Educating nurses for implementation of the European Programme of Work 2

Margrieta Langins
Nursing and Midwifery Policy Advisor

Health Workforce and Service Delivery Unit
Division of Country Health Policies and Systems
WHO Regional Office for Europe
Marmorvej 51, DK – 2100 Copenhagen O, Denmark

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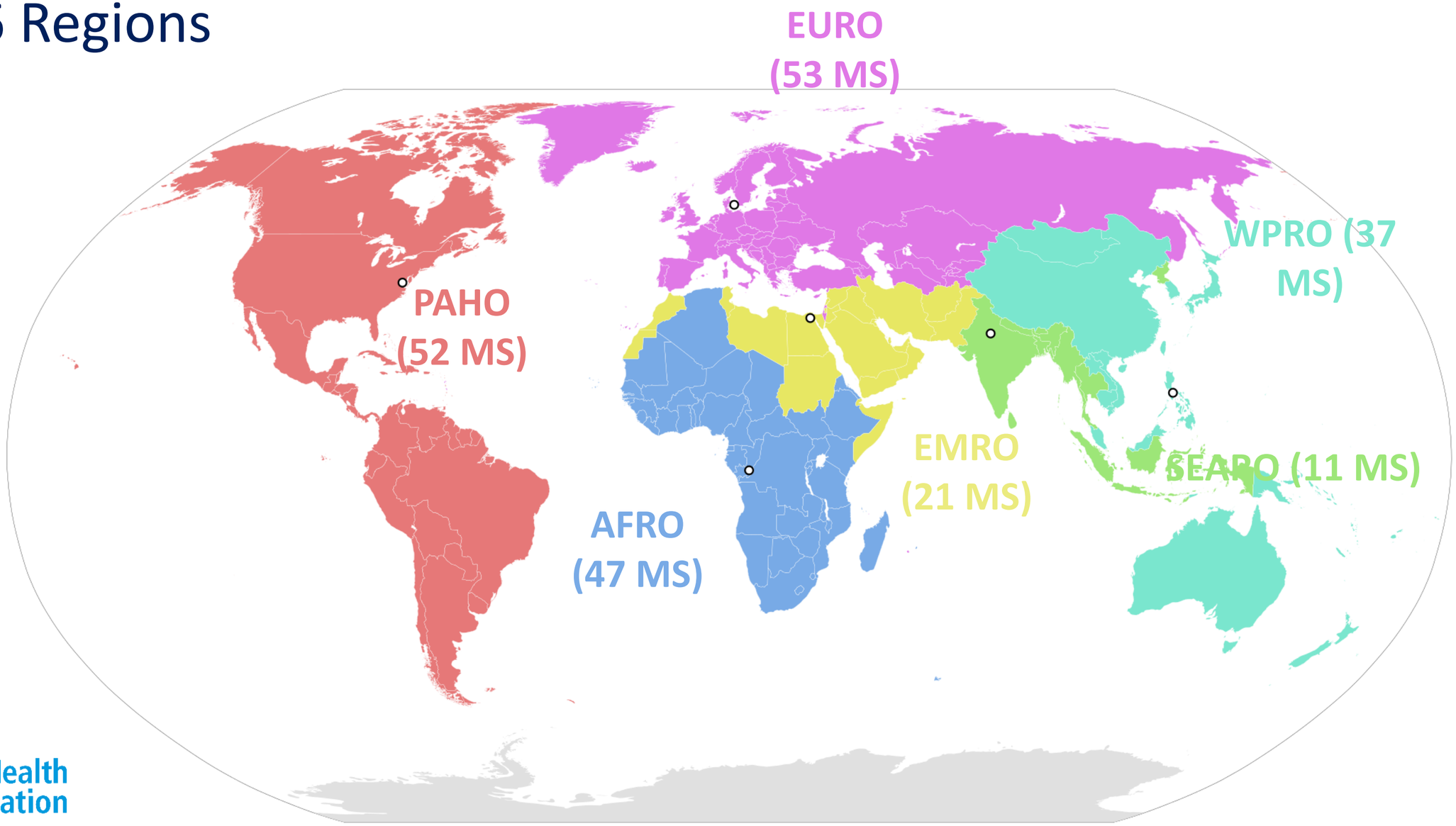
WHO’s 6 Regions



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WHO Regional Office for EUROPE

17 time zones,
4 official languages

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REGIONAL OFFICE FOR Europe

European health report 2024

Keeping health high on the agenda

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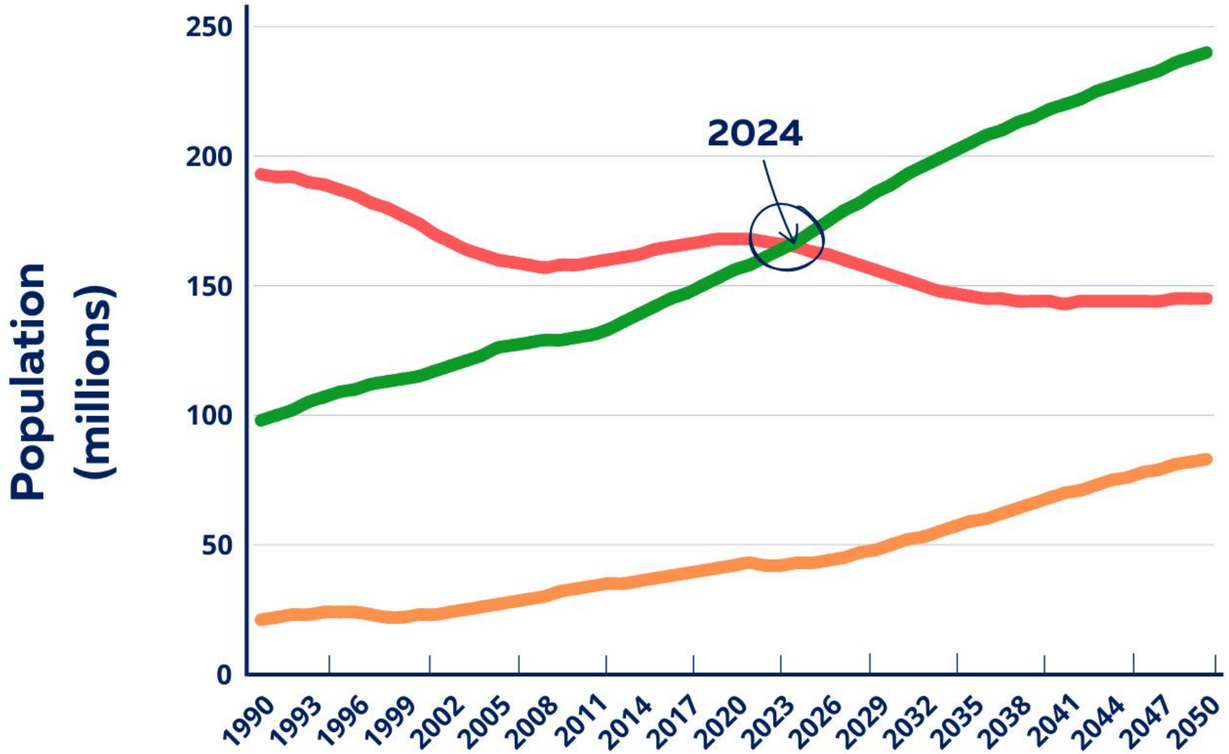
Population ageing has been accelerating in the WHO European Region, and fertility rates are going down….



Population by age groups from 1990 to 2050
Source: World Population Prospects 2022 (UN DESA (2022).

Population <15 years

Population 65+ years

Population 80+ years

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Decade of healthy ageing

75 HEALTH FOR ALL

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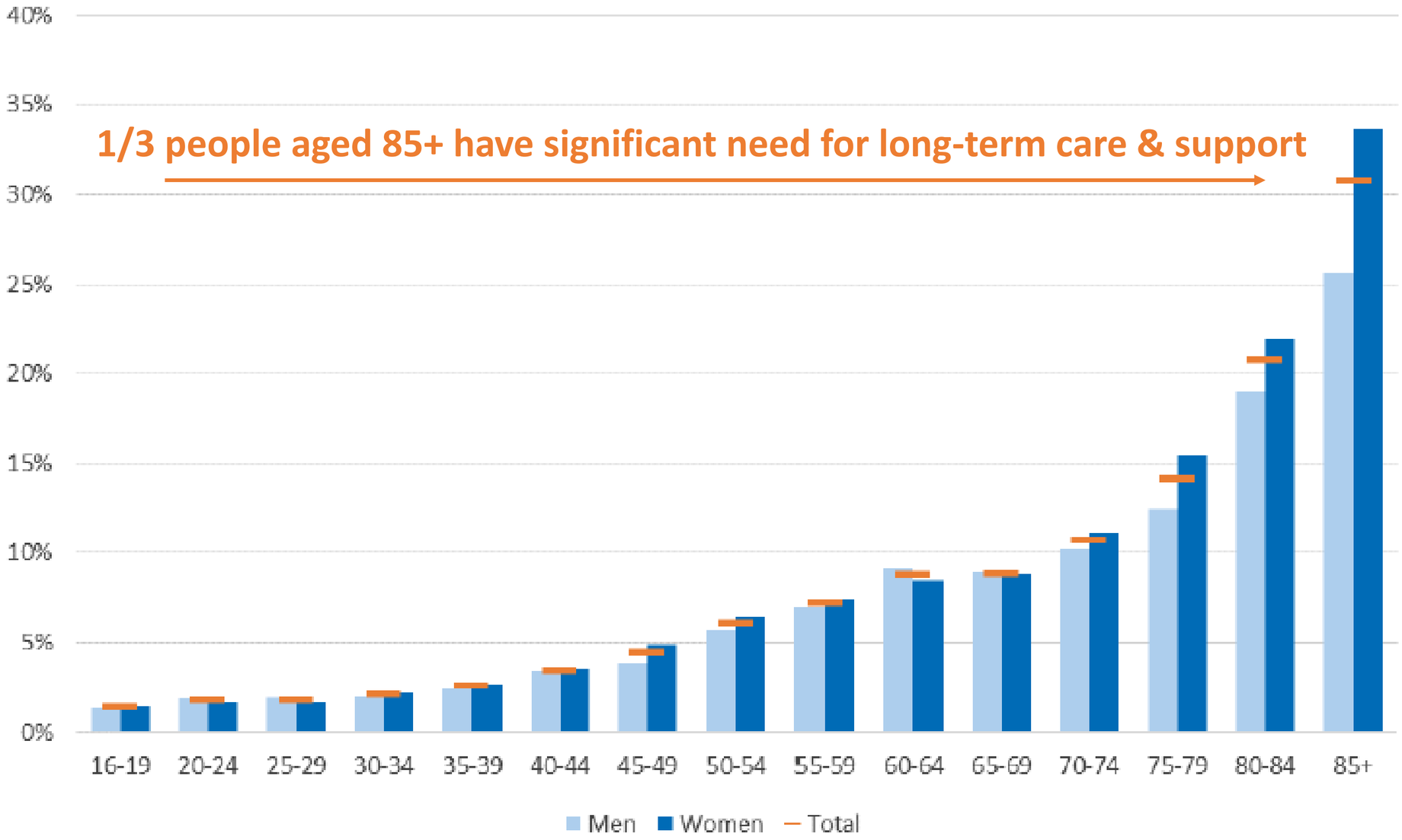
Considerably higher care needs with progressive (unhealthy) ageing of older population



Share of the EU-28 by age group population reporting a severe level of activity limitation (GALI)
EU-SILC 2019

European health report 2024

nearly

50%

of older people with severe self-care difficulties do not get the help they need

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Child mortality

76 000 children in the Region **die before their 5th birthday.**

There is a **21-fold difference** between Member States in child mortality.

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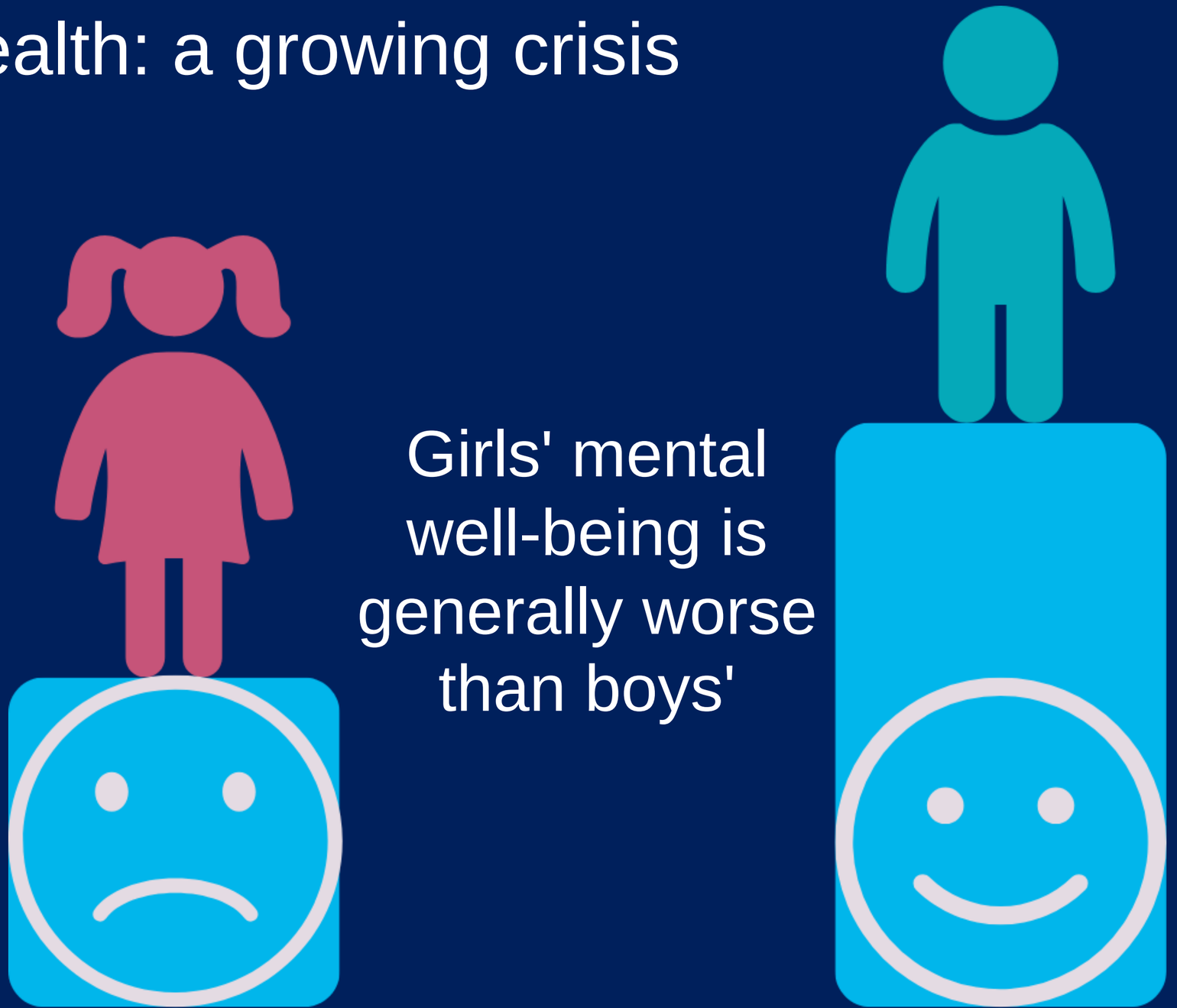
Mental health: a growing crisis



Girls' mental well-being is generally worse than boys'

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1 in 4 women and girls
experience violence in their lifetime.
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Suicide:

leading cause of death among young people.

Men are **4 times** more affected than women.

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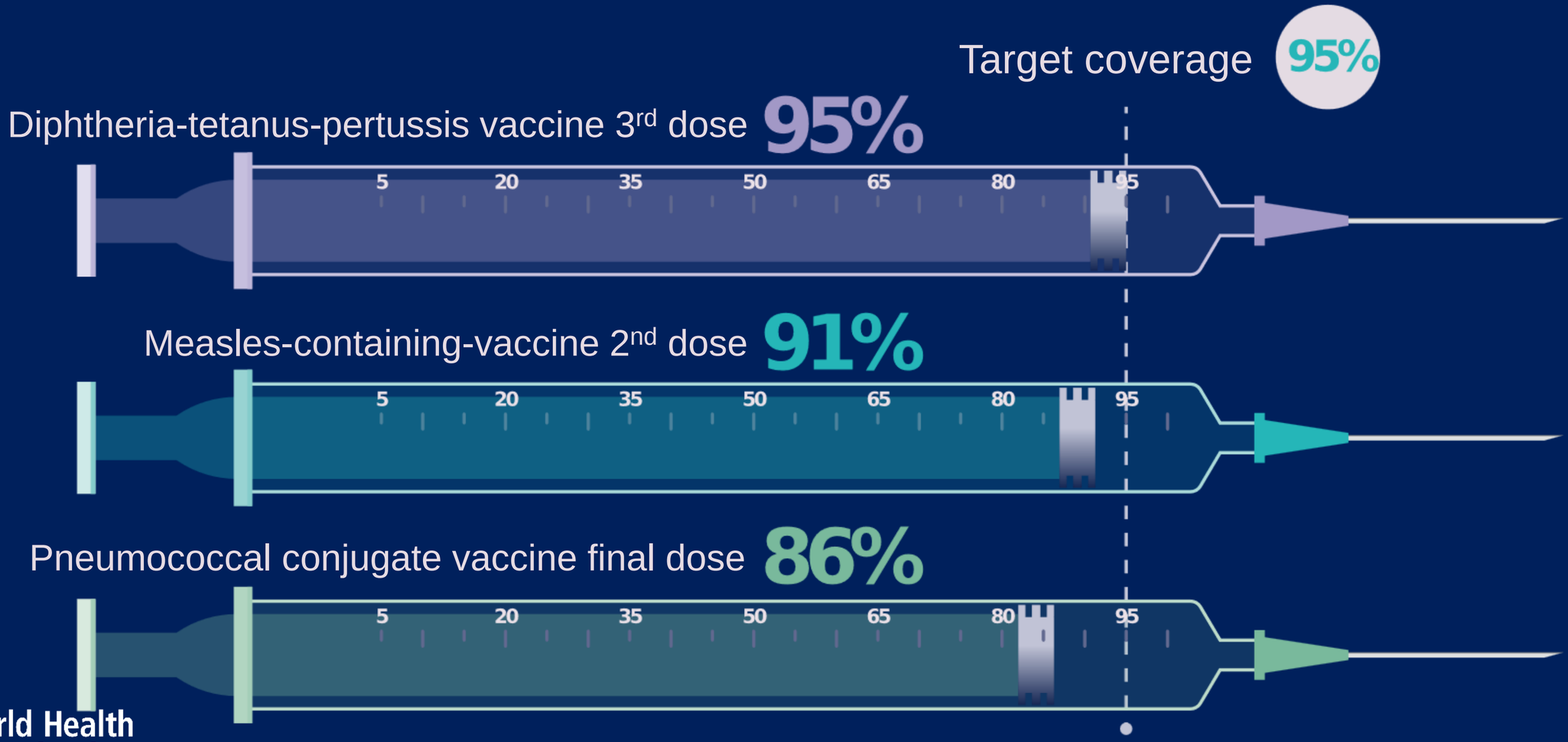
Gaps in vaccination coverage



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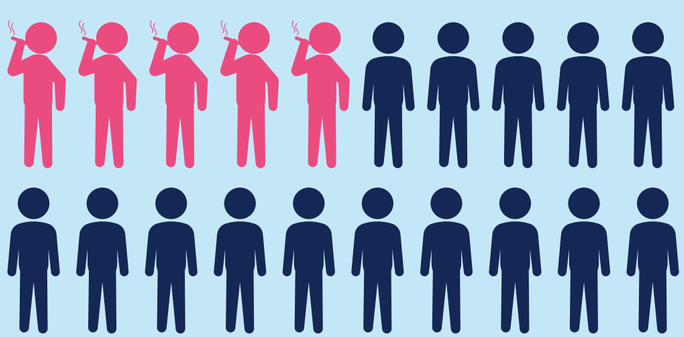
Risk factors contributing to NCDs



25.3%

of people in the region are **tobacco users**

1 in 6 people in the Region

die before the age of 70

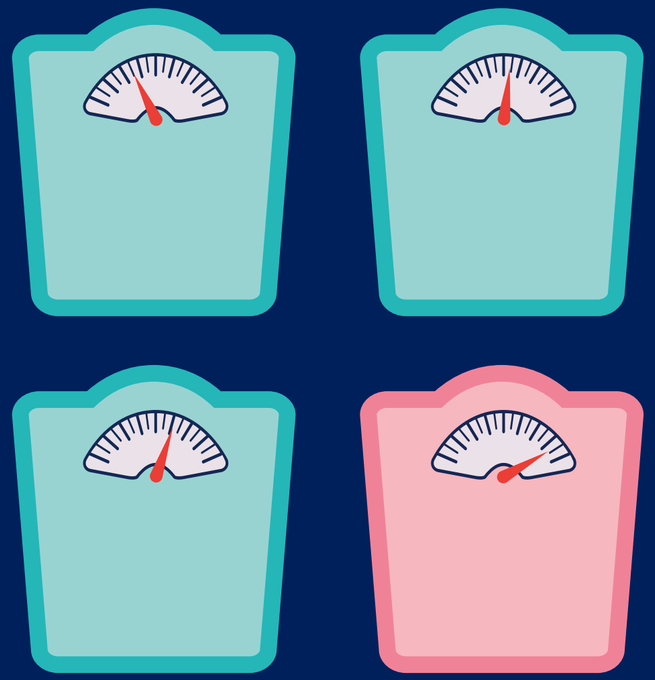
from 4 major **NCDs**

World's highest **alcohol intake**

8.8 litres

of pure alcohol per adult per year

European Region



Obesity

affects nearly **25%** of adults

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The European Programme of Work 2026-2030

World Health Organization
European Region

Regional Committee for Europe
75th session

Copenhagen, Denmark, 28–30 October 2025

EUR/RC75/22
Provisional agenda item 3

10 October 2025 | 250514

ORIGINAL: ENGLISH

Second European Programme of Work, 2026–2030 – "United Action for Better Health"

The Second European Programme of Work, 2026–2030 – "United Action for Better Health" (EPW2) is submitted for adoption by the WHO Regional Committee for Europe at its 75th session, following the recommendation of the Thirty-second Standing Committee of the Regional Committee for Europe.

EPW2 was developed through an iterative and participatory process. It included five public hearings, country and subregional consultations, a foresight exercise, regular meetings with Member State focal points and two rounds of feedback on written drafts from Member States.

EPW2 builds on the first European Programme of Work, 2020–2025 – "United Action for Better Health" (EPW) and on global and regional commitments, including WHO's Fourteenth General Programme of Work, 2025–2028 and the Sustainable Development Goals. It is ambitious in scope, specific in its commitments and strategic in responding to tighter resources.

EPW2 is composed of three parts:

- The health compass: a shared vision and collective agenda for health in the WHO European Region.
- WHO/Europe's programme of work: a focused set of priorities and actions that the WHO Regional Office for Europe (WHO/Europe) will deliver with and for Member States between 2026 and 2030.
- Organizational shifts in WHO/Europe: adaptation of structures and ways of working to strengthen performance, ensure accountability, and uphold the highest standards of technical and scientific excellence amidst resource constraints.

EPW2 provides the framework for united action by Member States, partners and WHO/Europe to advance health in the Region over the period 2026–2030.

One document, triple purpose

WHY? Health Compass
Chapter 1

WHAT? Programme of Work
Chapter 2

HOW? Future-proofing WHO/Europe
Chapter 3

5 Priorities and 2 Special Initiatives of EPW2

Maximizing health security

01

02

Tackling NCDs, mental health and drivers of ill health

Special Initiative 1: Violence against women

05

Health systems of the Future

Living and ageing in good health

03

04

Driving climate action

Special Initiative 2: Cross-cutting PHC

leadership – intersectoral action – social participation – trust in science - innovation

Framework for action on the health and care workforce in the WHO European Region 2023–2030

Adopted by 53 Member States at WHO Regional Committee for Europe 73, October 2023, Astana

INVEST

- Increase public investment and optimise use of funds
- Make the economic and social case for investing in the health and care workforce

BUILD SUPPLY

- Modernise education and training
- Strengthen continuous professional development
- Build digital health competencies

RETAIN & RECRUIT

- Improve working conditions and ensure fair remuneration
- Safeguard health and well-being
- Ensure policies that address gender inequality and have zero tolerance for abuse and violence
- Attract young students
- Recruit and retain in rural and underserved areas
- Address outmigration; ethical recruitment

OPTIMIZE PERFORMANCE

- Redefine teams and skill mix
- Improve interactions with patients
- Promote appropriate use of digital technologies
- Reconfigure services to be more efficient

PLAN

- Plan and forecast needs
- Adopt intersectoral planning approach
- Strengthen capacity of HRH units
- Regulate education, service delivery and professions
- Strengthen HRH information systems

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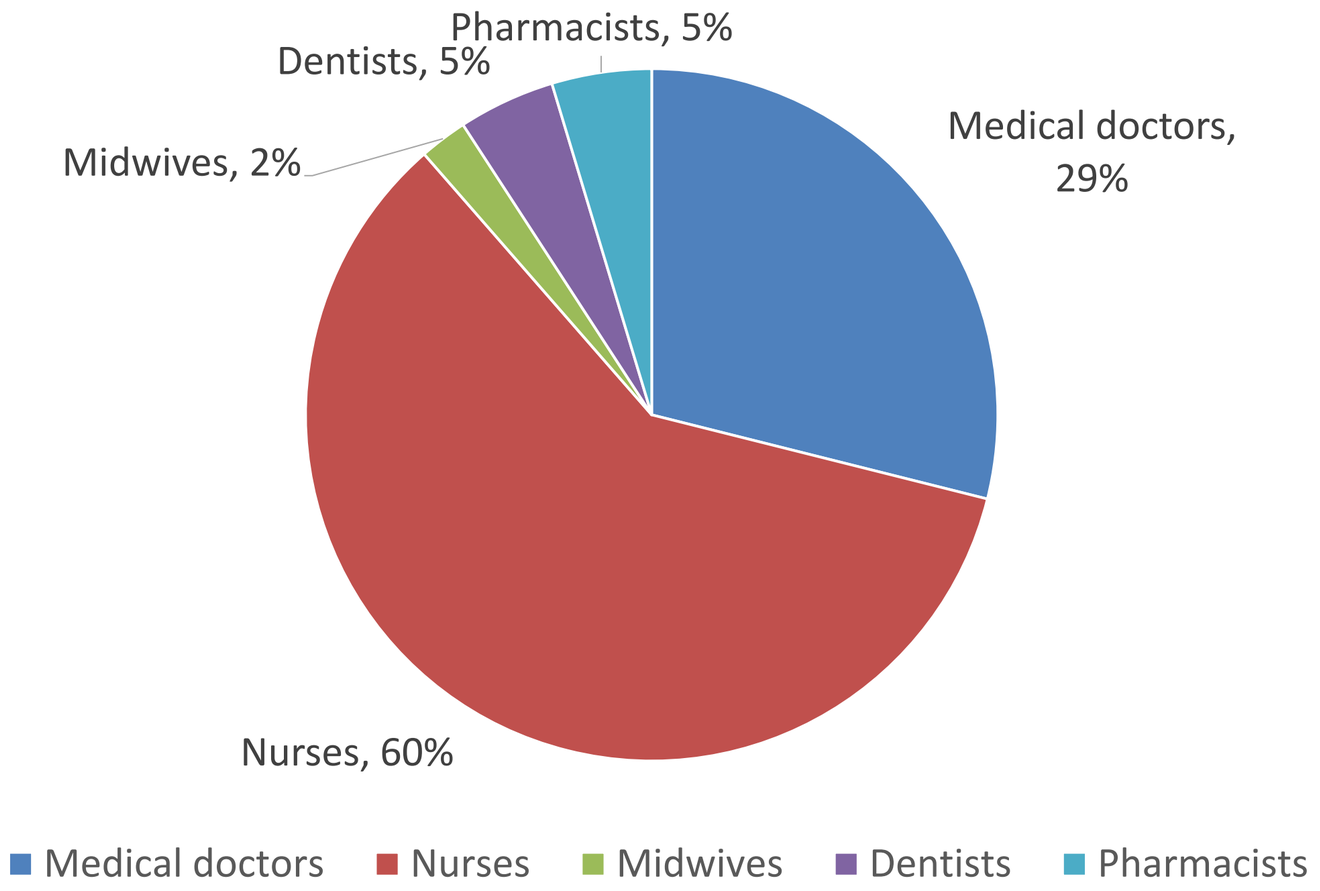
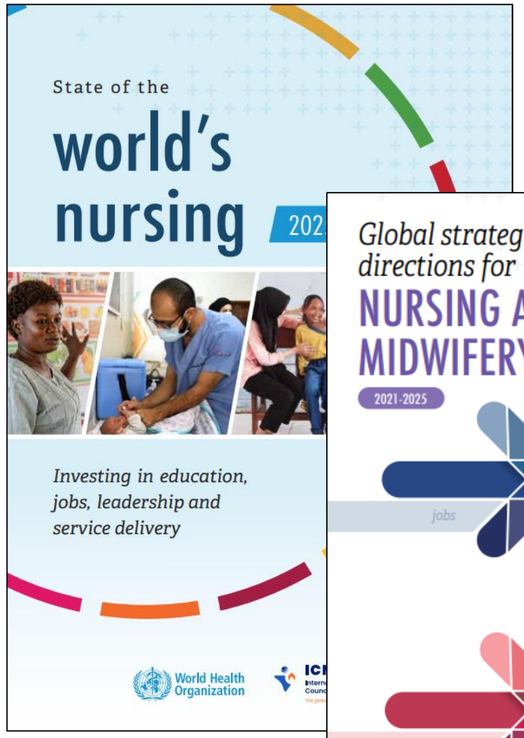
Share of health workers in the European Region

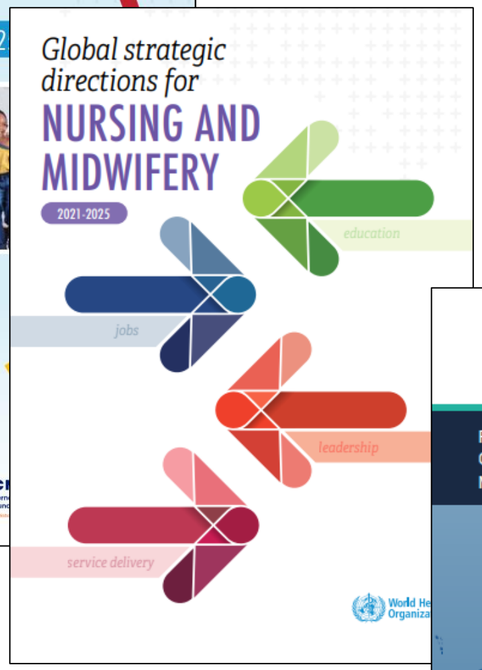


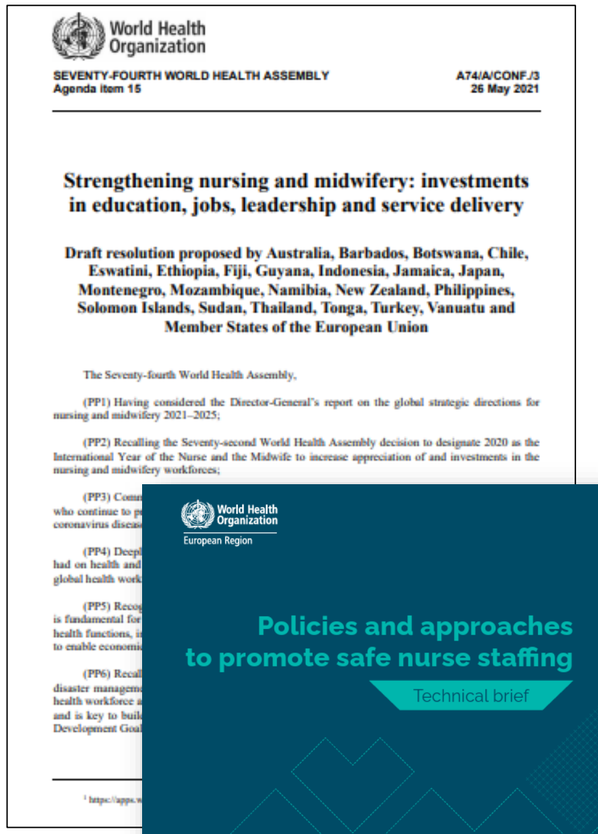
World Health Organization
European Region

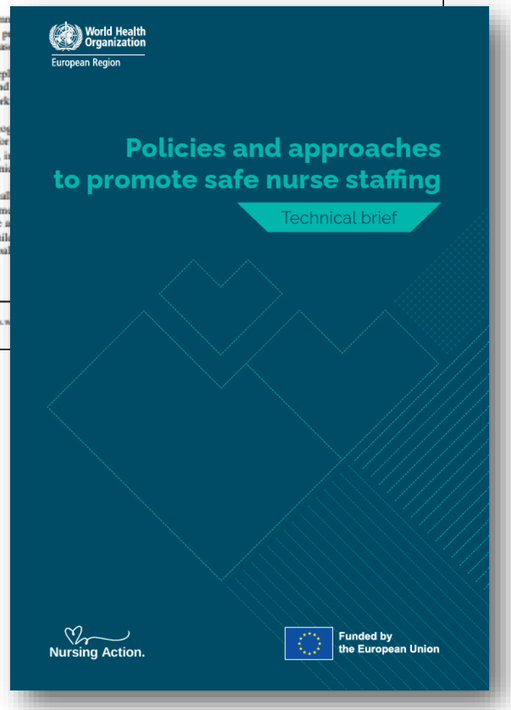
Global strategic directions for Strengthening Nursing and Midwifery

WHA Resolution 74.15- renewed!









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Aims of the Nursing Action

Nursing Action.

RETAIN NURSES.

Commit to and invest in our existing workforce to stem the number of nurses leaving the profession.

RECRUIT NURSES.

Focus policy and mobilize efforts to make nursing an attractive profession, ensuring a workforce that can meet future demands.

Funded by
the European Union

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Countries participating in the Nursing Action

Nursing Action.

21

Estonia	Bulgaria	Norway
Latvia	Cyprus	Spain
Lithuania	Malta	Netherlands
Finland	Ireland	Czechia
Poland	Greece	Hungary
Slovenia	Italy	
France	Portugal	
Sweden	Romania	

Funded by
the European Union

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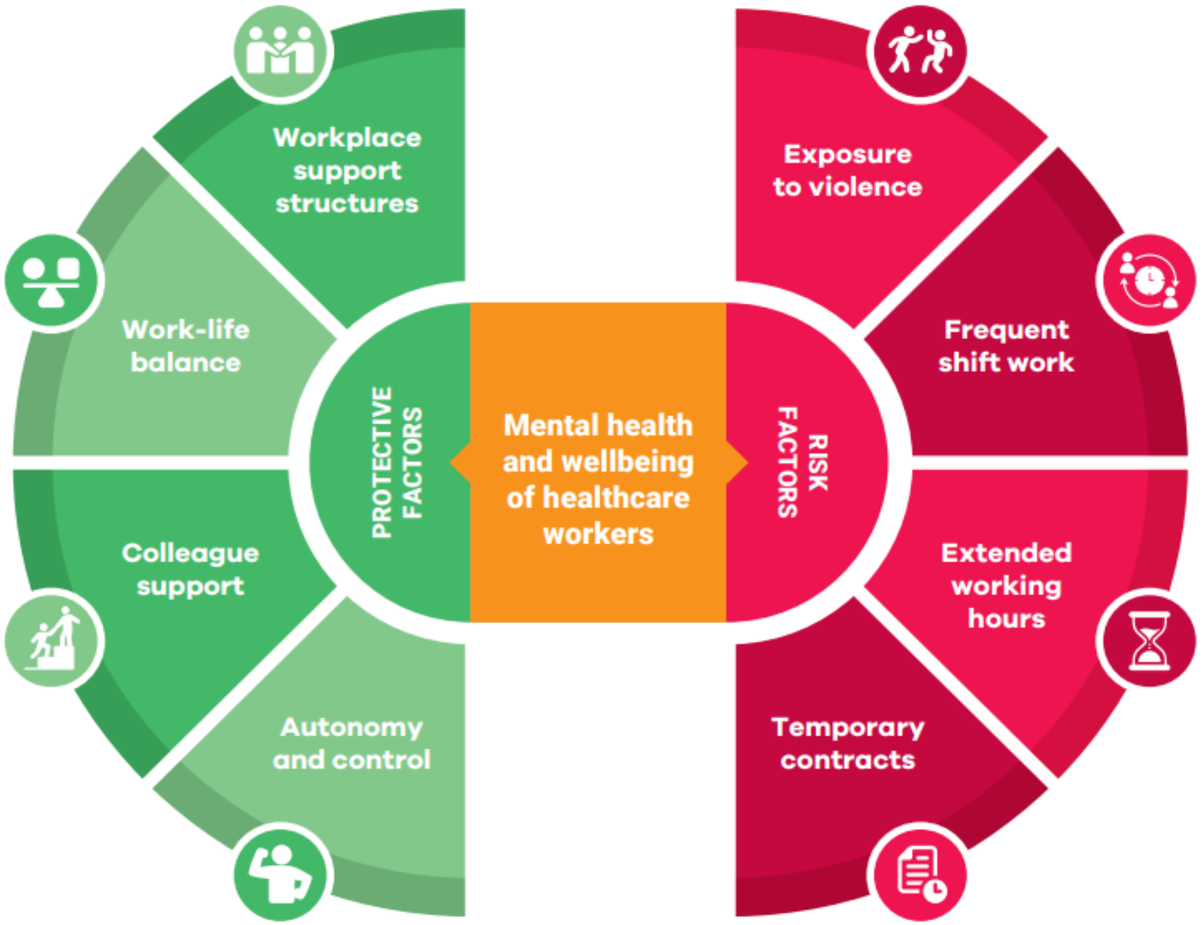
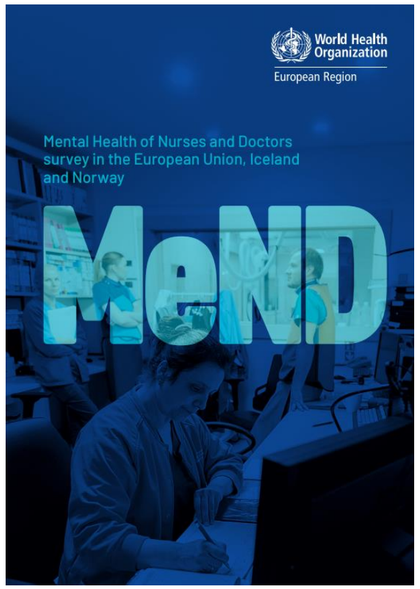
Mental Health of the Health Workforce

- One in three doctors and nurses report symptoms of depression or anxiety.
- Three per cent report signs of probable alcohol dependence.
- Doctors and nurses are five times as likely as the general population to experience symptoms of depression (32% vs 6%)
- Over 10% of doctors and nurses report thoughts of ending their life or harming themselves





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Nursing in the driver’s seat

The burden of unsafe care: What does it cost us?

- The occurrence of adverse events due to unsafe care is one of the 10 leading causes of death and disability globally.
- One in every 10 patients is harmed while receiving hospital care.
- As many as 4 in 10 patients are harmed in primary and outpatient healthcare.
- 134 million adverse events occur in hospitals in low- and middle-income countries (LMICs), resulting in 2.6 million deaths.
- The direct cost of treating patients who have been harmed during their care approaches 13% of health spending.
- Excluding safety lapses that may not be preventable puts this figure at 8.7% of health expenditure.

https://www.who.int/publications/i/item/9789240032705

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Nurses improve access to quality and timeliness of care

Personalize care

- ✓ Develop care plans
- ✓ Bridge clinical and social care knowledge (social determinants of health)

Expand care

- ✓ increase opportunities for prevention
- ✓ Increase moments for assessment and management
- ✓ Engage new services as needed
- ✓ Deliver care in non conventional settings – home, community

Connect care

- ✓ Care coordination
- ✓ Networking and connecting services to each other
- ✓ Steer multidisciplinary teams around patient

Secure care

- ✓ Implement care plans
- ✓ Monitor patients
- ✓ Identify and communicate gaps
- ✓ Training and managing nursing assistants

Why this Matters

Primary care teams increasingly rely on nurses– but education and pathways lag behind.

Nurses roles in primary care (examples)

- Triage and episodic care
- Chronic disease prevention/management
- Mental health and substance use support
- Health education, self-management, navigation
- Care coordination across services and settings

What the evidence suggests

- Nurses are a core part of team-based primary care in many jurisdictions.
- Team-based models that include nurses can improve access and continuity of care.
- Primary care nurses roles are underused when preparation, role clarity, and supports are missing.

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Key Message: make primary care visible, legitimate, and assessable across the undergraduate programmes—not as an “add-on.”

What gets in the way?

4 bottlenecks show up repeatedly—across undergraduate and postgraduate education.

Curriculum Misalignment

- Acute-care dominated curricula
- Primary care concepts not explicit
- Competencies too general / uneven

Placement & preceptor shortage

- Limited primary care placements
- Few prepared preceptors/mentors
- Competition & space constraints

Access Barriers (Postgraduate)

- Time off & clinical workload
- Cost & lack of funding
- Availability, travel, tech access

Missing pathways & standards

- No national curriculum framework for primary care nursing
- Role ambiguity affects scope enactment
- Career pathways not well-defined

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Curriculum still “hospital-first”

Problem Signals

- Primary care-specific content is often not prioritized in undergraduate curricula.
- Primary care competencies are integrated inconsistently.
- Research/QI competencies are weaker than in hospital-based care.

Curriculum Development: “Design for Primary Care Everywhere”

- Thread primary care functions (first-contact, coordination, continuity, comprehensiveness) through existing courses.
- Use real primary care cases (navigation, multimorbidity, social need, mental health).
- Assess collaboration, patient advocacy, and care coordination – not just tasks.
- Map learning outcomes to an explicit primary care competency framework (local or national).

Key Message: “primary care competence” = decision-making + relationships + systems navigation + improvement skills.

Placement capacity

65.8% of surveyed undergraduate nursing programs reported a specific primary care clinical placement, but availability to all students unclear) (Lukewich et al. 2023)

Common barriers educators report

- Few primary care sites with capacity (space & workflow constraints).
- Limited pool of qualified/experienced nurse mentors/preceptors in primary care.
- Mentoring/perceptoring can reduce direct-care time and add cost pressure.
- Role models may be underutilized or working below full scope, limiting learning value.

Placement capacity levers

- Mentor development + recognition (micro-credential, honoraria, CPD credit)
- Shared supervision models (e.g., team precepting)
- Dedicated primary care placement blocks/capstone projects for interested students
- Academic–practice “placement pipeline” agreements tied to scope optimization

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Mentorship & transition support

Mentorship is not just “nice to have” – it serves as a bridge the education-to-practice gap in primary care.

What “good” mentorship looks like in primary care

- **Role clarity**: scope, expectations, and how the team uses nursing.
- **Progressive autonomy:** scaffolded clinic workflows (triage → panels → complex care).
- **Feedback loops:** short-cycle observation + coaching during real clinics.
- **Belonging:** integration into the interprofessional team (not “RN in isolation”).
- **Mentor support:** time protection + recognition + access to educator resources.

0–30 days

Orientation + shadowing + safety net (triage, documentation, referrals).

31–60 days

Supervised independent visits + panels (chronic disease, prevention, vaccines).

61–90 days

Complex care coordination + QI micro-project + team leadership behaviors.

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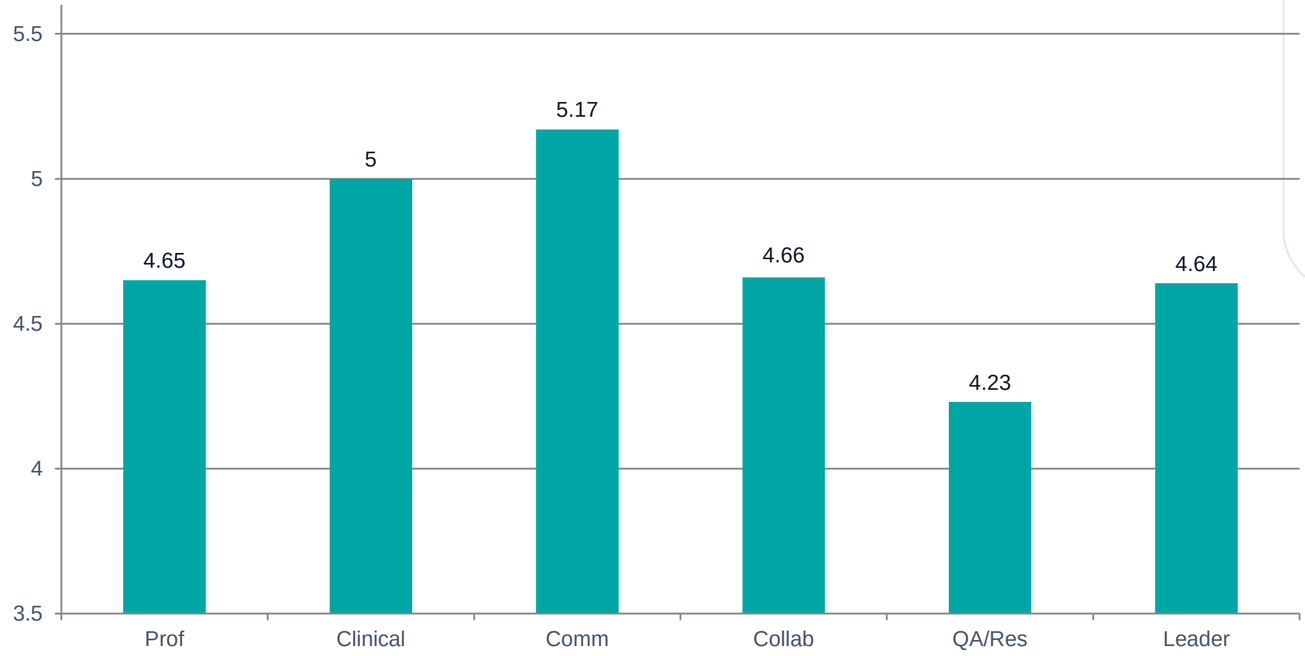
Building research & QI skills early

In a national survey of Canadian programs, “Quality Assurance, Evaluation & Research” had the lowest mean domain score.



Practical ways to build these skills

- Use “micro-QI” in every clinical course (run chart, PDSA, audit/feedback).
- Teach primary care performance indicators and panel management.
- Make evidence-to-action a required competency (brief appraisal → change proposal).
- Create student roles in practice-based research networks (PBRNs) or clinic QI teams.

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Lukewich, J. et al (2023) *Primary care nursing competencies in Canadian undergraduate nursing programs: A national cross-sectional survey*. **Nurse Education in Practice**, 71, 103738. https://doi.org/10.1016/j.nepr.2023.103738

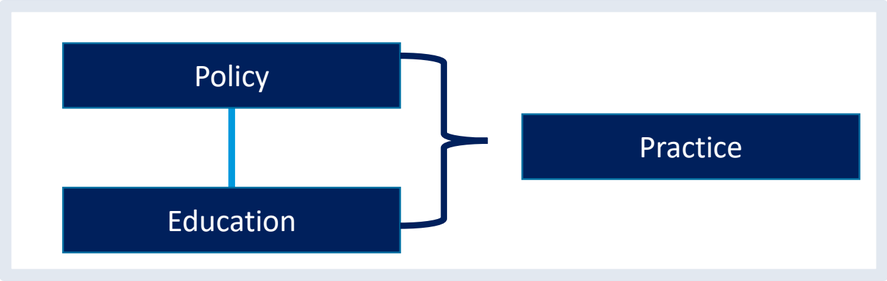
Faculty capacity & systems partnerships

If primary care is team-based, education has to reflect that team-based approach.

Faculty-facing challenges

- Limited faculty expertise or confidence in primary care content.
- Primary care often undervalued relative to acute care in curriculum decisions.
- Hard to sustain placements without long-term academic–practice agreements.
- Research & partnership work competes with teaching load and clinical service.

Systems-Level thinking necessary



- Joint appointments / practice educators embedded in PHC clinics
- Shared data infrastructure for student QI & research learning
- National or regional communities of practice for faculty & preceptors
- Partnerships with team-based primary care initiatives (training + evaluation)

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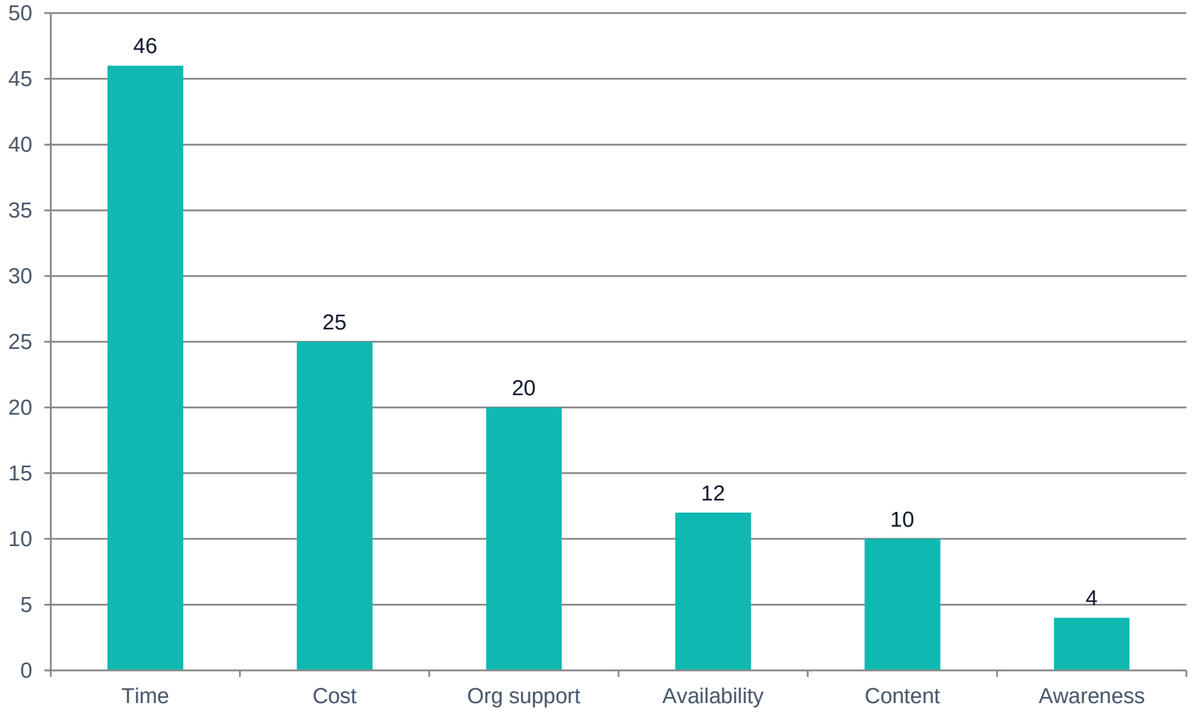
Postgraduate education: Access is the issue

Primary care nurses and administrators identified the following factors that influence participation (n = 63).



Programme design implications

- Offer asynchronous, modular learning with multiple start dates.
- Build employer supports: protected time & funding & backfill planning.
- Keep it role-specific (scope, PMH/team-based care, navigation, population health).
- Provide tech access and low-burden ways to demonstrate competence (badges).

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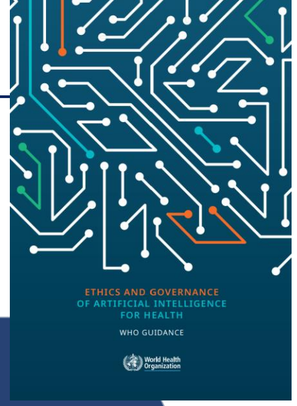
Lukewich et al (2024) *Canadian post-licensure education for primary care nurses addressing the Patient's Medical Home model and Canadian competencies for registered nurses in primary care: An environmental scan*. **Quality Advancement in Nursing Education – Avancées en formation infirmière**, 10(2), Article 8. https://doi.org/10.17483/2368-6669.1429

Digital + AI: risks and opportunities



Opportunities for Educators

- Simulation at scale: virtual patients, documentation, triage pathways
- Coaching: AI-assisted feedback on communication and clinical reasoning (with guardrails)
- Panel management & population health learning using real/realistic datasets
- Clinical decision support literacy: knowing when to trust, verify, or escalate

Challenges for Educators

- Privacy & data governance (Personal health information handling, vendor risk, consent)
- Bias, equity, and safety (who is harmed by errors?)
- Automation bias & accountability (documentation and clinical decisions)
- Academic integrity and assessment design in the era of generative AI

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World Health Organization (2021) *Ethics and governance of artificial intelligence for health*. Geneva: World Health Organization. ISBN 978-92-4-002920-0.

A Practical Action Set

1. **Make Primary Care Explicit –** Competency based learning outcomes
2. **Grow Placement Capacity –** Invest in mentor development and shared supervision models
3. **Standardise mentorship –** Structured transition supports and role clarity for new entrants
4. **Teach Research/QI and Embed in Practice –** Micro QI every term, data literacy and KPIs
5. **Prepare for Digital and AI –** Integrate ethics, bias and decision support literacy

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Thank You!

euronursingmidwifery@who.int

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