MEASURING EMPOWERMENT

The Application of an Empowerment Model to Nursing Development in Bosnia and Herzegovina

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Introduction

> *Even though nurses are the largest professional group in the health care industry, they still have not fully appreciated their potential and used the power they could attain.*[1]
>
> *The empowerment of women and their inclusion in policy-making and policy implementation should be an integral part of the policy initiatives for population, environment and sustainable development.*[2]

Feminist movements over the past 30 years have forced increased attention to issues of gender empowerment, at least in principle, among sectors generally recognized as mainstream and in institutions, both nationally and internationally. This has resulted in, (among other initiatives), an increased concern about gender equity and empowerment in international development work.

Until very recently, grassroots women's groups made the majority of efforts to effect change in the position and condition of women in society and have pressured formal institutions to change policy and practice. Thus, the analysis that underpins the emergence of gender as a political and social issue remains primarily in the domain of the feminist movement, remaining marginal because of the very reasons that sex roles and gender socialization dictate peripheral participation in mainstream society. In other words, for years, women's movements have been experimenting with ways that the empowerment of women can be understood. However, even though the *concepts* have been adopted into international and institutional policy, the tools and expertise needed to implement and evaluate them have not been promoted.

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1 Hitchock, Janice, Schubert, Phyllis and Thomas, Sue, Community Health Nursing: Caring in Action, Thomson Learning, USA, 1999 pg 746-747

2 UNFPA, Population, Environment and Poverty Linkages, 2000 (accessed from the website: . http://www.unfpa.org/tpd/publications/pop_env_pov.pdf, October, 2001)

Reform efforts in the health sector throughout the world have been fueled by an emphasis on cost effectiveness and thus rarely result in increased income for the expanded roles of various health professionals. However, the expanded roles could increase *inclusion* in the larger decision-making sphere of the health sector. In North America and Western Europe, health reform initiatives have been a significant focus for some time. However, for developing and developed countries in transition (CIT) the idea of providing 'more for less' while increasing national participation in a global market economy has become a recent necessity and is taking place rather quickly.

The focus on various levels of empowerment for workers undergoing occupational or sector reform is crucial, especially with groups who have been consistently and systemically disempowered and this should include occupations that may be compromised by virtue of gender socialization. Without the tools to integrate and measure equity principles into international work, international development organizations may contribute to a lack of empowerment simply by maintenance of the status quo. Without leadership and empowerment strategies beyond those taken by international efforts, workers in recipient countries must forward these through lobby efforts of local representative groups, unions or professional associations to the degree that they exist.

Nursing as a gendered profession

Nursing is a predominately female profession and thus *gendere*d as a profession, even though male nurses may represent up to 20% of the sector in some countries. This means that the position of the nursing profession within a primarily (male) doctor-led health system reflects the ways in which women have been socialized to take a deferential role, especially regarding positions of power and decision-making.

Power is defined as the ability to influence others; the ability to do or act; achievement of the desired result. Nurses have not been socialized to the concept of power. To many, the concept carries with it a negative connotation. Many nurses view themselves as powerless, and, often, the public also perceives nurses as powerless. There are several reasons, most having to do with gender: (1) Nursing is a female-dominated profession; (2) power is related to the male gender; (3) power is not "feminine"; (4) the majority of nurses still work in male-dominated organizations with powerful males (physicians); (5) the profession is perceived as altruistic rather than power-based.[3]

Developments in the nursing profession are chiefly subsumed under the auspices of the health sector reform in general. Although some attention has been paid to the work of nurses relative to that of physicians, little or no attention has been paid to the profession as one of a *gendered* occupation. Some research exists that examines the relative pay rate of females to males in a various occupations, (HDRC, 1988 is an example[4]), or evaluates the relative job dissatisfaction of nurses as a sector within the health profession, (Aiken et al, 2001[5]). Yet, evaluative tools which employ an analysis of

[3] Hitchock, Janice, Schubert, Phyllis and Thomas, ibid, pg 746-747

[4] This report is the most recent report of this nature available on-line and produced based of statistics gathered in 1987-88. Further, follow-up reports, if they exist, are not available on-line.

[5] Aiken, Linda, Clarke, Sean, Sloane, Douglas, Sochalski, Julie, Busse, Richard, Clarke, Heather, Giovannetti, Phyllis, Hunt, Jennifer, Rafferty, Anne Marie, Shamian, Judith, Nurses' Reports On Hospital Care In Five Countries: the ways in which nurses' work is

participation and access are not generally used when measuring the degree of empowerment afforded to gendered occupations (such as nursing) which are primarily, but not exclusively, female.

In 1988 HDRC Canada, applied a definition of “female jobs” to gather statistics. Predominantly "female jobs," clerical and health care work for example, are those with a femaleness rate of 60 percent or higher.[6] This study examined gendered professions only from the vantage of identifying wage differences and did not consider and other aspects.

Nursing is a higher paid occupation for women than most “female” occupations, and the sector has not been a significant focus for women’s disempowerment studies. Yet, much more can be explored in terms of nursing participation in decision making, as well as overall input into sector reform, particularly since nurses make up a significant portion of the health sector work force. In a study of nursing working conditions in 5 countries, it was found that:

> In four of the five countries, only a minority of nurses perceived that they have opportunities for advancement, although in Germany (where percentages of nurses dissatisfied and planning to leave their job were low) this was true of nearly seven in ten nurses. Finally, while more than three-fourths of U.K. nurses felt that their salaries were inadequate, nearly 60 percent of U.S. nurses and 70 percent of Canadian nurses felt that their salaries were adequate. In the United States and Canada, at least, nurses are more likely to be dissatisfied with working conditions than with their wages.[7]

Professional empowerment and job satisfaction includes but is not limited to income.

More can be explored in terms of nursing participation in decision making, as well as overall input into sector reform, particularly since nurses make up a significant portion of the health sector work force.

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structured have left nurses among the least satisfied workers, and the problem is getting worse, Health Affairs May-June issue, 2001, copyright Project Hope, 2001

6 Baker, Michael and Fortin, Nicole, Human Resources and Development Canada, (HDRC), Occupational Segregation and the Gender Wage Gap. Statistics Canada,1988, (accessed on the website: www.hrdcdrhc.gc.ca/arb/publications/bulletin/vol6n1/v6n1_07e.shtml)

7 Aiken, Linda, et al ibid.

Measuring Empowerment

In the Bejing Declaration adopted by the 1995 Fourth World Conference in Women, participating governments "determined to advance the goals of equity, development and peace for all women everywhere in the interest of all humanity".[8] The Bejing Platform for Action also gave new importance to the reflection in statistics of all issues related to women and men in society. As a result, several governments and international organizations are making considerable progress in the production of statistical publications on gender that present and interpret data on women and men.

Global health strategy: Health For All by the Year 2000 arose from study conducted by WHO in 1973. This study identified a correlation between the health status of the population and the social economic development of a country. With that study, health became recognized as more than the provision of health services and thus the WHO initiated a global strategy of Health for All by the Year 2000" at the 12\3th World Health Assembly in 1977. The seven principles of HFA outlined by the WHO are: the right to health, equity in health, community participation, intersectoral collaboration, health promotion, primary health care, international cooperation. These seven principles are seen as a framework guiding health care workers working with groups at a community, national, or international level. However, the specifically articulated "gender perspective" is stated elsewhere in the HFA document.[9] Although is it understood that the principles of gender empowerment are included in the seven principles, issues of gender may frequently be overlooked and excluded.

In Canada, in 1984, the Canadian International Development Agency, (CIDA), issued its first policy on Women in Development (WID) demonstrating Canada's commitment to integrating gender issues in development. However,

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8 Report of the Fourth World Conference on Women, Bejing, Platform for Action, Unitied Nations publication, 1995

9 World Health Organization, Health For All in the 21st Century, WHO,1996

during the past almost 2 decades, policy implementation has been challenging:

> In 1998, the *WID and Gender Equity 1992-1995 Performance Review Report* concluded that policy implementation had not been sufficiently woven into the "fabric" of CIDA, and that defining results remained a challenge. CIDA's *1999 Assessment of Women in Development and Gender Equity in Evaluations* also concluded that, despite a solid corporate policy environment, the Agency's performance-review policy failed to outline explicit expectations for progress on gender equality.[10]

These findings influenced the 1999 update of CIDA's "Gender-equality Policy", which emphasizes identifiable results. Measurable outcome examples include such quantitative factors as: "Increased numbers of women employed in non-traditional occupations", or in the case of health: "decreased infant, child and maternal mortality and morbidity rates or improved status of women through better female health". [11] Qualitative measures assess factors like the degree of satisfaction and sense of ownership of new services of reform efforts.

Yet, "empowerment is difficult to measure, and there is no agreed-upon method for measuring it." [12] True as this statement is, feminist theory and models of empowerment, usually applied to projects focussed on primarily on women, can be adapted and more widely applied to development work where the initial focus has not been one of the empowerment of women and where project personnel do not have a background in diversity or empowement work. They can be applied in order to integrate a more comprehensive feminist analysis including the *degrees* of women's disempowerment and they can and they can be analysed within the context in which issues of feminism have been advanced in the recipient country's cultural landscape. This paper describes the use of questionnaires derived from the UNICEF Women's Equality and Empowerment Framework (WEEF) to measure the effect of a training project as an empowerment strategy for nurses and nursing teachers in Bosnia and Herzegovina (BiH). As nursing is a gendered profession in BiH (as it is elsewhere), this project adds to the gender empowerment measurement strategies that can be used to assess the effect of international development efforts.

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[10] Canadian International Development Agency, (CIDA), CIDA's Sustainable Development Strategy 2001-2003: An Agenda for Change, (accessed from the CIDA website: www.acdi-cida.gc.ca, August, 2001)

[11] CIDA, Guide to Gender-Sensitive Indicators, Canada, 1997 pg 34-35

[12] CIDA, Guide to Gender-Sensitive Indicators, ibid

Health care reform in Bosnia and Herzegovina

Between 1990 and 1995 BiH experienced a 75% drop in per capita GDP and destruction of most infrastructure for the delivery of basic services, which was the most severe economic (political and social) collapse in Central and Eastern Europe since World War II. Approximately 35% of the physicians and nurses fled the country or were killed. Of the hospitals and health centres (Dom Zdravljas), 25-30% of were destroyed or severely damaged. The war in BiH came to an end with the signing of the Dayton Accord in November 1995. Health care reform had begun in 1991 before the outbreak of war, however, the devastation to the health care system caused by the war was extensive. After the declaration of peace, the process of redefining a strategy for health reform began again with a new exploration of possible models of organization, delivery and payment.

Similar to other Central and Eastern European countries, BiH comes from a medical care tradition that was highly centralized, hierarchical, and specialist-physician dominated. The initial contact function of the general practitioner was underdeveloped, services were not well coordinated between various levels of care, and there was little continuity of physician contact over the patient's life cycle. Still, in 2000, 160 EDLs[13] in the Federation and 105 for the RS were available to the public.[14] and it was estimated that "Primary Health Care is intended to cover 70/80% of all medical cases, but in reality covers only 10-20%.[15]

Together with the World Bank, the Ministries of Health of BiH and the RS developed a Primary Health Care Reform Initiative which proposed to rebuild the BiH health sector infrastructure using more effective and cost-efficient

[13] The WHO EDL (Essential Drug List) consists of 250-300 drugs which should be available free of charge as a basic standard of treatment.

[14] UNHCR Office of the Chief of Mission in BiH, Health Care in Bosnia and Herzegovina in the Context of the Return of Refugees and Displaced Persons, 2001, (accessed from the website: www.unhcr.ba, August 2001)

[15] UNHCR Office of the Chief of Mission in BiH, ibid

delivery systems, making Family Medicine the foundation of community level primary care.

In 1995, CIDA partnered with Queen's University to establish 11 Family Medicine Teaching Centres in BiH and to develop a Family Medicine Residency Program in the Faculties of Medicine in four participating universities. Despite substantial progress in fostering improved primary care at the community level, it was apparent that important gaps remained within the developing BiH health care system, particularly in the field of nursing.

In 1999-2001, the George Brown College (GBC) Faculty of Nursing developed training for general medicine nurses employed by the Queen's Family Medicine Centres. The project also included the development of corresponding curriculum for 8 general nursing educational programs.

There is no exact count of the number of nurses in the country. Health statistics from the Federation indicate that nurses comprised 64% of health workers in 1996.[16] Most nurses in BiH are employed after graduation from 4 year nursing programs delivered at the secondary school level. Currently there is no university level faculty of nursing in BiH. Post secondary nursing education takes place in "High Medical School". In 1996 there were 981 High Medical nurses/technicians in the Federation, thus qualified to act as a head nurse, a teacher in a secondary nursing program, or a patronage (visiting) nurse. At present there is no opportunity for advancement in nursing beyond these levels and attendance at High Medical School is difficult to access for working nurses. In terms of hours, the secondary school general nursing program are closer to EU standards of nursing education than the High Medical schools, yet at both levels of nursing education, the majority of educators are physicians.[17] Teachers who are nurses, despite their skills and knowledge, are regulated as 'technicians' who instruct students on clinical skills only.

[16] Federation of Bosnia and Herzegovina Ministry of Health, Strategic Health System Plan, 1998

[17] EU standards of nursing education have 4 main areas of focus: (1) the education of nurses by nurses, (2) current content in keeping with international standards of nursing theory and practice (3) number of total hours of nursing education in nursing schools in accordance with hourly standards (4) level of entry should be University, College (or High Medical school) levels, (however, at present several member countries who are in transition maintain 3rd year secondary school entry).

Development of the BiH Nursing Associations

The social and political context of gendered work in BiH is somewhat different than in Canada or the United Kingdom and these distinctions are important in understanding the evolution of the nursing associations and the implications of the empowerment evaluation.

In western countries, concern about gender segregation and gender based attitudes in the workplace and feminist issues overall have slowly begun to create concern at institutional levels. The backdrop of feminism and concern regarding women in the work place in Eastern and Southeastern Europe though, has a much different history than that of the west resulting in much less institutional resolve. BiH acceded to the Convention on Elimination of all Forms of Discrimination Against Women (CEDAW) in 1993, but have not complied with the (Article 18) requirement that an initial report be submitted within one year. Despite the fact that the Dayton Peace Accords adopted in 1995 were the first major peace agreement to be signed after the Beijing conference, it falls far short of the demands from Bejing and other human rights treaties because of its remarkably gender neutral stance. Thus since "women's special interests and needs are not taken into consideration in the Dayton Peace Accords, gender awareness in general has been lacking in the implementation process". [18]

> *"Four years after the Dayton Agreement, BiH is still struggling with its socio-economic development, political reconstruction and establishment of new legislative frameworks. In the process, little attention has been paid so far to the question of gender equality."*[19]

[18] Lithander, Anna, ed, Engendering the Peace Process: A Gender Approach to Dayton – and Beyond, Kvinna till Kvinna, Sweden, 2000, pg 9

[19] United Nations Development Programme, (UNDP) Gender in Transition: Five years of UNDP Projects in Eastern and Central Europe and CIS, United Nations publication, 1999 pg 19

Although such statistics for BiH are not available, in 1997, 45% of the labour force in Eastern Europe were women, (slightly more than Western Europe (42%) and other developed countries (44%). [20] The participation of women in the labour force in BiH was very high during the Tito years, (and to the extent that BiH is able to resource a labour force, it has remained so).[21] Prior to 1990, the emancipation of women was primarily connected to their status as workers, and thus evolved the economic rights of women: (health care rights, maternity rights, pension rights and childcare facilities).[22] Women's illiteracy fell from 80% in 1950 to 16% in 1991, women's sufferage began in 1945 and in 1974 family planning (including safe and free of charge abortion) was a constitutional right.

In the late 1980s and early 1990s, nationalistic political parties that value conservative religious interpretations of Catholic, Islam and Orthodox religions advocated patriarchal values and condemned the values upheld by communism, including gender equality, (to the extent that gender equality was a communist value). Women's participation in politics and decision making in Eastern Europe decreased during that decade. In 1987, 27% of parliamentarians in Eastern Europe were women compared to 10% in 1999. [23] In BiH women members of parliament decreased from 24% to 3 % during the same time period.[24] Many women's groups that exist now in BiH found their roots during this political upheaval.

> *With new democracies coming to power in Eastern Europe, one would expect a diversified public sphere to emerge in the twilight zone between state and society and a civil society emerge as the traditional patterns of power and gender relations are dismantled and the cornerstone of democracy are laid. But the New East European (mostly nationalistic) governments are… for the most part… repeating the old gender/power relations. These relations are inimical to civil society and to women's participation in the political sphere.*[25]

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20 Unitied Nations Secretariat, The World's Women: Trends and Statistics, United Nations publication, New York, 2000 pg 110

21 The war in BiH decreased the population from approximately 6 to 4 million and unemployment rates for the country are estimated at about 35-40%

22 Lithander, Anna, ed, ibid, pg 17

23 Unitied Nations Secretariat, ibid, pg 165

24 Lithander, Anna, ed, ibid, pg 17

25 Mežnarić Silva and Ule, Mirjana, In Pursuit of Framework: Delayed Modernization and the Emancipation of Women in the Balkans, in: Women in the Politics of Postcommunist Eastern Europe, edited by Marilyn Rueschemeyer, M.E.Sharpe Inc, New York, 1998 pg 196 - 201

In a civil society, state and public spheres are redefined and maintained through independent processes and democratic procedure protects the boundaries of each. Negotiation between state and society is forwarded by "private units, households, voluntary organizations, community-based services, [and] legally guaranteed self-organization".[26] The BiH Nurses Association, is legally guaranteed in that it is permitted by law to exist. However, it is not entirely self-organized.

Ministries of Health appointed executive representatives to create a Nurses Association where little prior vision of such an establishment existed either among the executive or the potential members. After more than 2 years of dissension and ineffectiveness, a gradual development of Cantonal Nurses 'Chambers' / Associations has emerged. Not all have reached 'legal" status and most define membership to include health professionals other than nurses, thus diluting to varying degrees a resoluteness regarding any specific nursing profession agenda.

[26] Mežnarić Silva and Ule, Mirjana, Ibid pg 196 - 201

GBC project gender analysis

During the CIDA-sponsored Family Medicine Nurse Development project, 52 nurses were trained by the GBC faculty of Health Sciences (Nursing) to work in newly developed Family Medicine Centres and 43 nursing teachers received instructional upgrading in order to deliver new nursing curriculum in the nursing schools in Bosnia and Herzegovina (BiH). A total of 4 men and 91 women were involved in the project. Of these, 89 (44F + 2M nurses and 41F + 2M teachers) participated in responding to a questionnaire designed to assess their experience of empowerment as a result in their participation in Primary Health Care reform and the development of Family Medicine in BiH. The WEEF Model was altered to include the responses of both male and female nurses and question areas were developed for each of the empowerment levels, (Appendix B). Questionnaires were developed for both the nurses and the nursing teachers.

The GBC project has increased the skills and knowledge of Family Medicine Nurses and has increased the scope of curriculum for nursing teachers, adding new nursing and medical theory to their course content. However, the empowerment questionnaire results demonstrated that the experience of empowerment was significant and positive for the more personal and direct levels, other than income, than the levels of empowerment that included participation at a political or occupational control level, (Appendix C). Participants were very aware of the various changes needed to increase the overall status of nursing, (Appendix D), but lacked control over their profession in order to make these changes. There were 89 respondents and results have been expressed as percentages. There were only four males in the survey, two in each group, so no analysis by gender was possible in the end. Also, in the 'open response' sections, men and women showed no significant difference in viewpoint. Comparisons were drawn between the nurses and nursing teachers.

Regarding the empowerment category of overall welfare, both groups experienced a significant increase in personal self esteem (74%), sense of competency (73%) as well as increased job satisfaction (68%). In terms of

real change, 89% and 86% of nurses and teachers respectively had no change in income (this is reflected in the appendix D summary regarding what is needed to improve the professional a status of nursing). But at the same time, both groups felt that they had increased opportunity for involvement in new initiatives, (nurses more than teachers), 73% and 51 % respectively. Working conditions were rated much higher for nurses (73%) than teachers (23%) as their new role also takes place in the new environment of the Family Medicine Centres.

As the levels of empowerment became more complex, responses began to change. Although the two groups experienced a sense of empowerment on a more personal level, formal status and participation in decisions regarding their profession demonstrates little significant change and the newly formed professional Nursing Association(s)[27] are not yet positioned to advance these goals. Nursing practice as well as education is still highly controlled by a "medical professional elite previously unconstrained by business planning and sustainability considerations."[28] Thus, as with any long term, overarching goal, the overall goal of increased decision-making and participation for nurses can be expected to be 'put in motion' by international support but not achieved during the project's short duration. The use of the WEEF model helped to identify areas, beyond the project, that nurses can consider as they continue to develop leadership strategies in the future.

As professional organizations are often a key force in maintaining standards and developing educational opportunities for their members, it must be mentioned that, in BiH, the professional Nursing Associations for nursing are very fledgling. In the survey, nurses and teachers were asked about their membership in the new Nurses Association. Their aggregate answers regarding the strengths and weaknesses of the new association can assist in future decision making.

In terms of access to resources, nurses and teachers had very different survey results. Nurses (67%) experienced an increased access to resources beyond their training while teachers (23%) generally did not. This was due to the new environment of the Family Medicine Centres, new computer access and colleague physicians receiving parallel training. Teachers, on the other hand, work in an environment largely without computer access and were the sole recipients of new learning in their workplace. Both groups generally

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[27] This document has been first written in English wherein the words "association" and "chamber" have essentially the same meaning, thus, the word "association" will be used throughout.

[28] Staines, Verdon, A Health Sector Strategy for the Europe and Central Asia Region, pg 37-38, *Bosnia and Herzegovina*, World Bank, Washington, D.C. 1999

experience significant lack of access to international nursing research and information due to language barriers.

Throughout the survey, the most common comment in all categories was the lack of opportunity for higher education in BiH.

Both nurses and nursing teachers were asked how they thought other professions saw them, a question asked under the empowerment category of awareness. Teachers generally felt that other nursing colleagues felt positively toward them (67%), whereas only 43% of nurses felt this way. Regarding attitudes from physicians, 80% of nurses felt that their physician colleagues held them in positive regard, compared to only 39% of teachers. The groups were also mixed regarding ministry regard, 69% of teachers felt that ministry regard for them was low and 34% of nurses felt the same. Factors contributing to negative regard included; nurses being seen both by doctors and by nursing management as being less subordinate than in the past; and a historical devaluation of nursing in general. Generally physicians teaching in nursing schools were seen as threatened by a decreased role in nursing education and nursing colleagues outside of Family Medicine who had not been included in new nursing education activities were, understandably, seen as feeling left out. Respondents strongly advocated for inclusion of their colleagues in future opportunities. Some respondents felt that only patients truly viewed nursing in a positive light. Several mentioned that in the new health model, nurses had not had an improved classification written into law, thus the negative environment would never change. A few respondents mentioned nursing passivity as a contributing factor to a negative regard by others.

Gender was not mentioned as a contributing factor. This is not surprising given that what little research and literature that exists on the subject of nursing as a gendered profession is not available in the Bosnian language as well as the strong sense of gender *desegregation* constructed by post WWII Eastern Europe. It should also be mentioned, here again, that there is very little translated information available regarding the development of professional nursing associations in other countries, guidelines for the development of standards of nursing practice, nursing research and texts in general.

Longstanding division was identified as a problem with the Nursing Association(s), (Appendix D). With respect to membership, some nurses said that all nurses were automatically "enrolled" and in other areas this was not the case. Some respondents said that the Association only needed certain numbers and that they and others had not been invited. Many described the Association as an educational (seminar) organization, some a social opportunity, while some described it more as a workers union. Most who joined did so in order to improve the condition of nursing and to forward

improvements in the profession although at the same time, most active members were also disappointed with the organization's functioning. Overall, although there was a fair amount of discrepancy about whether the associations actually existed in various areas, 63% of nurses and 53% of nursing teachers belonged to their local Association. 34% of both teachers and nurses did not belong.

Again, information regarding the *process* for the development of a strong professional association, available in other countries, is not widely available in BiH, thus, the 'grassroots' potential of such as endeavor has not been realized as yet. However, regardless of membership or confidence in the Association, almost all respondents were very knowledgeable about what was needed to increase the overall professional status of nursing. The disparity between the considerable level of awareness among nurses in general regarding their occupational status and the present ability of their association to help to create meaningful change clarifies one of the many challenges ahead. Nursing groups in BiH will need to develop participatory leadership skills and methods for ensuring constituency in organizational decision making if they are to strengthen the civic skill and political influence of their profession.

The idea of nursing standards and scope of practice was introduced by the GBC project, (inherent in all training activities), and the new materials modeled the sorts of activities in which nurses could participate. In the survey, all respondents were asked to respond to an overall list of participatory nursing activities and then asked to compare their real experience, (Appendix C pages viii and ix). Both groups expressed significant difference between what they understood to be areas of nursing practice and areas in which they were actually able to participate. Many felt that physicians and managers were not given enough information (by internationals and by ministry representatives) about their expanded capabilities and thus their actual scope of practice (despite training) was narrowed in their workplace. For example, nurses lack of participation in basic nursing functions such as involvement in patient care planning and nursing note-taking regarding patients. Although these were included in training, often real practice fell to previous habit (and the present DZ regulations permit nurses to record only medications and appointments). While new educational curriculum includes these areas of practice, in keeping with accepted international standards and scope of nursing practice, they have yet to be permitted in the nursing workplace.

Responses to questions developed for the empowerment area of control revealed that 73% of nurses felt that their practice guidelines (interpreted as 'job description') were clear but very few knew where they came from and few said that they had ever participated in the development of any guidelines.

Some felt that guidelines were under the control of the DZ director, some the ministry, and some mentioned that since such things were not written down, guidelines were simply a matter of who one worked under. Regarding job choice, nurses also reported that 17% were assigned to Family Medicine without choice, while 63% were chosen (but agreed to the choice). Again, the role of a professional organization in helping determine hiring practices and nursing practice guidelines has not yet been developed in BiH.

This overview of the application of an empowerment survey model hopefully provides a quick view of the sorts of information that can be obtained beyond the project outcome evaluations generally required of international projects. Although well articulated in the mandates and principles of major funding bodies more specific measurements of empowerment levels are frequently overlooked.

Nurses are the majority of health care workers and are primarily women. If leadership refers to the "power to make and implement policy and control in training, practice and administration, then women as a group have been and continue to be underrepresented."[29] Information and opportunity to experiment with leadership methodologies is crucial to the development of meaningful influence. Nurses in BiH have been struggling to redefine and take control over their profession in a context where outmoded and restrictive structures are the norm. Nurses in BiH are highly supportive of health care reform in their country and personally rewarded by recent changes. But the lack of educational and advancement opportunities and the absence of consistent standards of practice or job security, make BiH nurses the group which is both most vulnerable to any negative consequences of health reform as well as the group most necessary to its fundamental success.

> *... at the center of the changing health care arena will be nurses, representing the largest number of health care workers... not only do nurses need to be prepared to debate the issues; they need to step forward and define the issues as health care moves toward the 21st century.*[30]

[29] Trudiver, S and Hall, M, Women and Health Services Delivery in Canada, 1996, in, Women and Health Services: An Overview of Women's Health - Final report Volume 2, National Forum on Health, 2001

[30] Hitchcock, Janice, Schubert, Phyllis and Thomas, Sue, ibid pg 746-747

Addendum: George Brown College, Canada wishes to extend sincere appreciation to all of the Family Medicine nurses and nursing teachers who participated in this study. We hope that the information gathered will be useful as you continue in your endeavor to increase the vibrancy and strength of your profession in Bosnia and Herzegovina. Thank you also to Dana Peebles of Kartini International for her inspirational thoughts on the matrix.

Mandy Bonisteel, R.N.

Appendix A

Women's Equality and Empowerment Framework (WEEF)[1]

UNICEF applies the Women's Equality and Empowerment Framework (WEEF) as the tool for mainstreaming gender in its country programmes. This tool builds on the analytical framework developed by Sara Longwe as outlined in Sara Longwe, 1991, "Gender Awareness: The Missing Element in the Third Development Project" in Changing Perceptions: Writings on Gender and Development, Oxfam, Oxford.

The WEEF framework was developed using the following goals:

Welfare - The *Framework* identifies 'access' as one of the five levels of equality which are important in the process of development. It is particularly concerned with gender gaps in access to resources and services which present one type of obstacle to women's development.

Conscientization - is the process of becoming aware of the extent to which problems arise not so much from an individual's inadequacies, but rather from the systematic discrimination against a social group which puts all members of that group at a disadvantage. It is the stage at which group members come to understand the nature of the obstacles they face, and the need therefore to mobilise for collective action.

The next phase of the process is gaining of control or means ***the ability to direct***, or to influence events so that one's own interests are looked after. Framework Criteria equality of control as the most important aspect of development - where women ensure that resources and benefits are distributed so that both women and men get equal shares.

Development means both the improved material well-being (**welfare**) of people and the process through which this improved well-being is achieved. The concept of development also includes an element of equality - that material benefits from the development process should be fairly spread. Therefore the special interest in women's development arises because women experience gender discrimination.

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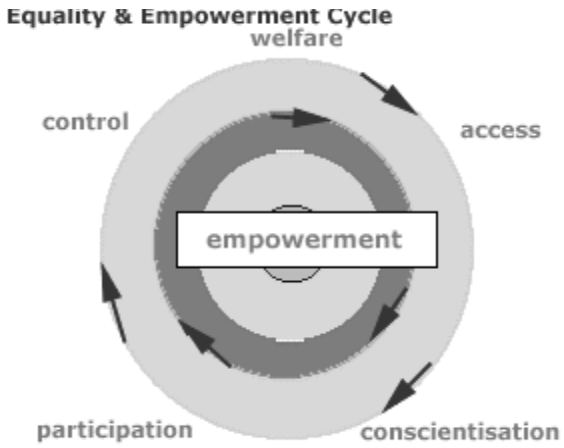
[1] This section is an excerpt from the UNICEF Women's Equality and Empowerment Framework, 1992, (accessed on the UNICEF website, February, 2001)



The final step after moving through this process is that of ***empowerment***, an important part of development, being the process of people taking control and taking action in order to overcome obstacles. Empowerment especially means the collective action by those affected to overcome the obstacles of structural inequality, which have previously put them in a disadvantaged position.

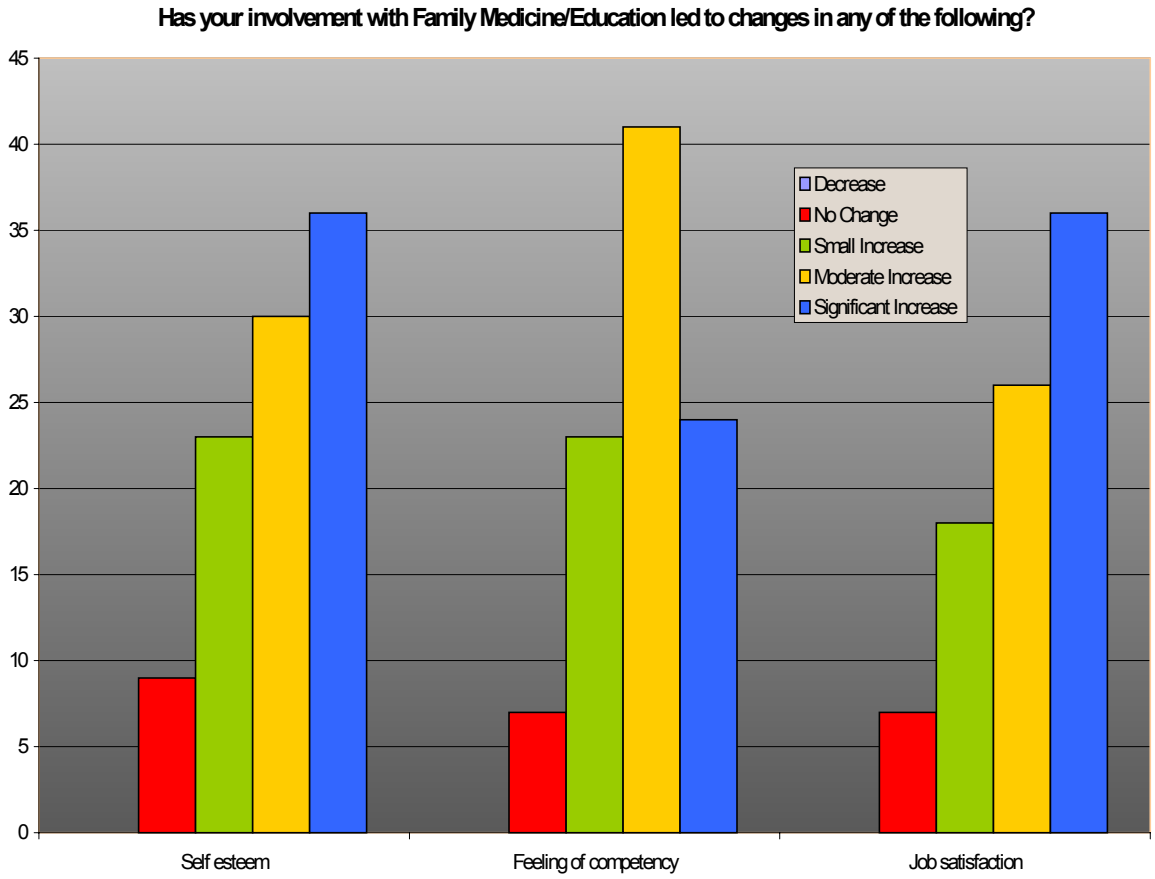
Appendix B

Empowerment Framework Matrix

Project Activity	Welfare		Access to Resources		Critical Awareness		Participation		Control and Ownership		Assumptions
	F	M	F	M	F	M	F	M	F	M	
Training of 52 Family Medicine Nurses in 11 Family Medicine Centres											Nurses are usually "assigned" to areas of work and do not apply for jobs. Pay and responsibilities for nurses generally the same regardless of gender.
Training of 43 Nursing Instructors in 8 Nursing School Programs											Nursing programs not all taught by nurses. "Professors" are physician-educators who teach "theory".

Question topic groupings	Welfare	Access	Awareness	Participation	Control
	- self esteem - competency - job satisfaction - income - working conditions - job access and new initiatives	- resources/ information - opportunities to attend workshops and conferences - public profile - writing	- awareness of regard from others - awareness of factors contributing to perceptions - self perception of career - analysis of professionalization needs	- Nurses Association membership - role as FMN - scope of practice participation – ideal vs real	- ability to initiate new ideas - control over job assignment - guidelines and standards - scope of practice with and without permission from physician

Appendix C



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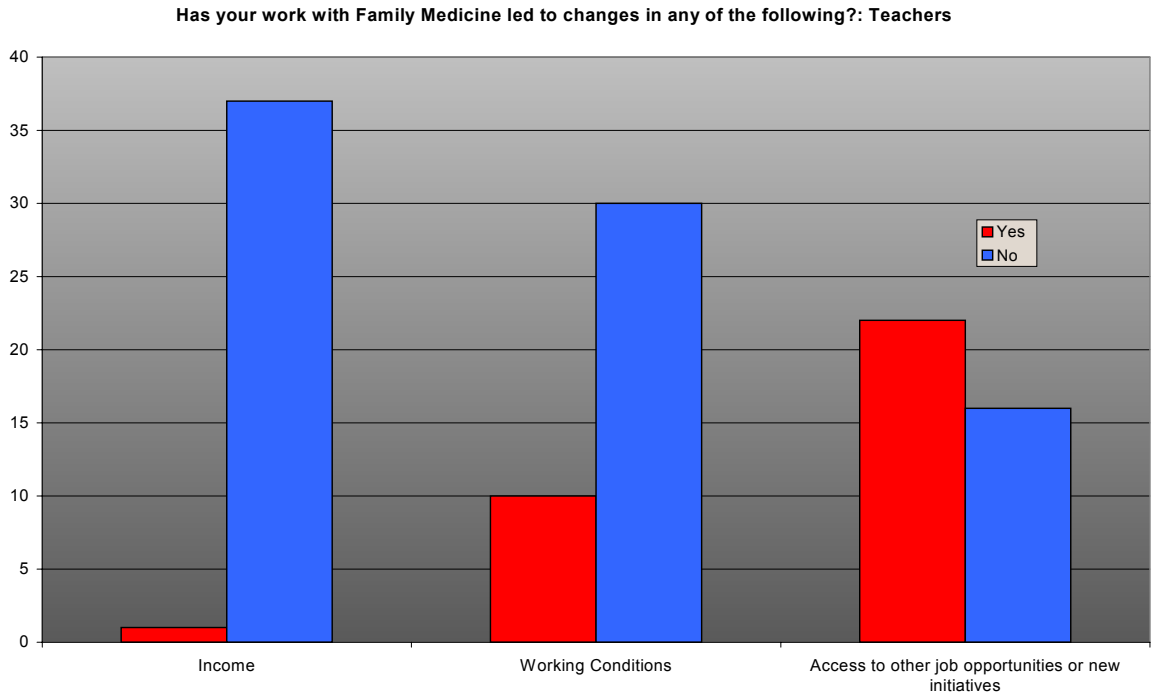
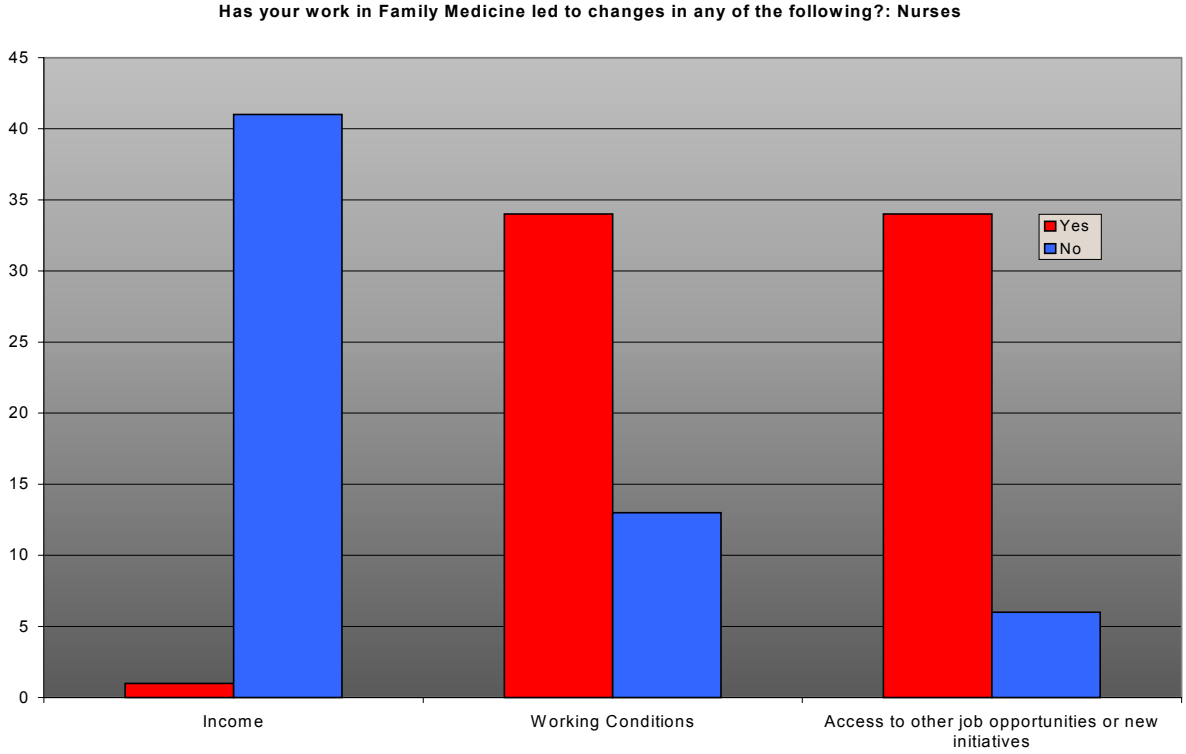
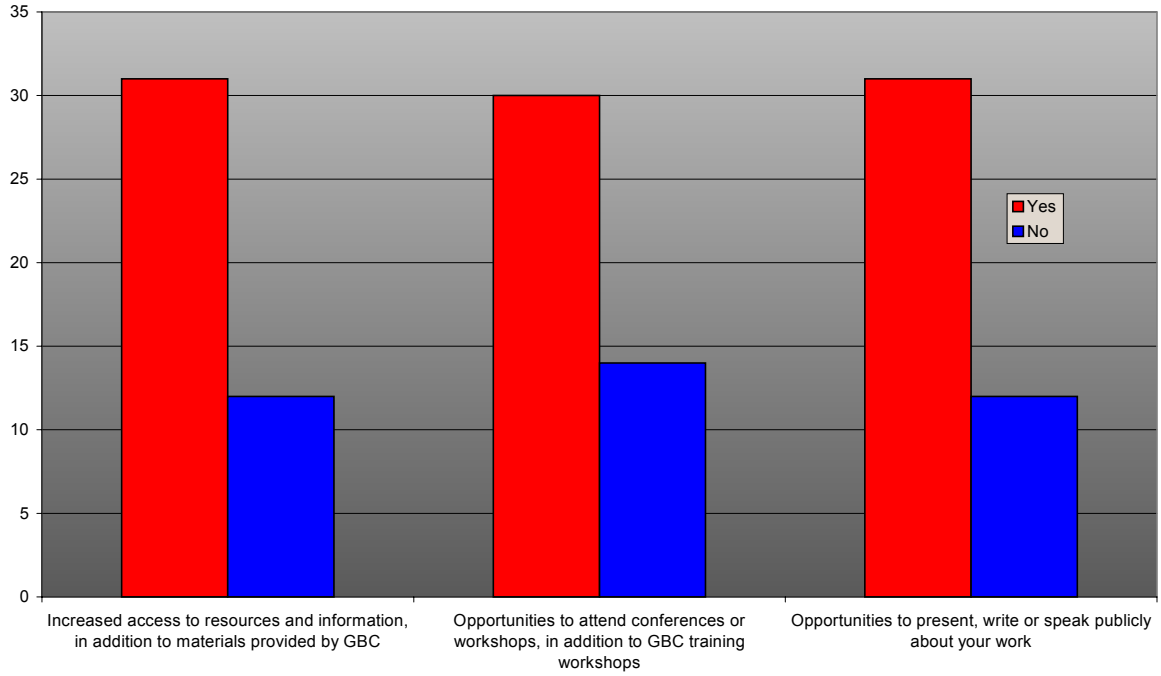
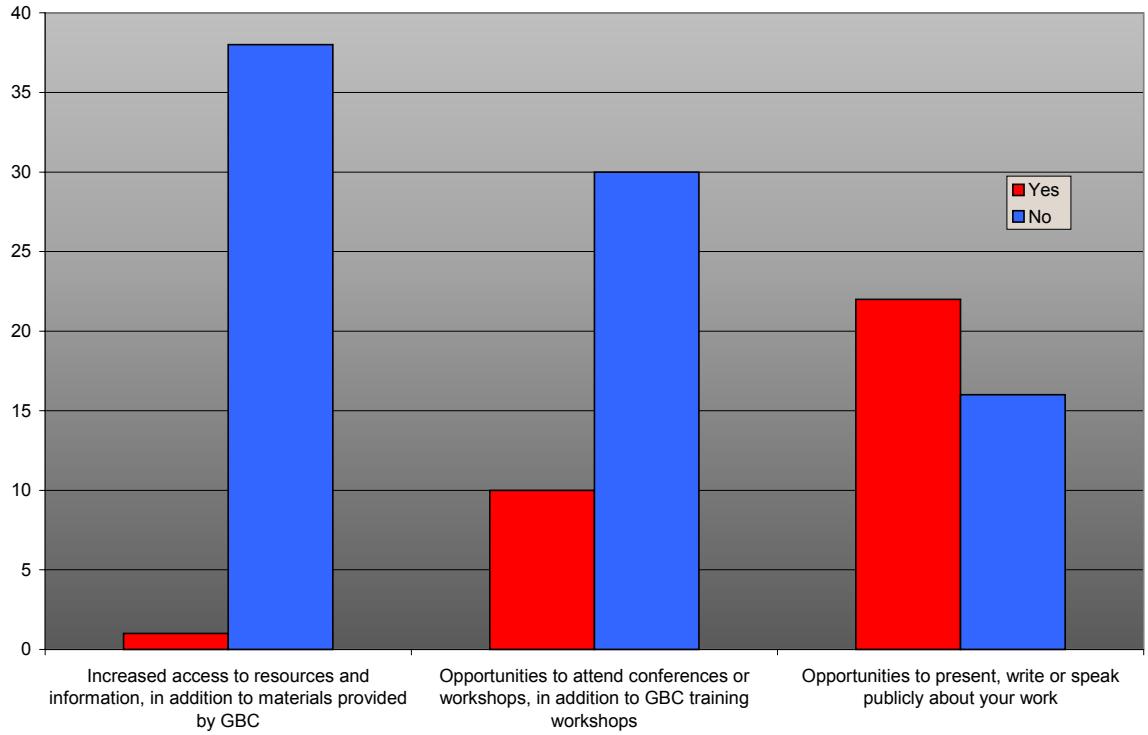

Has your work with Family Medicine led to changes in any of the following?: Teachers
40
35
30
25
20
15
10
5
0
Yes
No
Income
Working Conditions
Access to other job opportunities or new initiatives


Has your work in Family Medicine led to changes in any of the following?: Nurses
45
40
35
30
25
20
15
10
5
0
Yes
No
Income
Working Conditions
Access to other job opportunities or new initiatives

Has involvement in Family Medicine Training increased any of the following?: Nurses



Has your involvement in the development of Family Medicine Education led to any of the following?



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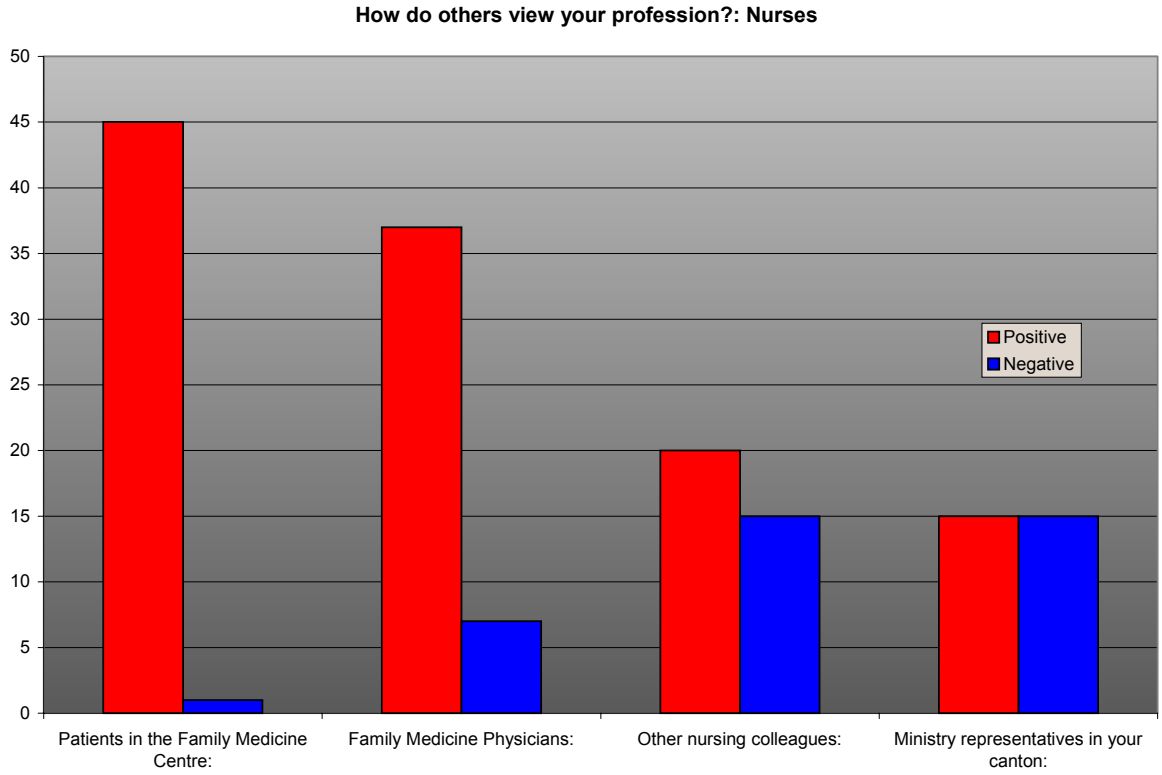

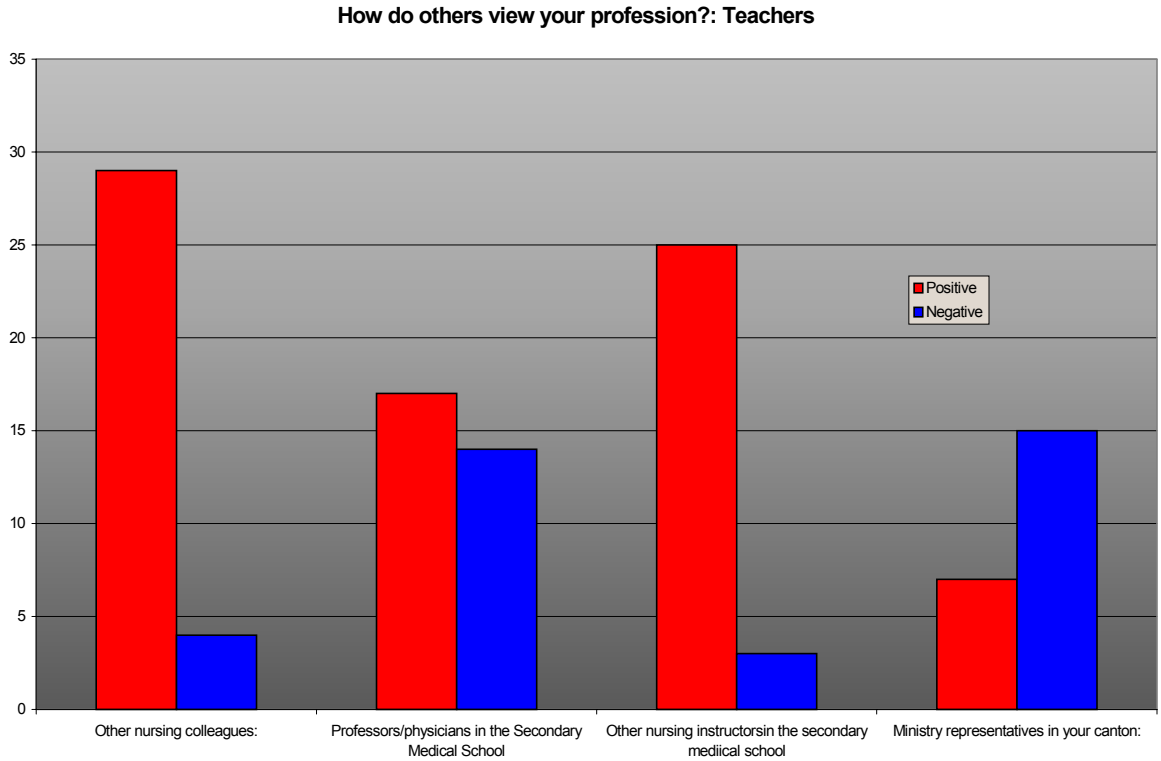

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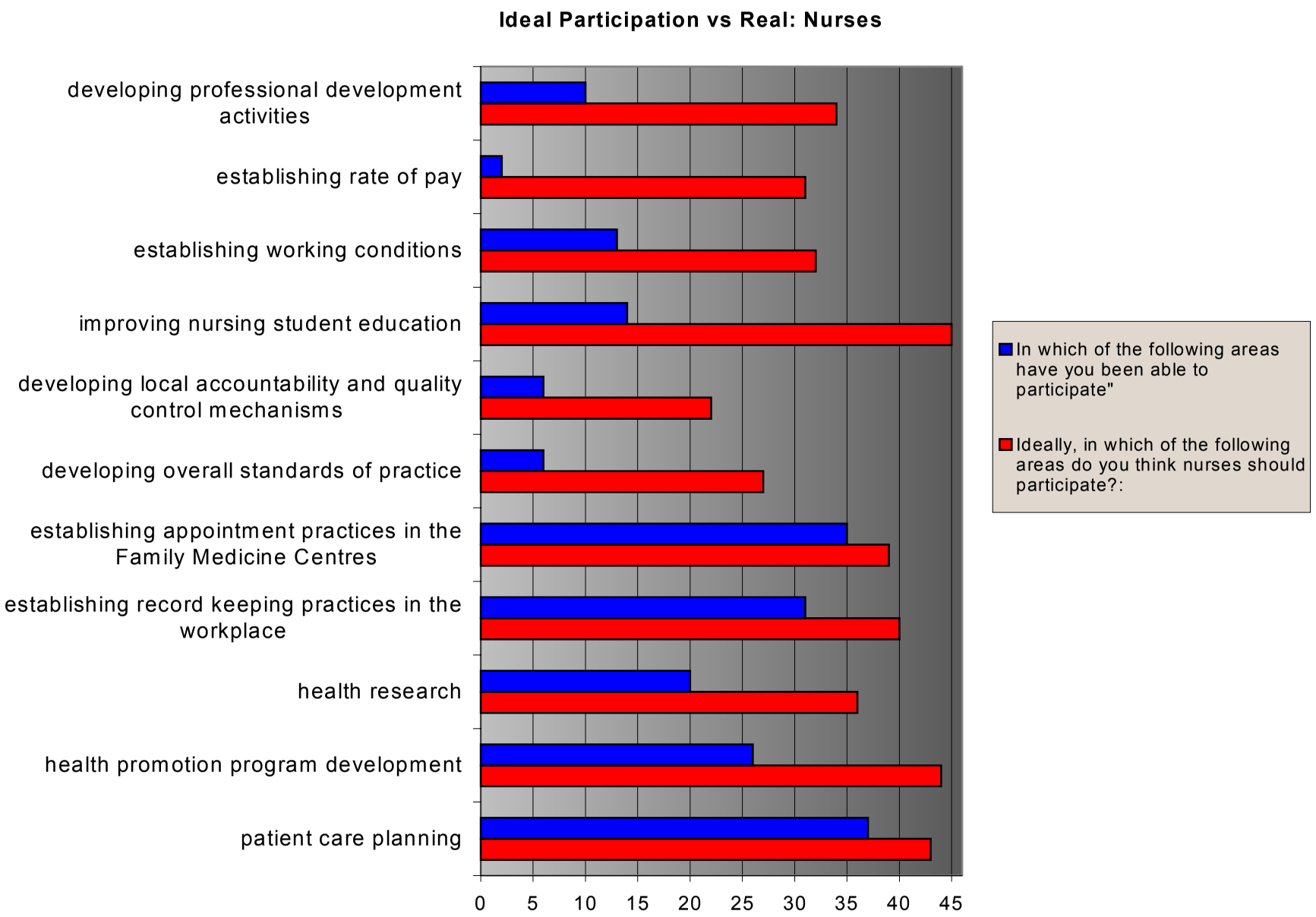

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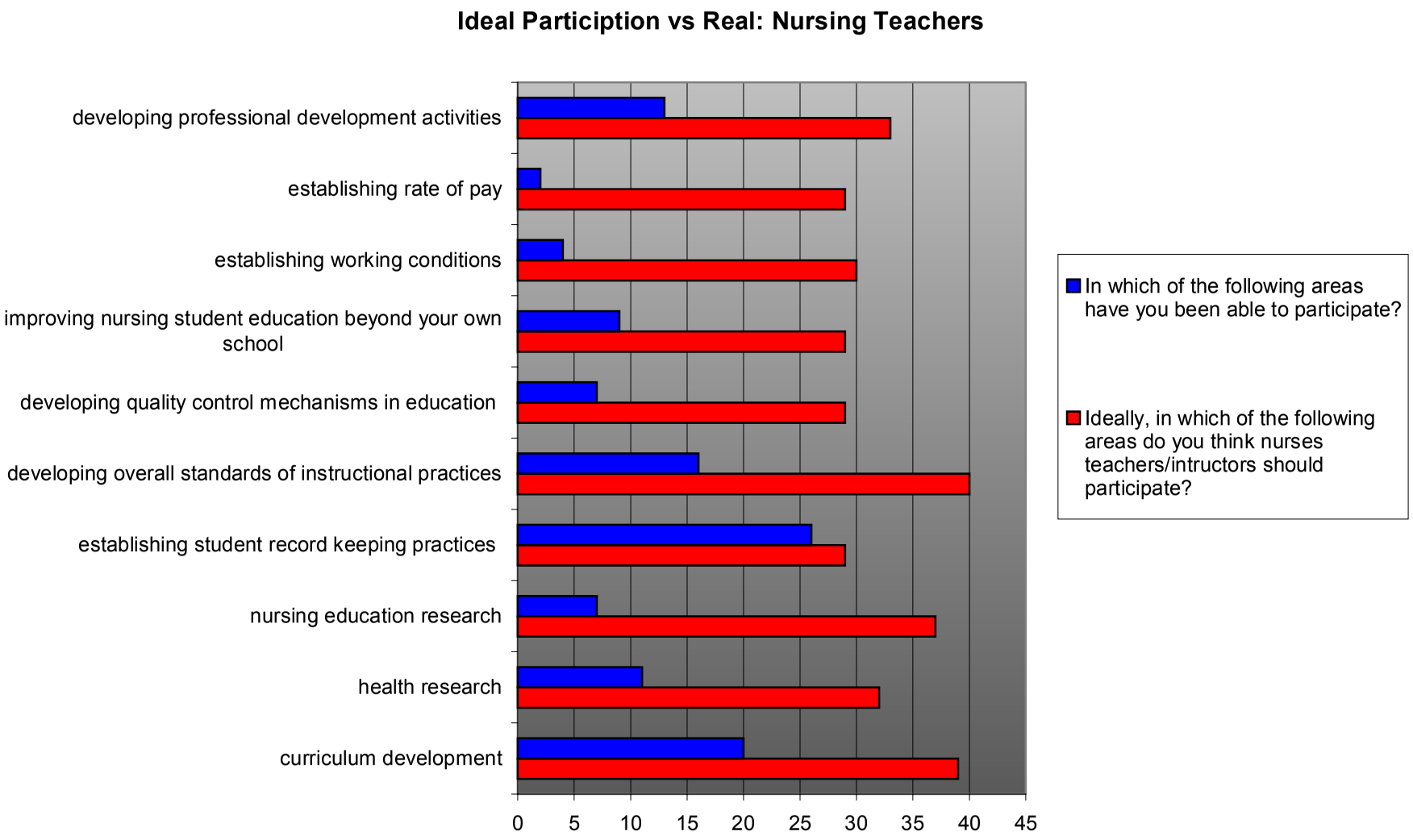

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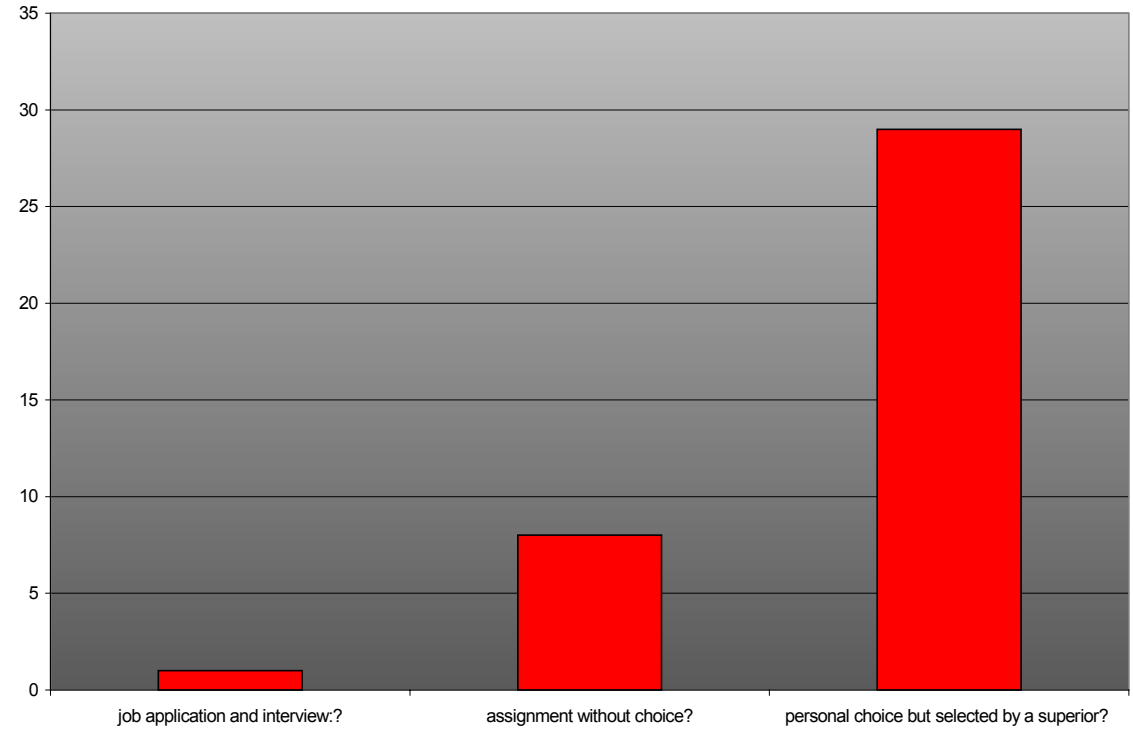
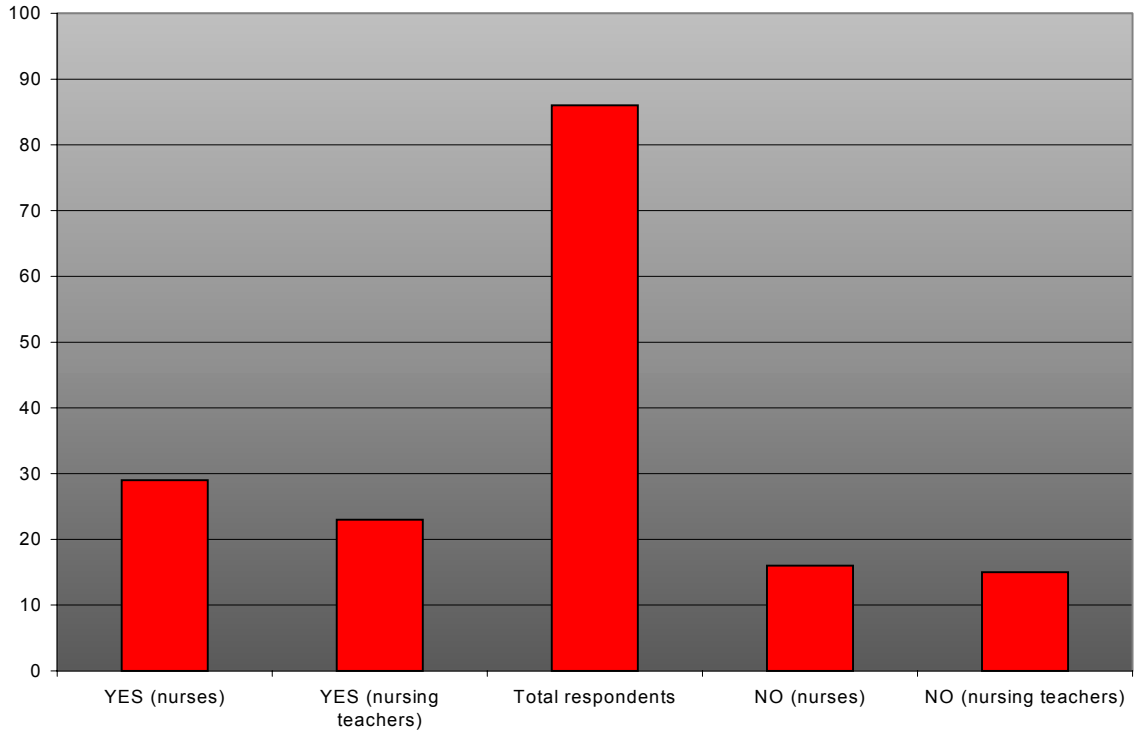
Under what circumstances did you become involved in Family Medicine Nursing?



Membership in Nursing Association(s)



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Appendix D

Summary of Responses

What is needed to increase the overall professional status of nursing?

Salary and working conditions

- we need to be stimulated by salary
- nurses should receive financial help for ongoing education
- improve our finances
- higher income = higher investment in health care
- better salary = more status
- merit should improve income
- to win status we should get paid adequately for work
- increase respect and salary, value the work of nurses and award work well done in order for nurses to obtain higher status
- remove people from management who are unable to do their job
- work conditions should improve
- need more material resources in workplace
- better material circumstances and conditions in health care institutions

Educational opportunities for nurses

- each and every nurse should refresh her knowledge and follow-up on world events in nursing
- nurses should be able to visit other institutions
- Nurses should be participants in the creation of work programs and health education programs
- we should participate in developing our own standards and regulations regarding their implementation
- we need options to improve our knowledge
- we need a nursing faculty (college)

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- all nurses should have access to education (not just Family Medicine nurses)
- education is very necessary
- primary, secondary and teriary level nurses have to be respected and involved
- better nursing education
- need better quality programs
- nurses need more professional experiences and opportunities
- better education is needed to achieve higher status
- we need education programs to be ongoing
- we should increase nursing theory classes and decrease medical theory taught by doctors in nursing programs
- professional nursing requires the availability of higher education
- more current nursing literature should be available in Bosnian languages
- nurses should be engaged in writing books e
- education should be continuous (mentioned several time)
- nursing programs need to be modernized
- nursing teachers need more significant role in education (less doctors)
- need to change the nursing curriculum
- review and improve programs in schools, need to exclude some subjects

<u>Improved organization and role of the Nursing Association</u>

- change should take place at the ministry level but we can do a lot by forming our own association
- we should organize our Nurses Association differently than it is now
- we should choose our leaders in nursing by election and evaluation of their
- nursing leaders should not be appointed based on political suitability
- the Association should participate in the development of regulations and standards

- it should educate us and give us news about nursing in the world and at home
- Nurses Association should get some financial help
- the association should invite more active participation
- we need strong representation by Association in government
- we should organise our Association to be strong so that nurses can work *through* it to realize and fulfill obligations
- nurses need to be more involved in the political environment
- greater membership and improved organization would make the Nurse's Association stronger

Portrayal and perception of nursing

- must recognize nursing as a separate branch of health care
- the nurses role should demonstrate a significant increase in prevention and health promotion activities
- overall awareness of the nursing profession should be increased (media campaign?)
- need to increase consciousness and knowledge of nurses (themselves) about their role
- nurses should be convinced to fight for workplace rights
- need big changes in thinking along with changes in the health care system
- the development of health promotion programs would enlighten patients about health issues and about nursing work
- more perseverance among nurses is needed
- nursing management (head nurses) need to change awareness and not allow us to be servants to doctors
- need to change thinking about nursing among people with state power
- need to educate doctors about work of nurses
- the community nurse should have a greater role – health promotion
- must change the mentality of system and doctors
- nurses should get united on an international level

- nurses status in health facilities should be improved
- regard and respect nurse wherever she works treat her as professional
- we need more respect

Relationship with Ministries

- real health care reform should truly be implemented on all levels
- ministry needs to realize their role in solving the problem of nursing status
- need better consultation with nurses
- reform of health care should be properly adopted on a state level and include nursing input from our (elected) representatives
- nursing profession should not be interfered with by politicians making decisions for only a select few
- need total change in the whole organization (structure) of nursing in order to elevate the level of nursing
- need a coup d'état or something similar
- there should be changes in our working agreements and changes in MOH
- need to improve the health care laws which limit nurses professionally
- change the law
- change the schools
- change our work
- need to create better cooperation and communication with MOH and MOE
- we need participate in developing quality control and self regulation of nursing work
- nurses need to be involved in all levels of state power
- nurses need proper job description and standards
- educate the executives and politicians and we'll do the rest ourselves