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Positioning Nurses in Primary Health Care in Bhutan

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ABSTRACT

Introduction: Nursing in Bhutan had its beginning in the early 1960s, approximately 20 years prior to the Alma Ata Conference. From basic nursing care and housekeeping roles, Bhutanese nurses have now occupied central place in nursing service, administration and management and education. Nursing education has progressed from certificate level in the 1960s to bachelor, master and PhD levels in 2014. Although nurses have been closely associated with Primary Health Care development in Bhutan, apart from the role of the Auxiliary Nurse Midwives, nurses have rarely been explicitly associated with this area of practice. Therefore, the objective of this study was to find out the role of Bhutanese Nurses in PHC. **Methods:** qualitative case study method was used to carry out focus group and in-depth interviews with 66 respondents that included policy makers, planners, educators, regulators and implementers. Data were analyzed through manifest and latent content analysis. **Results:** The centrality of the nursing role in the area of PHC has not been realized. Discharge of the PHC role was identified more in terms of the place of work and by title or designation of the nurses. Primary Health Care momentum appeared to have slowed down and nurses differed in their understanding of PHC concept. **Conclusions:** Although Nursing in Bhutan has made much progress, the uneven development of the nurses' role in PHC in Bhutan and globally suggests a need to identify and implement strategies such as standardizing, role profiling, curricula review and leadership improvement to ensure progress in this area.

Keywords: Primary health care; Positioning nurses; Role of nurses.

INTRODUCTION

The role of nurses in Primary Health Care (PHC) was perceived as pivotal even prior to the declaration at Alma Ata. Resolutions on the role of nursing and midwifery in PHC were passed during the 30th World Health Assembly (WHA) in 1977[1] and the International Council of Nurses (ICN) in 1978 declared its solidarity and support for PHC as the means to achieve health needs of the population. Despite the ICN, WHO and national nursing associations lobbying for the inclusion of PHC principles and concepts in education, practice, policy and research[2], nursing and midwifery momentum faded. This was despite the ongoing rhetoric of the WHO on the role of the nurses as leaders in PHC[3-8]. Nurse's role in PHC included basic PHC activities; PHC nurse practitioners[9]; community health nurses[10] and running PHC clinics[11-13], thus indicating uneven development globally.

Since 1967, Bhutanese nurses have been involved in PHC activities, mainly in the area of maternal and child health[14]. Specific PHC roles became visible in 1975 with the start of a two year certificate in Auxiliary Nursing and Midwifery (ANM). Bhutan's health care system is based on a three-tiered system with Satellite Clinics, Outreach Clinics and Basic Health Units (BHU) at the primary level, District Hospitals at the secondary level and Regional and National Referral Hospitals at the tertiary level. The BHUs used to be manned by Health Assistants (HAs), ANMs and Basic Health Workers (BHWs). The ANMs were largely responsible for maternal and child health, family planning and immunization activities. However, the amalgamation of HAs and ANMs as one category, HA, seemed to have blurred role clarity. Moreover, of the three main categories of nurses, ANMs, General Nurse Midwives (GNMs) and Assistant Nurses (ANs), which existed during that time, ANMs were thought to be more involved with PHC activities. Research exploring the roles of nurses in PHC in Bhutan has not been undertaken which was in part, the impetus for this study. Therefore, the aim of this qualitative case study was to explore the role of Bhutanese nurses in Primary Health Care.

METHODS

This qualitative case study was conducted between February 2013 and April 2015 in 19 of the 20 Dzongkhags in Bhutan. A sample of 66 respondents that included policy makers, planners, educators, regulators and implementers were purposively recruited. Samples were selected based on their ability to contribute on the topic under study and their area of work. Thus, the chiefs and heads (8)

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in the Ministry of Health (MoH), the educators (12), the district implementers (5 from each of the three regions), the district policy makers (5 from each region), the regulators {one from Bhutan Health and Medical Council (BMHC)}, chief nurses (11), nursing head, one from WHO Bhutan and two from WHO SEARO were purposively recruited. Ethical clearance for the study was obtained from the Queensland University of Technology Human Research Ethics (approval number: 1200000508) as well as the Research and Ethics Board of Health, Ministry of Health Bhutan (REBH/Approval/2012/015). Site clearance to visit the health facilities was obtained from the Ministry of Health (12/06/12).

After contacting the human resource officer of the MoH to obtain the phone numbers of potential participants, departments in the MoH, Bhutan Medical and Health Council, Faculty of Nursing and Public Health (FNPH), WHO office, Jigme Dorji Wangchuck National Referral Hospital (JDWNRH), regional hospitals, district hospitals and the basic health units were contacted by phone. Participant information and consent forms were provided either by post, email or distributed at the time of interview. The interviews took place in the offices, BHUs, hospitals, fields, clinics and homes. Open ended question guide was used and all interviews were carried out in English and tape recorded. In addition, field notes were taken. In total, 39 face-to-face in-depth interviews and three focus group interviews consisting of 11, 11, and 5 members (11, 11, 5) were undertaken. The study objectives and process was explained to all the respondents and voluntary informed written consent obtained. In-depth interview and focus group were chosen as these two methods were considered an effective tool to study experiences and a phenomenon of interest[15-19].

Data were analyzed manually using manifest and latent content analysis[20-25]. Familiarization of data was achieved by listening to the tape recordings repeatedly, transcribing them accurately, reading and re-reading the transcripts and noting down related analytical ideas. This study used a combination of analytical units. In the absence of foolproof software programs, or concrete steps to be used in qualitative data analysis and interpretation[26-27], analytical outcomes were generated using word tables, figures and diagrams. Data were grouped under the emergent themes to generate convergences and divergences. Latent content analysis of data was then carried out to explore relationships and deeper structural meanings. Transcribers were used for fifteen of the transcriptions but cross checked the by the researcher. This was followed by indexing the audio tapes and the transcribed files as WHO (WHO1, WHO2 and so on); central policy and planning (CPP1, CPP2 and so on), district policy and planning (DPP1, DPP2 and so on); implementers (I1, I2 and so on); educators (E1, E2 and so on) and hospital nurses (N1, N2 and so on).

FINDINGS AND DISCUSSION

The overarching findings of manifest and latent analysis were categorized into (1) role centrality; (2) scope of practice; (3) unclear categorization; and (4) arbitrary remuneration.

Role centrality

PHC is considered a key dimension of care in nursing. Furthermore, nursing has been promoted by the WHO as the global leader for PHC reform[28]. Despite the relatively recent refocus on PHC the centrality of the nursing role in this area has not been realized as stated by some respondents:

*Nurses' role has not been recognized.*CPP3
We were ignorant of our roles since we always worked in the wards. N12
Nurses' role in PHC has been overlooked. N6

This is supported by the fact that nurses were perceived to have carried out PHC roles long before the declaration of Alma Ata. Preventive and promotive aspects of PHC in nursing were recognized and emphasized as early as the nineteenth century during the Florence Nightingale era when greater attention was given to clean air, nutrition, care of the well and a clean environment[29-30]. Nightingale's views supported the five principles of PHC[31]. In addition, the values of nursing were found to be closely aligned with the principles of PHC[32]. These have endured and have been reproduced by the ICN definition of a nurse as a role that encompasses preventive, promotive and rehabilitative responsibilities[33].

In addition, nursing in Bhutan endorsed the ICN definition and the nurses have carried out similar roles and functions. Nonetheless, it appeared that discharge of the PHC role was identified more in terms of the place of work and title or designation. While literature on the nurses' role in PHC in Bhutan may indicate inadequate acknowledgement of nurses undertaking PHC activities some shared understanding was evident in this research about enhancing the role of nurses and midwives in PHC.

Scope of Practice

Findings indicate a shift from 70% preventive and promotive and 30% curative services to 70% curative services and 30% preventive and promotive services. In addition, the duration of community attachment for nurses has decreased from four weeks to one week in the BHUs and the curricula were found to be deficient in health promotion and communication as reflected in the following data excerpt:

Currently nurses' role is mainly curative focused. CPP8
Curriculum is focused more on curative aspects. E8

Table 1. Areas of convergence and divergence in healthcare among six countries on four continents and current research findings

	Areas of convergence	Areas of divergence	This study findings
Health challenges	Rising cost of health care Healthcare Infrastructure focused on acute care Aging society and aging workforce	Lack of universal health care Epidemiologic changes Ratio/ distribution of health workforce	Financial sustainability Inappropriate infrastructure Epidemiologic changes
Nursing challenges	Shortage of nurses: workforce deployment Ambiguous scope of practice Lack of autonomy of nursing practice	Education levels: requirements for entry to practice Remuneration structures Workload	Shortage Deployment issues Unclear scope of practice Multiple levels Remuneration structures Workload

Further, the Bhutan Medical and Health Council had four clauses, 5.16.1 to 5.16.4 under the professional code of practice for nurses and none mentioned PHC roles[34].

This is supported by the fact that WHO, since 1951, stressed the importance of nurses in health programs of a country[35] and passed approximately 15 pertinent World Health Assembly resolutions to this effect. Despite the WHO challenging nurses to lead PHC activities[13,36], little progress has been made at the global level[32]. Other supporting facts include the Cumberlege Report in England that found many PHC teams existed in name but functioned more in sickness and crisis intervention than in health promotion and preventive activities[37]. The scope of nursing practice in many settings was confined to just the medical management of patients[32]. The Alma Ata conference, global nursing bodies such as the ICN and declarations such as the Chiang Mai declaration[28] have recognized the importance of nursing and midwifery in PHC and MDG.declared a commitment and support towards PHC. Nurses were found to be a cost effective and crucial resource in reducing mortality, morbidity, disability and in promoting healthy lifestyle, preventing illnesses and addressing workforce shortages[6,38-39]. In addition, leadership was one of the four sets of reforms identified by the 2008 World Health Report to enable PHC based health system performance[40]. Acknowledging this deficit, the ICN, supported by Pfizer External Medical Affairs, launched the Global Nursing Leadership Institute (GNLI) in 2009 to impart national and global leadership knowledge and skills[41].

One such team in 2010 consisted of nursing leaders from USA, Thailand, Lesotho, Lebanon, Bhutan and Australia who carried out a comparative analysis of their country's health profiles and identified health and nursing challenges. Findings included areas of convergence and divergence in health and nursing as shown in Table 1. Findings from the current research aligned well with the GNLI.

Thus, there is a need to expand the scope of practice to preventive, promotive, supportive and rehabilitative care and practice in settings such as community centers and lead community teams; rather than just medical management of patients.

Unclear Categorization

Findings indicated that among the three main categories of nurses, ANMs, GNMs and ANs, which existed during that time, ANMs were thought to be more involved with PHC activities since GNMs and ANs mainly worked in the hospitals, although the work of the latter two did include activities such as maternal and child health care, immunization, health promotion, prevention and rehabilitation.

Initial manifest analysis of the nursing roles indicated 22 different categories of nurses in Bhutan as shown in Figure 1. These included ward assistants, nurse aids to nurse specialists and nursing superintendents.

Literature suggests that the WHO considered nurses a human resource central to the achievement of PHC focused activities[1,3,42-43] and the ICN, since 1978, had been reminding nurses to "step up" PHC reforms[44]. Nurses and nursing organizations continue to indicate the relevance of PHC[45]. Despite these, the development was uneven and confusing and there was little progress at the global level[32,45]. In some countries, nurses were preoccupied with the medical management of patients[5] and meeting acute care demands[46]. PHC was thought to be more of medical work than nursing[2] and nurses were more focused on fostering a nursing profession than population health[47]. However, countries such as Australia, Canada, New Zealand and United

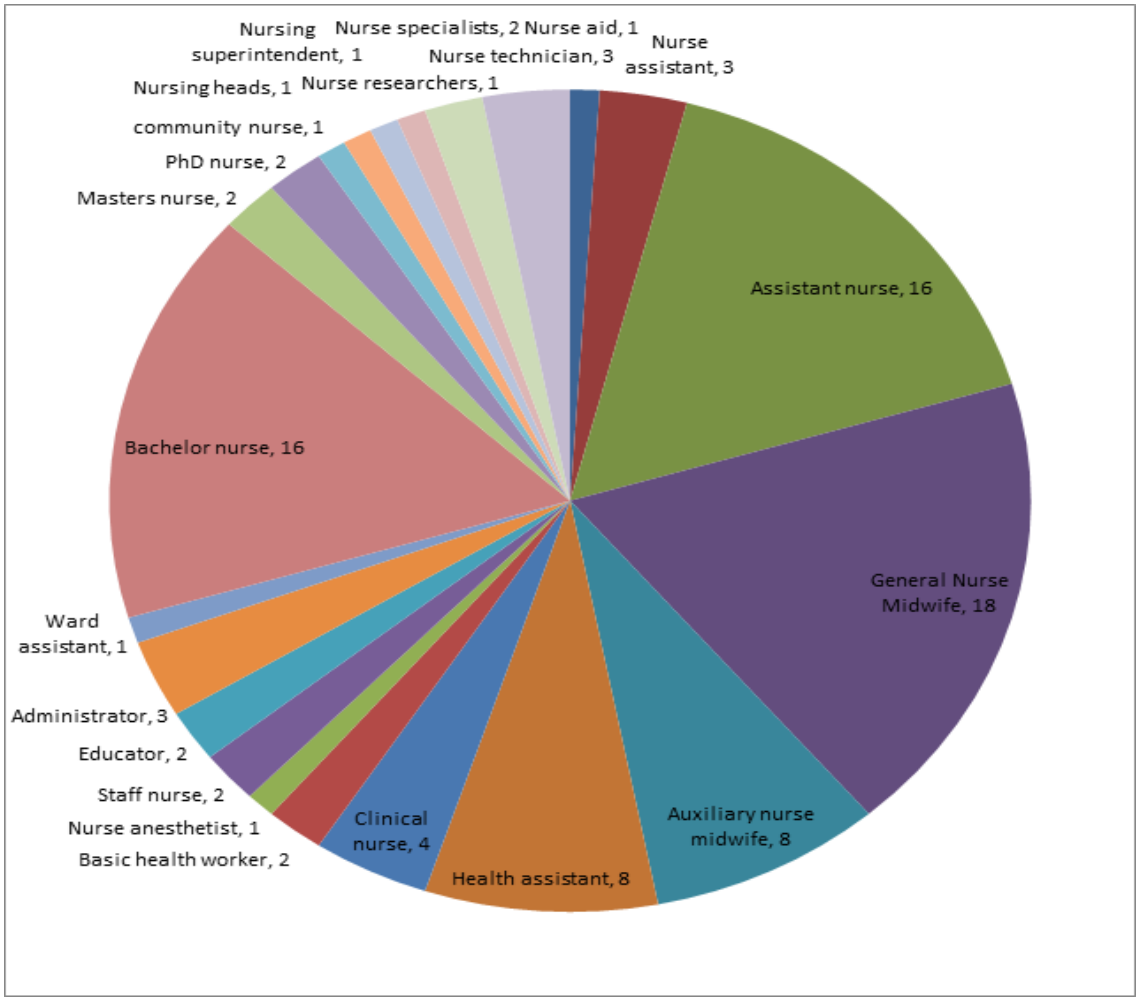

Figure 1. Manifest analysis of nursing roles in Bhutan

States had PHC clinics run by nurses[11-13,32], the Cook Islands, Australia, US, Canada, New Zealand, UK, Ireland, Botswana, Thailand and Taiwan had nurse practitioners[12,48-50] and the Republic of Korea, Nova Scotia and Sweden had community health or PHC nurses[10,48,51-52]A recent analysis of the WHA resolutions regarding WHO's initiatives to strengthen nursing and midwifery found that numerous resolutions specifically highlighted the importance of nursing and midwifery in PHC, nursing and midwifery role in health for all, and the need for qualifications and professional training to deliver effective services[1,3-8,42,53-56]. In giving strength to this position, the WHO created nursing positions within its structure, starting with the position of chief nurse.

Initial latent analysis suggests categorization by designation; qualification; area of work such; and by group as presented in Table 2. However, a national workshop on the finalization of strategic direction for Nursing and Midwifery 2015-2020 held in Paro Bhutan from 21st November to 22nd November 2014, identified only three categories in nursing, namely assistant nurse, staff nurse and clinical nurse.

Focused latent analysis of nursing roles in Bhutan found that there was indiscriminate role profiling, job description and deployment of nurses leading to role blurring and ambiguous scopes of practice. Primary Health Care was confined to the ANMs who worked in the BHUs and not to those nurses who worked in the hospitals. This indicates that PHC role was not clearly understood and not consistently applied.

The early role of nurses in PHC in Bhutan was mainly in the area of service delivery but nurses have since assumed positions in management, as public health program officers in the Ministry of Health and as educators, for example as public health lecturers at the FNPH, Khesar Gyalpo University of Medical Sciences of Bhutan. It appeared that although nurses had been closely associated with PHC activities, their role was largely not

Table 2. Initial latent analysis and suggested categorization of nurses in Bhutan

By designation	By qualification	By area of work	By group
Nurse aid	Bachelor nurse	Educator	Staff nurse
Nurse assistant	Masters nurse	Administrator	community nurse
Assistant nurse	PhD nurse	Nursing heads	Nurse specialists
General Nurse Midwife		Nurse researchers	
Auxiliary nurse midwife			
Health assistant			
Clinical nurse			
Basic health worker			
Nurse anesthetist			
Ward assistant			
Nursing superintendent			
Nurse technician			

Table 3. Role of nurses in PHC

Past/present PHC roles	Future PHC roles	Future titles
Advocacy	House visit	Advanced nurse practitioner
Women's health	Work at community level	PHC nurse
Immunization	Run public health clinics	Public health inspector
Family planning	Health education	Rehabilitation nurse
Child Health	ORC and BHU visits	Community health nurse
Delivery	Prescribing	Public health nurse
Patient Care	Household survey	Clinical educator
Service provision	Community diagnosis	Nurse practitioner
Nutrition	Specialized roles	Nurse entrepreneur
Antenatal clinics		Nurse educator
Curative services		Clinical nurse specialist
Reproductive health services		Emergency care nurse
Preventive and promotive health care		
Prescribing medicines		
Maternity wards, medical wards, surgical wards		
Emergency care		
Bedside care		
PAP smear		
Cervical cancer screening		
Outpatient department		
Maternal and child health clinic		
Early childhood care and development		
Patient care and awareness on diseases		
Health education		
Basic care		

perceived as integral to PHC. According to Banner, MacLeod and Johnston (2010), some of the international nursing roles in PHC were advanced practice nurse, health visitor, nurse practitioner, practice nurse, public health nurse and community nurse. Some PHC roles developed as new roles to address physician shortage[57], while some carried out PHC activities as part of their extended nursing role[50,58-59]. The respondents listed several past, present and future roles of nurses in PHC, as set out in Table 3, and expressed some possible future PHC titles for the nurses and midwives in Bhutan. Thus, it can be seen from Table 3 that future PHC roles clearly indicate the need for more preventive, promotive and community based activities and recognition and education of nurse specialists and practitioners.

Arbitrary Remuneration

Analysis indicated the need to review the remuneration as qualification seemed to be the only differentiating factor at present and not the type of service rendered as stated by some respondents:

> *Everybody did the same job regardless of qualification but the only differentiating factor was salary. DPP6*

Regardless of training and qualifications nurses performed similar roles and functions, particularly during the evening and night shifts. Everybody did everything. It was also found that there still were differences among the nurses in their understanding of PHC. For instance, an analysis of 254 articles on how nurse authors interpreted PHC revealed that 184 (72%) applied the WHO definition, while the remaining 70 articles (28%) used concepts such as selective primary health care, primary care and community health nursing interchangeably with PHC[45]. In order to bring all nurses and midwives to the same level of understanding and to fulfill the expected roles in PHC and optimize their full potential an international standard for PHC nurse practitioner was proposed. This was because there were no existing standards among PHC Nurse Practitioners in the developed world and the role was more acute care based in the developing countries. Discrepancies existed around qualifications as well as roles. On this point, the 2014 Global APN Symposium endorsed the context based definition of the ICN (2002) and recommended the removal of barriers and the full utilization of training and education. Further recommendations were enhancement of country specific curricula, sharing of information within and across countries and the creation of funding[25].

The renewed PHC movement was perceived as an opportunity to revitalize the nursing workforce[32] and to reorient nursing roles in line with PHC concepts and principles. In addition, a systemic review of 69 articles suggested that nurses' eagerness to embrace new PHC roles was associated with job satisfaction and retention and could result in innovative patient care approaches[58].Limitation of the study was not being able to include the consumer group.

CONCLUSIONS

This study concluded that nursing role in PHC has not been realized, there was unclear scope of practice, too many categories leading to role blurring and arbitrary remuneration. The study therefore, recommends the need to review nursing curricula, reorient the nursing role in PHC, standardize the levels and categories of nurses, and strengthen leadership. Primary Health Care roles must be inherent in all nursing roles regardless of whether they work in the hospitals or BHUs.

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AUTHORS CONTRIBUTION

The following authors have made substantial contributions to the manuscript as under:

DW: Concept, study design, data collection and oversight, critical reviews, research dissemination

CW: Concept, study design, data analysis, manuscript drafting, critical reviews, research dissemination

MC: Data collection management, critical reviews, research dissemination

Authors agree to be accountable for all respects of the work in ensuring that questions related to the accuracy and integrity of any part of the work are appropriately investigated and resolved.

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None

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