the midwifery practice.

3.10.2.5 Zambia Operating Theatre Interest Group (ZOTNG)

It is a group of professionals in theatre nursing to help boost the interest of each other in the practice and update each other on the current changes in the practice. Its members meet annually for a scientific conference where they discuss issues relating to their profession such as infection prevention as they work in operating theatres, research and how they can improve in their profession.

3.10.2.6 Public Health Interest Group

It is a group of professionals and students in public health nursing to help boost the interest of each other in the practice and update each other on the current changes in the practice. This group is committed to advocate for and partnering with other communities in an effort to improve health outcomes particularly among the underserved citizens. The group also helps to address the dilemmas in public health through health screening, patient navigation, nutrition outreach, public policy discussions and community needs assessment. Its mission is to improve awareness of care and delivery of care to at risk population.

International Council of Nurses (ICN)

Introduction of ICN

The International council of nurses is a federation of national nurses associations representing nurses in more than 128 countries. Founded in 1899, ICN is the world's first and widest reaching international organization for the health professionals.

ICN is an organization operated by nurses for the nurses and it works to ensure quality nursing care for all sound health policies globally, the advancement for nursing knowledge and the presence of a respected nursing profession and a competent and satisfied nursing workforce. The Headquarters of ICN are in Geneva, Switzerland.

ICN MISSION STATEMENT

To represent nursing worldwide, advancing the profession and influencing the health policy.

Goals of the ICN

(i) To bring nurses and nursing together world wide
(ii) To advance nurses and nursing world wide
(iii) To influence health policy

The Core Values are

(i) Visionary leadership
(ii) Inclusiveness
(iii) Flexibility
(iv) Partnership
(v) Achievement

The ICN code of ethics

Definition

The codes of ethics are regulations or guidelines for action based on social values and needs.

A standard regulating behaviour or conduct of a group

The ICN code of ethics is the foundation for nursing practice throughout the world. ICN standard guidelines and policies for nursing practice, education management, research and social -economic welfare are accepted globally as the basis of nursing policy

This code was first adopted in 1953. It has been revised and reaffirmed with the most recent being completed in 2005.

Preamble

Nurses have four fundamental responsibilities which are to provide health, prevent illness, restore health and alleviate suffering. The need for nursing is universal.

Inherent in nursing is respect for human rights, including the right to life, dignity and to be treated with respect. Nursing care is unrestricted by considerations of age, color, creed, culture, disability, illness, gender, nationality, politics, race or social status
Nurses render health services to the individual, family and the community as well as coordinating their services with those of related groups

Elements of the code

The code has four elements that outline the standards of ethical conduct

1. Nurses and the people
2. Nurses and the practice
3. Nurses and the profession
4. Nurses and co- workers

Nurses and the people

- The nurses primary responsibility is to people requiring nursing care
- The nurse provide care to promote an environment in which the human rights, Values, customs and spiritual beliefs of the individual, family and community are respected
- The nurse should give sufficient information to the individuals on which to base consent for care and related treatment.
- The nurse holds in confidence personal information and uses judgment in sharing it.
- The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public especially to the vulnerable populations

The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction.

Nurses and practice

- The nurse carries personal responsibility and accountability for nursing practice as well as maintaining competence by continued learning.
- The nurse maintains a standard of personal health so that the ability to provide care is not compromised.
- A nurse uses judgement regarding individual competence when accepting and delegating responsible.
- The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhances public confidence.
- In providing care the nurse ensures that the use of technology and scientific advances are compatible with the safety, dignity and rights of people.

Nurses and the profession

- The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.
- The nurse is active in developing research based professional knowledge.
- The nurse acting through the professional organisation participates in creating and maintaining safe equitable social and economic working conditions in nursing.

Nurse and co-workers

- A nurse sustains a cooperative relationship with co-workers in nursing and other fields.
- The nurse takes appropriate action to safeguard individuals, families and communities when their care is endangered by a co-worker or any other person.

The roles of ICN in maintaining Standards of Nursing Practice

Dear learner, we can now look at the roles of ICN as regard to maintaining standards of nursing practice.

Professional nursing practice

- International classification of nursing practice. It classifies nurses according to the training undergone by the nurse.
- Advocates for advanced nursing practice and entrepreneurship among nurses.
- Organizes workshops regionally and internationally to enlighten nurse especially on public health and women's health.
- Advocates for sound health policies globally through partnerships and strategic alliances with governmental, nongovernmental organizations and agencies, foundations, regional groups nationwide.

- Improvement of the health profession through lobbying e.g ICN and WHO issued a joint declaration on HIV/AIDS dealing with rights and responsibilities of nurses in caring for people with the infection.
- Recognizing nursing vital role in health care.
- It represents nurses world wide and provide a forum for nurses to share their experiences during conferences.
- It serves as a consultation body on matters pertaining to nursing education and practice.

Professional regulation

- Advocates for continuing education through study programmes.
- Acts as a consulting body in education issues. e.g helped ZNA in the development and establishment of post basic nursing in Zambia.
- Facilitates the development of nursing data sets used in research to direct policy by describing and comparing nursing of individuals, families and communities worldwide.
- Improves communication within the discipline of nursing and across other disciplines by enlightening nurses on human rights.
- Represents nursing concepts used in local, regional, national and international practice across specialties, languages and cultures through publications and other literature in common international languages such as French, Spanish and English.
- Serves as a unifying nursing language system for international nursing based on state of the art terminology standards.

Social Economic Welfare for nurses

- Advocates for occupational health and safety in places of work.
- Advocates for better remunerated nurse through press releases on how much a professional nurse is suppose to get at international level.
- Helps in human resource planning by issuing publications with regard to nurse patient ratio on the wards.
- It creates opportunities for career development in the nursing profession.
- It plays a role in leadership. e.g calls for workshops, seminars in order to stimulate change in the nursing profession and other areas of interest to the nurse such as politics, economics among other things.
- It gives awards and fellowships to nurses such as the TB award.
- ICN through national nurses associations coordinates girl child education for children of deceased nurses worldwide.
- ICN works closely with World Health Organisation, International Labour Organisation, United Nations International Children's Emergence Funds, World Bank and other organisations on matters affecting health.

International Confederation of Midwives (ICM)

It is an international non-governmental organisation that unites 85 national midwives' association from over 75 countries. The ICM has been in existence for over 86 years now. ICM cerebrates the international midwives day which falls on 5th May yearly.

The headquarters of the ICM are in The Hague, Netherlands.

Furthermore, there are countries with midwives who are not nurses like South Africa, Ghana and The United Kingdom among other countries and some examples of midwives associations are; American Midwives Association, Australian Midwives Association, Austria Midwives Association and a few but to mention.

Committees

1. **Executive committee:-**
    - Carries out the administrative function of ICM.

2. **Research standing committee:-**
    - It is involved in originating a midwifery research e-mail network and an international panel of experts in midwifery research.

3. **ICM education standing committee:-**
    - Co-ordinates the input from a global panel and has been carrying out developmental work in a model midwifery curriculum.
    - Advocates for the competencies for midwife teachers.

NB: Other forums at which ICM members meet are; the International Council of Midwives and in the workshops.

Mission Statement

To advance world wide the aims and aspirations of midwives in the attainment of improved outcomes for women in their child bearing years, their new borns and their families where ever they reside using the ICM midwifery philosophy and model of care.

GOALS

- Works to improve women's health globally for example promotion of vaginal delivery in the absence of evidence-based clinical criteria, partnerships for health women and infants and care of women post-abortal.
- To promote and strengthen the midwifery profession.
- To promote the aims of the organisation internationally.

ICM code of ethics

I. Midwifery relationships

a. Midwives respect a woman's informed right of choice and promote the woman's acceptance of responsibility for the outcome of her choices.
b. Midwives work with women, supporting their right to participate actively in decisions about their care, and empowering women to speak for themselves on issues affecting the health of women and their families in their culture/society.
c. Midwives, together with women, work with policy and funding agencies to define women's health services and to ensure that resources are fairly allocated considering priorities and availability.
d. Midwives support and sustain each other in their professional roles, and actively nurture their own and other's sense of self-worth.

e. Midwives work with other health professionals, consulting and referring as necessary when the woman's need for care exceeds the competence of the midwife.
f. Midwives recognise the human interdependence within their field of practice and actively resolve inherent conflicts.

II. Practice of Midwifery

a. Midwives provide care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures.
b. Midwives encourage realistic expectations of childbirth by women within their own society, with the minimum expectation that no women should be harmed by conception and childbearing.
c. Midwives use their professional knowledge to ensure safe birthing practices in all environments and cultures.
d. Midwives respond to the psychological, physical, emotional and spiritual needs of women seeking health care, whatever their circumstances.
e. Midwives act as effective role models in health promotion for women throughout their life cycle, for families and for other health professionals.
f. Midwives actively seek personal, intellectual and professional growth throughout their midwifery career, integrating this growth into practice.

III. The Professional Responsibility of Midwives

a. Midwives hold in confidence client information in order to protect the right to privacy, and use judgement in sharing this information.
b. Midwives are responsible for their decisions and actions, and are accountable for the related outcomes in their care of women.
c. Midwives may refuse to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health care.
d. Midwives participate in the development and implementation of health policies that promote the health of all women and child bearing families.

IV. Advancement of Midwifery Knowledge and Practice

a. Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women as persons.
b. Midwives develop and share midwifery knowledge through a variety of process, such as peer review and research.
c. Midwives participate in the formal education of midwifery students and midwives.

Roles of the ICM in maintaining the standards of midwifery practice

- It works to develop the role of the midwife as a practitioner in his/her own right by advancing the provision of maternity care and thereby improving the standards of care provided to mothers, babies and family throughout the countries of the world.

- It supports and advices associations of midwives in liaison of their governments.
- To represent midwifery to international bodies and agencies in meetings, consultations and in direct relationship with the leaders of governing bodies of such organisations.
- It seeks to advance globally the position and value of midwifery.
- Seeks to achieve a reduction in rates of maternal and neonatal mortality and morbidity.
- It brings the midwives of the world together.
- Partnerships and alliances with colleagues in health care, including Doctors and Nurses who are proving not only effective for women's health outcomes but successful in raising the profile of midwifery and extending the opportunities for midwives to play a key role at international policy-making level.
- Publishes education, practice and activities materials to member associations for example midwifery journals and the international midwives' day Tool kit.
- Ensures good legislation and regulation of midwifery making safe motherhood possible.

SELF ASSESSMENT: 15

As we end this unit, write in your note book what these professional organizations and interests groups stand for and mention two functions for each group o ZUNO o ECSACON o MAZ o AMREN o ZOTNG o ICN
Answers ZUNO- Zambia union of Nurses Organization ECSACON- East, Central and Southern African College of Nursing MAZ- Midwives Association of Zambia AMREN: Africa Midwives Research Network ZOTNG- Zambia Operating Theatre Interest Group ICN- International Confederation of Midwives

3.9 Summary

Dear learner, we have now come to the end of this unit were we want you to know that professionalism is a very important regulator of nursing care. A professional nurse with very good values and attitudes always provides quality care to patients and relates well with core workers and the members of the community. The

knowledge on the legal aspects of nursing practice, clients rights as well as his/her own rights, further improves his/her delivery of care.

3.11 References

http://www.merriam-webster.com/dictionary/professionalism

http://www.moh.gov.zm

htt://sharp Zambia.blospot.com/p/our-child policy.ht

http://www.amrn Kenya. Org/

http://:www.who.int/hrh/ nursing -midwifery-nursing-convention.

Hht://community saem.org/community view.

CHITTY, K.K (2005) Professional Nursing: Concept and challenges, Elsevier Saunders, St. Louis.

Kozier, Erb, Berman and Burke (2000) Fundamentals of Nursing: Concepts, Process and Practice, Prentice Hall Health, New Jersey.

Stanhope and Lancaster (2004), Community and Public Health Nursing, Mosby, St. Louis.

United Kingdom Central Council for Nursing, (1996)

Potter, P.A and Perry, A. G (2005), Fundamentals of Nursing, Mosby, St. Louis.

Fundamentals of Nursing, 6th Edition (2005), Mosby Inc., St Louis Missouri

National Health Strategic Plan 2011-2015, (2011), MoH, Lusaka

Grossman, S., & Valiga, T. (2000) The New Leadership Challenge: Creating the future of nursing, Philadelphia, FA. Davis.

http://www.businessdictionary.com/definition/informed-consent.html#ixzz2h2MeG1mc

UNIT 4: ATTITUDES

4.1 Unit Introduction

Welcome to the discussion on attitudes. Attitudes are important in the management of clients by nurses. Attitudes are not learnt from text books, they are acquired by social interaction. They are perhaps best thought of as the thriving forces which determine how people tend to behave or perform. Attitudes are different from knowledge and skills in several ways. They are partly based on logic and on emotions.

Activity 8

In your own words, write down the meaning of attitudes in your note book

Compare your meaning of attitudes as you read through this unit.

4.2 Unit Objectives

At the end of the Unit, you should be able to:

1. Define the term “attitude”
2. Explain the development of attitudes
3. Describe positive and negative attitudes
4. Describe factors influencing a ttitudes

4.3 Definition of Attitudes

Attitudes are driving forces that determine how people behave or perform. It is a relatively enduring organization of beliefs around an object, subject or concept which predisposed one to respond in a preferential manner. Attitudes are acquired characteristic of an individual and are not learnt from text books but acquired by social interaction- towards persons, things, situations and issues**.** Attitudes are not completely stable; they change over a period of time although there must be a degree of stability.

4.4 Development of attitudes

Now learner, let us look at how attitudes develop. Attitudes are composed from various forms of judgments. They develop on the ABC model, that is, the affect – feeling (emotional component), behavioural change or active component and cognition – thought (thinking component).

The affective response is a physiological response that expresses an individual’s preference for an entity. The behavioural intention is a verbal indication of the intention of an individual, while the cognitive response is a cognitive evaluation of the entity to form an attitude. Most attitudes in individuals are as a result of observational learning from their environment.

Self Assessment Test: 16

Matching **Match the words which describes how attitude develop (ABC MODEL) in column 1 with their meaning in column 2** **COLUMN 1**	**COLUMN2**
1. Affect 2. Congnitive 3. Behavioural change	a. Thinking component b. Active component c. Emotional component
Answers: 1-c, 2-a, 3b	

4.5 Teaching attitudes:

This is not like teaching a fact. Attitudes can only be taught through giving of examples of appropriate attitudes or by encouraging your learners discuss their attitudes, providing information or experiences on attitudes.

Good attitudes encourages**:**

- A desire to continue learning throughout life
- An eagerness to overcome difficulties
- Respect for convenience, comfort and beliefs of all patients.
- A willingness to share in the whole range of attitudes.
- A desire to share knowledge and skills
- A desire to co-operate with other workers

4.6 Positive and negative attitude

We are now going to look at positive and negative attitudes and before we go in details in our discussion, let us do the following activity.

ACTIVITY: 9

Mention two positive attitudes you expect any nurse to possess?

Mention one negative attitude that a nurse should not possess.

Compare your answer as you read

4.6.1 Positive

Well learner, the following are some of the positive attitudes one expects the nurse to posses:

- Reporting on time for work is a positive attitude to work
- Attending to client's/patient's needs on time
- Explaining a procedure to client before it is done
- Teaching of student nurses and other staff by an experienced nurse
- Welcoming clients/patients in the ward
- Always working towards providing quality nursing care to client's/patients.
- Always having good communication with the client's/patients

4.6.2 Negative Attitudes

The negative attitudes are generally the opposite of the positive attitudes. For example, Missing work, late reporting, rudeness to patients is negative attitudes to work.

4.7 Factors influencing attitudes

Dear learner let us discuss some of the factors that can influence attitude under the following headings:

- Environmental factors
  It is generally accepted that the home environment is of primary importance in the formation of early attitudes, but friends, associates and the general social environment come to have an increasing influence as one grows older and has more social contacts. The environment to which one is exposed influences the attitude either desirable or undesirable. Exposure to social media like radio, television, films and printed matter have a strong influence on one's attitude.

- Experience
  Attitudes are formed without direction and also by directions the result of careful planning by the person who desires to encourage the development of certain attitudes in others. Attitudes development is also influenced by the enlarging adjustment problems one has with the expanding groups and their emotional interactions.

- Education
  One function of school is to stimulate young people towards acquisition of attitudes that are individually and socially desirable. Through initiation,

emotional experience and deliberate efforts on the part of the individual, the teacher and others new attitudes develop.

Activity: 10

Explore how the following factors may influence one's attitude:

- Intellignce
- Self-esteem
- trustworthiness and interpersonal interaction or attractiveness
-

Changing people's attitudes

The key to attitude change is the need for most people to maintain consistency and this can be achieve through mentorship and role modelling.

4.6.1 Mentorship and Role models

Dear learner, the other things that could probably help change the nurse's attitude are mentorship and role modelling to student nurses and newly qualified nurses by the professionally experienced nurse.

Mentorship

Work place learning is vital for nurses throughout their careers. Whether this is in the form of mentoring students or the newly registered or practicing nurses the approaches, skills needed are the same. Mentoring offers experienced professional nurturing and guiding to students and novice practitioners who benefit from being taught and receive practice based teaching relevant to their specific needs. Nurses should make use of the different learning strategies in their everyday practice. The skills that are crucial for successful learning whatever the method, include active listening, questioning, communication and looking to being accountable.

Mentoring is to support and encourage people to manage their own learning order that they may maximise their potential, develop their skills, improve their performance and become the person they want to be (The Oxford School of Coaching & Mentoring).

Mentoring is a powerful personal development and empowerment tool. It is an effective way of helping people to progress in their careers and is becoming increasing popular as its potential is being realised. It is a partnership between two people (mentor and mentee) normally working in a similar field or sharing similar experiences. It is a helpful relationship based upon mutual trust and respect.

A mentor is a guide who can help the mentee to find the right direction and who can help them to develop solutions to career issues. Mentors rely upon having had

similar experiences to gain an empathy with the mentee and an understanding of their issues. Mentoring provides the mentee with an opportunity to think about career options and progress.

A mentor should help the mentee to believe in herself and boost her confidence. A mentor should ask questions and challenge, while providing guidance and encouragement. Mentoring allows the mentee to explore new ideas in confidence. It is a chance to look more closely at yourself, your issues, opportunities and what you want in life. Mentoring is about becoming more self aware, taking responsibility for your life and directing your life in the direction you decide, rather than leaving it to chance.

Role models

Nurses and midwives have a duty to facilitate student nurse's development despite working under pressure due to overwork as the country is experiencing shortage of nurses due to human resource for health challenges and stress. In light of the increasing demands on their time, role modelling may be the most effective teaching method available; as students work alongside practitioners, so that tasks need not take more of their time. Mentors need to think about how to engage students in professional activities if role modelling is to be successful.

Role modeling is a process that allows students to learn new behaviours without the trial and error of doing things for themselves. It is a form of learning from experience that uses humanist and social learning theories. A key feature is the experience learners bring to a situation. The following definitions may also be considered when looking at modeling:

A person who rules or guides or inspires others;

A person whose behaviour in a particular social setting is imitated by others, especially by young people;

A person regarded by others, especially younger people as good example to follow.

Individuals want to learn and do so best when they feel free to express and choose their own direction. When they are able to do this, mentors fulfill a dual role of teacher and learning facilitator (Rogers, 1983). They must therefore help their students to identify what direction learning should take and to facilitate the best conditions for this to occur

Self assessment: 17

Dear learner as we come to the end of this unit, answer these questions to test your understanding
1. Name the two key elements to attitude change ---------- and ---------- 2. Mention two (2) environmental factors, 2 educational factors and 2 experience

factors

that can influence attitude.

Well done, now compare the answers with what is in the notes.

4.7 Summary

In summary we can say that, attitudes are acquired characteristics of an individual which develop through experience and social interaction of an individual with the society. Attitude can basically be positive or negative, although can be neutral or ambivalent towards an item, issue or event. Moreover, there are several factors that influence attitude and among them are self – esteem, intelligence, fear and anger. In nursing attitude is a very important attribute which should be positive as a nurse interacts with her patients, colleagues and the community.

4.8 Reference

1. Nash, S., Scammell, J, (2010) Skills to ensure success in mentoring and other workplace approaches, Nursing Times; 106:2
2. Kozier, Erb, Berman and Burke (2000) **Fundamentals of Nursing: Concepts, Process and Practice**, Prentice Hall Health, New Jersey.
3. Daly, J (2005) Nursing Leadership, 2nd edition, Churchill Livingstone, Marrickville.

UNIT 5 INTERPERSONAL RELATIONSHIP

5.1 Unit Introduction

Hello learner, at the core of nursing is the therapeutic nurse-client relationship. The nurse establishes and maintains this key relationship by using nursing knowledge and skills, as well as applying caring attitudes and behaviours. Therapeutic nursing services contribute to the client's health and well-being. The relationship is based on trust, respect, empathy and professional intimacy, and requires appropriate use of the power inherent in the care provider's role.

Nurse-client relationships are referred by some as ***interpersonal relationships***, by others as ***therapeutic relationships***, and by still others as ***helping relationships***. Helping relationships

are the foundation of clinical nursing practice. The role of the professional helper is to know the client as an individual who has unique health needs, human responses, and patterns of living. Helping relationship is the growth-facilitating process that strives to achieve two basic goals:

1) Help clients manage their problems in living more effectively and develop unused or underused opportunities more fully.

2) Help clients become better at helping themselves in their everyday lives.

For good interpersonal relationships to exist, communication should always be considered and it's a lifelong learning process for the nurse. The nurse client relationship is based on trust, respect and intimacy, and requires the appropriate use of power. The nurse influences specialized knowledge and skills to manage a therapeutic relationship and establishes appropriate boundaries with their clients. The helping relationship is influenced by personal and professional characteristics of the nurse and the client. Age, sex, appearance, diagnosis, education, values, ethnic and cultural background, personality, expectations, and setting can all affect the development of the nurse-client relationship.

Activity 11

In your own words, write down the meaning of interpersonal relationship

Good, now compare your answer with what is written in the document below.

5.2 Unit Objectives

At the end of the Unit, the student should be able to:

1 Define interpersonal Relationship

2 Explain the types of relationships

3 Describe the characteristics of interpersonal relationship

4 Explain the roles of a nurse in interpersonal relationship

5. Importance of interpersonal relationships

6. Describe the barriers of interpersonal relationship

5.3 Definition

Interpersonal relationship is a strong bond between two or more people. It's a facilitating process in which one person assists another to solve problems and to face crisis in the direction the assisted person chooses.

Therapeutic communication is an interactive process between nurse and the client that helps the client overcome temporary stress, to get along with other people, to adjust to the unalterable, and to overcome psychological blocks which stand in the way of self realization.

5.4 Types of relationships

There are three types of relationships:

1. **Reciprocity**: This is the ideal relationship. This type of relationship is characterized by loyalty, self-sacrifice, mutual affection, and generosity. This friendship is based on equality.

2. **Receptivity:** In this type of relationship there is an imbalance in giving and receiving. One person is the primary giver and the other is the primary receiver. However, there is still much to gain out of this relationship so it is a positive one.
3. **Association**: This is a cordial relationship, but there is no depth.

1. Nurse Health Care Team Relationship

Nurses function in a role that requires interaction with multiple care team members. It focuses on estimating a healing working environment and accomplishing the work and goals of clinical setting. Communication in this type of relationship focuses on team building, facilitating group process, collaboration, consultation, delegation, supervision, leadership and management.

2. Nurse Community Relationships

Many nurses form relationships with community groups by participating in local organizations and volunteering for community service. Nurses in community based practice need to be able to establish relationships with their community to be effective change agents. Communication within the community occurs through channels such as neighbourhood, radio and television.

5.5 Characteristics of Interpersonal relationship

Interpersonal relationships involves the following:

A. an intellectual and emotional bond between the nurse and the client and is focused on the client.

B. Respecting the client as an individual, including:

- Maximizing the client's abilities to participate in decision making and treatments.
- Considering ethnic and cultural aspects
- Considering family relationships and values.

C. Respect clients confidentiality
D. Focuses on client's well-being
E. Is based on mutual trust, respect and acceptance

5.6 **Roles of A Nurse in Interpersonal Relationship**

(a) Nurse/client relationship

This is also known as a helping relationship. It is the foundation of clinical nursing practice. In this relationship, the nurse assumes the role of professional helper and comes to know the client as an individual who has unique health needs, human responses and patterns of living.

The role a nurse plays in providing care to a patient can make a significant impact on how well and how quickly a patient is able to recover. When a client chooses a medical facility to receive long-term care for a chronic illness it is important that the client watch how the nurses interact with other patients before the patient makes a decision on which facility he or she will go to for treatment.

Nurses can play a huge role in the success of a patient's recovery and this success is a result of how a nurse and patient interact together. A healthy nurse/client relationship will provide vast benefits to the patient and will also make the nurse's life and job much easier and more enjoyable. This stimulates a positive atmosphere that is beneficial for both parties.

Components of the nurse-client relationship

Well learner there are five components of the nurse-client relationship, which are trust, respect, professional intimacy, empathy and power. Regardless of the context, length of interaction and whether a nurse is the primary or secondary care provider, these components are always present.

Trust

Trust is critical in the nurse-client relationship because the client is in a vulnerable position. Initially, trust in a relationship is fragile, so it's especially important that a nurse keep promises to a client. If trust is breached, it becomes difficult to re-establish.

Respect

Respect is the recognition of the inherent dignity, worth and uniqueness of every individual, regardless of socio-economic status, personal attributes and the nature of the health problem.

Professional intimacy

In the type of care and services that nurses provide. It may relate to the physical activities, such as bathing, that nurses perform for, and with, the client that create closeness. Professional intimacy can also involve psychological, spiritual and social elements that are identified in the plan of care. Access to the client's personal information, within the meaning of the *Freedom of Information and Protection of Privacy Act*, also contributes to professional intimacy.

Empathy

Empathy is the expression of understanding, validating and resonating with meaning that the health care experience holds for the client. In nursing, empathy includes appropriate emotional distance from the client to ensure objectivity and an appropriate professional response.

The picture shows the nurse dialoguing with the client as the care is being provided – taking the clients pulse

Power

The nurse-client relationship is one of unequal power. Although the nurse may not immediately perceive it, the nurse has more power than the client. The nurse has more authority and influence in the health care system, specialized knowledge, access to privileged information, and the ability to advocate for the client and the client's **significant others**. The appropriate use of power, in a caring manner, enables the nurse to partner with the client to meet the client's needs. A misuse of power is considered **abuse**.

Nurse and family

In many nursing situations especially those in home care setting and community, require the nurse to form a helping relationship with the entire family. The principles that guide helping relationships also apply in this case. Communication in the family requires additional understanding of the complexity of family dynamics needs and relationships.

Nurses and families each bring strengths and resources to the relationship and have specialized expertise in maintaining health and managing health problems. Reciprocity in the relationship is emphasized, with the relationship characterized as non hierarchical. Feedback processes simultaneously occur at several different relationship levels among nurses and families, and other systems. The nurse should reflect on her own relationship with the family when interviewing the family about her relationship with them.

Nurse and community

There are many external forces that affect nursing today some of which are societal changes; population dynamics like migration, population shift from rural to urban areas, increasing life span; HIV and AIDS; high fertility ratios; non communicable diseases and high poverty levels. Nursing as a profession responds to such changes by exploring at new methods for the provision of nursing to communities for example changing educational emphasis and nursing practice standards.

Nurses need to provide care that is culturally aware of different cultures and competent. Emphasis on health promotion and illness prevention are approaches that nurses can consider when providing care to their clients. Nurses may respond by providing programs among communities such as health fairs, wellness programs, educational programs for specific diseases, family teaching activities for the promotion of health.

Nurse and Health Care Team

The nurse cares for the client, carries out procedures ordered by the doctor and, in collaboration with the doctor and other team members, assesses the client and treats his or her problems. The nurse coordinates the work of others involved in caring for the client, including the client's family, who may do a lot of the caring for the client. The nurse also protects the client, working to prevent infection and ensure a safe, healthy environment in health-related matters and promotes clients' well-being in all situations, speaking for them (advocating), if necessary. The hospital nurse plays many roles on the health care team.

Self Assessment Test:18

Well learner, indicate whether the following are components of the Nurse-client relationship or not (true/false)
1. Mistrust ---------- 2. Respect ---------- 3. Power ---------- 4. Personal intimacy---------- 5. Empathy ---------- **Answers: 1-F, 2-T, 3-T, 4-F, 5-T**

5.7 Importance of Interpersonal relationship

Dear learner, it is important to note that at the core of nursing are caring relationships formed between the nurse and those affected by the nurse's practice. Communication is the means to establish these helping-healing relationships. Communication is essential to the nurse-client relationship in establishing a therapeutic relationship and it is the means by which an individual influences the behaviour of another, which leads to the successful outcome of nursing interventions.

A nurse spends around eight to nine hours in his/her organization and it is practically not possible for him to work all alone. Human beings are not machines who can work at a stretch. We need people to talk to and share our feelings with. We are social animals and we need friends around. An individual working in isolation is more prone to stress and anxiety. They hardly enjoy their work and attend office just for the sake of it. Individuals working alone find their job monotonous.

5.8 Barriers in interpersonal relationship

Barriers in interpersonal relationship may develop due to varieties of reasons like mistrust and fear of rejection is the life blood of any relation whether it is friendship or business or husband–wife relations. No relationship can last longer, if the persons involved in relationship start losing trust on each other that will eventually lead to suspicion, hiding information and emotions, and gradually the ending of the relationship. So, for the initiation and maintenance of IPR, it requires trust between both the persons involved in a relation.

Some people don't/can't think positive about themselves. They have a preoccupation that the other person will not accept him/her as a friend or girlfriend/boyfriend. So, the person never tries to initiate relationship with the other person because it is unacceptable to him/her to be rejected. For example, fear of rejection can be seen when a person of low socioeconomic status wants to initiate some social relationship with a person of high socioeconomic status.

5.9 Summary

We have now come to the end of our discussion in this unit were we looked at interpersonal relationship which is an interactive process between the nurse and the client. This relationship helps the client overcome temporary stress, get along with other people, adjust to the unalterable, and to overcome psychological blocks which may stand in the way of self realization of the client. Therapeutic nursing services contribute to the client's health and well-being. The relationship is based on trust, respect, empathy and professional intimacy, and requires appropriate use of the power inherent in the care provider's role. We also talked about some of the barriers to interpersonal relationships like mistrust, fear of rejection and lack of respect.

Assessment: 19

In your note book, write the correct answer for these multiple choice questions
6. The types of relationship include the following except a. Reciprocity b. Empathy c. Receptivity 7. Barriers in interpersonal relationship may develop due to a. Trust b. Sharing information c. Fear of rejection 8. Components of the Nurse- client relationship includes the following except a. Personal intimacy b. Trust c. empathy
Answers: 1b, 2c, 3a

5.10 Reference

1. American Nurses Association, 2001, Milton 2005
2. College of Nurses of Ontario, Practice stand: Therapeutic-Client Relationship, Revised 2006
3. Potter, P.A and Perry, A. G (2005) Fundamentals of Nursing, 6th Edition, Mosby, St Louis.

UNIT 6 ASSERTIVENESS

6.1 Unit Introduction

Welcome to the discussion on assertiveness. Earlier we looked at issues of interpersonal relationship and how the nurse should relate to the client, family members, the community and members of the health care team. Assertiveness is a very important behaviour for a modern nurse, as the roles of the professional nurse are constantly changing. Assertiveness is necessary for nurse-patient communication as well as with health care stake holders.

6.2 Unit Objectives

At the end of the Unit, you should be able to:

1. Define assertiveness
2. Explain assertiveness in relation to other styles of interpersonal behaviours

3. Explain how assertive behaviour can be learnt
4. Describe barriers to assertive behaviour
5. Mention techniques for practicing assertiveness

Hello learner, we are now going to define terms, but before we do that, let us do the following activity:

ACTIVITY 12

What is assertiveness in your own understanding?

Write down your answer in your note book and compare it as we define terms.

6.3 Definitions

Assertiveness

1. **Assertiveness is the ability to express one's feelings and assert one's rights while respecting the feelings and rights of others** (Bower, 1994). Assertiveness is the direct and honest communication of your opinions, feelings, needs, and rights in a way that does not violate the personal rights of others. It involves standing up for your own rights while acknowledging the rights of others, and working towards a win-win solution. Being assertive is to stand up for your rights and not being taken advantage of. It also means communicating what you really want in a clear fashion, respecting your own rights and feelings and the rights and feeling of others.

2. Ability to express your thoughts, your ideas, and your feelings without undue anxiety and without expense to others. (Riley, 2004).

3. Assertiveness is appropriately direct, open, and honest communication which is self-enhancing and expressive (Robbins et al 2004).

Aggressiveness

Aggressiveness is expressing one's thoughts in a way that is inappropriate and violets the rights of others. It involves putting our wants, needs and rights above those of others (Encarta, 2009).

Passiveness

It is a tendency to obey without arguing or resisting, not participating actively and usually letting others make decisions. (Encarta 2009)

6.3 Assertive Behaviour Vs other types of Behaviour

We have just defined terms related to assertiveness; now let us look at the same assertive behaviour and other types of behaviours.

Table 1 below will help us compare these behaviours to assertive behaviour.

Table 1

ACTION	PASSIVE BEHAVIOR	ASSERTIVE BEHAVIOR	AGGRESSIVE BEHAVIOR
Goal response	Protects self	-	-
Mechanism of action	Indirect	Direct, honest, firm	Emotional and protective
Response type	No response	Neutral and empathetic	Judgmental and impulsive
Self-image interaction	Diminished sense of self worth and potentiates inferior position in relationship	Enhance equal worth in relationships	Acts as an antagonist and potentiates defensive behaviour
Effects of self	Feelings of being	Feelings of self-esteem rationale and fair	Rationale and exploitative
Request for change	Hidden bargaining	Will be asking for change	demand for change
Reaction to conflict	Under-reaction	Collaborative interaction	Overreact
Effects on rights	Discounts personal rights	Respects self and person rights	Discount rights of others
Effects on position in relationship	Inferior position	Will have equal position	Superior position

6.4Characteristics of Assertiveness

The following are the characteristics of assertiveness:

- the ability to insist upon personal rights and put oneself forward in an instant manner and having the mental strength, and professional background to do so.

- Thinking and behaving that allows adherence to what one believes in and want to do while respecting the rights of others.
- Talking or advocating for self and advocating for people around
- Recognizing that each individual has rights.-legal, individuality, to have and express personal preferences, feelings and opinions.
- believing in his or her rights and also committed to preserving those rights

6.5Learning Assertive Techniques

- **Distance and personal space**- Don't let someone you don't know very much invade your space, it makes you uncomfortable.
- **Good time management-** Being early for meetings and appointments.
- **Broken record technique-**State clearly what you want or don't want, e.g. use terms like I am not interested.
- **Disclosure -** effective to be honest.
- **Fogging- A**gree with 'critics. 'Allow criticism in through one ear and out through the other. Agree when someone criticizes you.
- **Maintain eye contact-** makes the listener feel respected
- **Stand upright-**Standing upright and walking slowly when entering a room makes you look assertive.
- **Sit up-** Don't cross your legs or fold your arms. It's a sign of nervousness.
- **Active listening-** Repeat what the other person has said, keep it short and don't interrupt the speaker.
- **Tone of voice-** An assertive person does not change the tone of voice when annoyed

6.6 Barriers to assertive behaviour

These are factors that block persons and nurses from practicing assertive behaviour. As much as it is simple to know what one's rights, responsibilities and obligations are, and to stand for them, there are, however, many reasons why nurses find assertive behaviour difficult (Cotler, 1977). Some of the reasons could be as follows:

- Lack of self-esteem, meaning, "how I feel about myself
- Inexperience
- Lack of confidence
- Negative belief : Some beliefs are against other people's rights
- Lack of knowledge as to how to behave, lower level of education not knowing their rights as education builds self-respect.

- Fear or anxiety over what might happen or how people may see them if they do behave assertively. The fear of being... Rejected, Criticized, Considered unfeminine/not masculine enough, considered motional, being seen as pushy, considered uptight/under pressure (stressed out), misunderstood etc.
- Wrong or negative perception - these are mistaken perception.
- Gender : Men easily assert themselves than women
- Cultural differences: Some cultures value assertive behaviour while some emphasize non assertive behaviour.
- The need to... Be nice, Avoid conflict, Be self-effacing, Be liked, Be feminine/masculine
- And the desire not to... be selfish, hurt others, seem vulnerable, show anger, show liking, have your own wants, make the first move, make a mistake, admit a mistake, take a risk, ask for what you want, put others under pressure**.**

Some other reasons why nurses find assertive behaviour difficult could be:

a) Female sex role socialization process

In the nursing profession, most nurses are women. They have been constrained by and inherited the early female sex role socialization messages and these have been effective barriers to our becoming assertive. Most women see themselves as having the second-class status and are viewed as accommodating, submissive, helpless, dependant, emotional and security oriented (Bower, 1994).

Traditionally, society has socialised women to allow others to set goals for them rather than initiating their own and hence many have lost sight of who they were or what they wanted as individuals from life. They may find it particularly difficult to be assertive because they fear to:

1. Be rejected
2. Be unfeminine and confronted
3. Be aggressive
4. Lose control of oneself in yelling or screaming, even crying
5. Learning the truth about oneself
6. Be retaliated against
7. Be punished by authority figures

b) Nursing education

In many cases, nurse educators prepare students to develop many nursing skills, but there has been little attempt, if any, to teach students how to assert themselves as skilled practitioners. In fact, nursing instructors may be helping to keep nurses “down” by treating students as inept children who must be watched as they draw up medication and by stepping in to handle conflicts between head nurses and students, between students and doctors. Although there are some nurse students and doctors who believe that students can teach and supervise one another but in

general, they seem to be over protective of students and over defensive in their relationships with members of other professions. Perhaps the trend continues in nursing education because educators have not learned to be assertive themselves, thus nursing faculty tend to oscillate between submission and attack toward physicians (Ian, 1991).

c) Lack of role models

There are few role models practicing assertive behaviour in that it is very common to hear that under graduates and graduate nursing faculties tell about how they got mad at doctor so and so. They either yelled out loud or withdrew to the tea room. It is very difficult to expect nursing students to practice assertive behaviour by simply reading articles or books about independent nursing practice, they really need role models.

d) **Health care systems norms**

The norm in most health care system is that the physician makes the decision and this will greatly affect an assertive nurse. A nurse who tries to be assertive about their practice may meet negative reactions, for example, the non-assertive nursing group may side with the physician and exert pressure on the assertive nurse to submit and return to the flock. Trying to fight the tide of combined nurse-physician forces can be an extremely frustrating effort.

SELF ASSESSMENT: 20

Encircle the most appropriate answer

1. All of the following are barriers to assertive behaviour **EXCEPT**:

a) lack of mentorship to a novice nurse

b) Imparting confidence in student nurses

c) Faculty treating student nurses like children

Indicate True or False against the following statements:

2. lack of self esteem by a student nurse may be a barrier to assertive behaviour

3. Lack of confidence in a nurse may be a barrier to assertive behaviour

ANSWERS: 1. B 2. True 3. True

6.7 Techniques of practicing assertiveness

Even though barriers hinder or disturb the attainment of goals in nursing practice, they can be overcome by the following ways:

1. The need to look at the other's interests first even if you are hungry or tired;
2. Being humble and kind towards others and telling them positive things about yourself;
3. Always listen, be understanding, compassionate and never complain;
4. Always find what the other person is thinking or feeling;
5. Be willing to give to others without expecting a reward;
6. As a nurse, the first step is to become aware of yourself, as a woman/man know your thoughts, feelings and behaviours;
7. Work to increase your positive beliefs;
8. Realize that everyone is entitled to act assertively and to express honest thoughts, feelings and beliefs; and
9. Become aware of your thoughts in regards to events, decide which ones are irrational and which are rational.

Other Techniques

According to (Smith, 1975), the other techniques you can employ in assertiveness include:

- Include positive and negative information in a statement. i.e. "I like your plan but……"
- Start the statement with "i" and avoid generalizations. i.e. we believe……
- Express your own beliefs and rights i.e. "I believe that ……"
- Express your thoughts and feelings directly to reinforce your identity.
- Make assertive statements:

a) Simple assertive, "I think……"

b) Emphatic assertive, "I realize you are tired but……."

c) Confrontive assertive, "you said you would bath Mr. C but you didn't……"

d) Soft assertive, "I agree with what most of you said but I also think……"

SELF ASSESSMENT: 21

Indicate True (T) or False (F) against the following statements:

1. Being humble and kind towards others and telling them positive things about

yourself is one way of practicing assertiveness. 2. Always listen, be understanding, compassionate and complain is one way of practicing assertive.
ANSWERS: 1. T 2. F

6.8 Summary

During the discussions on assertiveness, we looked at various aspects of the topic like definition, assertive behaviour versus other styles of interpersonal behaviour and barriers to assertive behaviour. Assertive behaviour means stating your own feelings whilst acknowledging the other person's point of view. It involves clear and steady communication, standing up for your rights and beliefs, whilst looking for ways to resolve possible problems. It is important that nurses consider assertiveness in their training seriously for the provision of effective nursing care to their clients.

6.9 REFERENCES

- Barbra K et al (1987) 3rd edition, ***Fundamentals of Nursing-concepts and procedures,*** Addison-wesley, Menlo Park, California. pp 179,379,564-5, 805
- Bower, Sharon A. (1994**) "*The Assertive Advantage*"**, London**:** National Press Publications
- Cotler, Sherwin B. and Cotler, Susan Morgan (1977) **Four myths of non assertiveness in the work environment**, in Robert E. Alberti (Eds.) *Assertiveness: Innovations, Applications, Issues.* San Luis Obispo, CA: Impact Publishers, Inc. Desmond F. (1990) 1st edition, ***Developing your Career in Nursing,*** Hapman and Hall, Cornwall, Great Britain, pp 24-35.
- Hibbered M. and Smith L. (2004)3rd edition, ***Nursing Leadership and Management in Canada,*** Elsivier Canada, Toronto, Canada, pp521-527
- Ian, Mark (1991) "***The New meaning of Educational Change*****"**, London: Cassel Educational Limited.
- Robbins, P .Stephen et al (2004) **"*Management: Seventh Edition",*** Delhi: Pearson Education Limited.
- Smith, Manuel J. (1975) **"When I say No, I feel Guilty"**, London: Bantam Books.