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**REPORT OF A  
WORKSHOP ON  
WOMEN IN HEALTH: NURSING LEADERSHIP  
FOR HEALTH AND DEVELOPMENT**

**MBABANE, SWAZILAND**

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## CONTENTS

|   | PAGE |
|---|------|
| 1. INTRODUCTION .....                                   | 1    |
| 2. OBJECTIVES .....                                     | 1    |
| 3. WORKSHOP PROCEEDINGS .....                           | 2    |
| 4. WORKSHOP THEMES: .....                               | 3    |
| THEME I - WOMEN AND DEVELOPMENT .....                   | 4    |
| THEME II - ACHIEVEMENTS AND CHALLENGES IN NURSING ..... | 8    |
| THEME III - VALUES/VISIONS .....                        | 12   |
| THEME IV - LEADERSHIP AND NURSING .....                 | 14   |
| THEME V - ANALYSES OF STRENGTHS AND WEAKNESSES .....    | 17   |
| 5. FUNCTIONAL GROUPS .....                              | 19   |
| 6. COUNTRY PLANS - DISCUSSION .....                     | 20   |
| 7. CLOSING .....  | 22   |
| ANNEXES:  |      |
| 1. Country Plans .....                                  | 23   |
| Lesotho .....   | 23   |
| Namibia .....   | 27   |
| Swaziland .....   | 29   |
| Zambia .....  | 31   |
| 2. Workshop Programme .....                             | 35   |
| 3. List of Participants .....                           | 39   |
| 4. World Health Assembly Resolution WHA42.27 .....      | 45   |
| 5. Declaration of Alma-Ata .....                        | 47   |

## **WORKSHOP ON WOMEN IN HEALTH: NURSING LEADERSHIP FOR HEALTH AND DEVELOPMENT, MBABANE, SWAZILAND, 3-10 APRIL 1992**

### **1. INTRODUCTION**

Nursing personnel are a valuable asset of any health care system, and represent a very considerable investment of national resources. If countries are committed to primary health care and the Health For All strategy, a new set of values and approaches are required from all health professions. While most developing countries have made impressive efforts to improve their health infrastructure, health services still fail to reach those in most need. What is required is a leadership that can help build a system that is practical and equitable: strong leadership is necessary as an instrument both to initiate and sustain change and to mobilize people towards assuming responsibility.

Nurses have a key role in implementing the changes in both the infrastructure and the delivery of health care. The nature of their work - providing care at all levels and in all settings and in direct contact with people - gives them a distinct advantage. The development of their leadership skills would increase their ability to not only influence policies and decisions, but also to formulate them.

In World Health Assembly Resolution WHA42.27 (Annex 4), Member States are urged "to encourage and support the appointment of nursing/midwifery personnel in senior leadership and management positions and to facilitate their participation in planning and implementing the country's health activities". In order to do that we need to identify and understand the socio-cultural, political and economic circumstances that constrain the full participation and leadership of nurses in both the formal and informal health sectors.

This workshop served as a bridge between already identified issues that impact negatively on leadership opportunities for nurses, and women in general, since nursing is the major female health care profession and thus intimately linked to the status of women, and the identification of strategies to overcome the negative factors.

### **2. OBJECTIVES**

#### **Overall Objective**

To help create a critical mass of people in the field of nursing, capable of initiating and sustaining the process of leadership development for health.

#### **Specific Objectives**

- i) Develop/promote the role of nurses in particular (and women in general) in actively participating in the formulation and implementation of health care policies, and in the delivery of health care services.

- ii) Increase the leadership capability of nurses, both in the governmental and non-governmental sectors, in order for them to fully participate in overall national development, particularly health development.
- iii) Promote collaboration and concerted action between relevant government and non-governmental organizations in order to better implement strategies for the greater participation and leadership of nurses in both decision-making and implementation of health care policies and programmes.
- iv) Increase capabilities of participants to better identify and define the social, cultural and economic issues related to both opportunities and constraints to promote a more active leadership role of nurses in the health care system.

In methodological terms, a major objective was to facilitate a workshop process whereby the participants themselves, with their diverse expertise, drew upon their own leadership and participation skills in addressing the major nursing issues in the context of overall health and development. The agenda and the timetable of the workshop is given in Annex 2.

### 3. WORKSHOP PROCEEDINGS

The Intercountry Workshop was held from 3-10 April 1992 in Mbabane, Swaziland. Participants representing three different levels; central, regional and/or district and peripheral; and three sectors - government, non-government and education - participated. The list of participants is given in Annex 3. The workshop was opened by the Honourable Mrs Miriam Dlamini, wife of the Prime Minister of Swaziland, who emphasized the challenges and responsibilities of nurse leaders in health and development, and particularly, Primary Health Care. She pointed out to the group that the convictions and ideas she was sharing were not based on mere theory - she too, was a nurse and was well aware of the strengths and weaknesses of the professions. She hoped that this workshop would provide the opportunity for the participants, representing three countries, to discuss openly and frankly the major issues at hand, and reminded participants of the need to keep in mind the responsibility of nurse leaders to translate government policies and strategies into community programmes that belonged to the people.

Participants were then welcomed by the WHO Representative, Swaziland, on behalf of Dr H. Nakajima, the Director-General, the Regional Director for Africa and the Director of the Division of Human Resources for Health. It was pointed out that this was the second workshop of its kind (the first was organized in Zimbabwe in November 1991), and the recent but pronounced changes in political, economic and health situations of all countries presented a challenge to nurses that required skills and leadership. In fact, it could be stated that change was the only constant. A few of the fundamentals in this evolving situation were innovation, continuing education, and increased skills and competencies. To address these issues that have emerged in the 1990s, leadership skills are critical in order to help nurses, worldwide, towards effecting change in order to function more effectively and efficiently.

## **Method of Work**

In an effort to best meet the objectives of the workshop, a participatory and flexible method of work was applied in its planning, implementation and evaluation. The working method was designed, through a collaborative process, at the facilitators' working group meeting held a day prior to the workshop. Flexibility, openness, equality and mutual respect were the fundamental criteria in the design of the workshop.

A "learning by doing" rather than a purely didactic approach was used, and this approach not only drew on the varied resources that the participants represented, but also fostered an appropriate working climate enabling participants to conduct their own learning by sharing their real life experiences and situations. From the start, participants were encouraged to take leadership responsibilities in order to generate the interactive group process needed to fulfil the objectives of the workshop. Through dialogue and exchange of views, participants directed discussion as they saw fit, resulting in a rich variety of thoughts and ideas that was evident in the plenary sessions when groups shared a synopsis of their discussions.

The participants were divided into four working groups, each consisting of a proportional representation of countries and sectors involved. Following the opening, participants spent the remainder of the first day getting to know each other, establishing interactive working relationships and reviewing the relevance of the proposed agenda and timetable with respect to the objectives of the workshop. The chairpersons and rapporteurs for each group, rather than being elected/selected, evolved through group consensus. The plenary chairpersons for each theme were chosen by the four group chairpersons. The group presenter/rapporteur rotated among each member of the group. This approach gave most participants the opportunity to lead and to be responsible for generating a productive group interaction.

The workshop proceeded in roughly two phases. In the first, participants discussed each of the four themes in small working groups. At the conclusion of each theme there was a summing-up plenary session moderated by a theme chairperson. Brief evaluation plenaries were held at the end of each day when participants gave feedback on the workshop's proceedings or made logistical comments and suggestions. In the second phase, participants worked in country teams, utilizing the output/feedback and method experienced in the first phase, to formulate country team action plans which were presented on the last day of the workshop. Country plans are included in Annex 1.

## **4. WORKSHOP THEMES: SUMMARY OF DISCUSSIONS**

The themes discussed in the workshops were:

- Women and Development
- Achievements and Challenges in Nursing
- Values/Visions
- Leadership and Nursing
- Analyses of Strengths and Weaknesses

## **THEME I - WOMEN AND DEVELOPMENT**

An exploration of the topic of women and development established the framework for discussion of the more specific themes of the workshop. Without an understanding of the larger socio-economic environment in which women must live and work, and of women's situation and status within this framework, the fundamental changes required for the more equitable participation and leadership of women in society (and in nursing) cannot be achieved. The discussion of the four working groups on the topic of Women and Development is synthesized below.

Development is a process of change that in the best sense of the word moves towards the fulfillment of basic needs of all people. Ideally, the people who are affected by development are active participants in determining the direction and quality of change, and have equitable access among themselves to the resources available for development. There is little doubt, however, that development in practice does not usually equate with women's advancement. Whether the arena is political, socio-cultural, economic, educational or health-related, development has a different impact on women and men. In turn, the opportunity for women to influence the development process has not been the same as that of men. This is true both because of their specific biological reproductive functions and pre-existing inequalities (e.g. social and cultural factors, that inhibit access to opportunities).

Increased recognition of this fact has been a step forward. The UN Decade for Women has played a catalytic role in promoting greater awareness of the disparities between men and women with regard to development: women themselves have become more aware of their rights, and have gained greater visibility in the general community. Over the last ten years there has been a proliferation of women's groups and organizations as well as a strengthening and legitimization of those that already exist. Whether formal or informal, the networking among women, and for women, has helped make them a force to be recognized.

Political commitment to the advancement of women has been forthcoming in terms of legislative support for the rights of women, policy change and resolutions to improve the situation of women in all respects. Concomitantly, in an effort to implement the principles of equity, planners and decision-makers have begun to take stock of the nature and extent of problems facing women. National mechanisms have been established to promote and monitor the situation of women. There have been tangible results in many areas, for example, in the increased literacy and school enrolment rates of females in some countries.

### **Constraints to more equitable leadership and participation of women in development**

However, despite these and other improvements, large gaps remain between the formation of appropriate policies and their implementation at all levels. Among the primary constraints that persist in this regard are the inadequate resources allocated to actualizing the spirit of the law, and inequitable distribution of existing resources in all areas. Until a major shift in resources occurs, there is a danger that equity between men and women will remain a distant goal. Additionally, a lack of coordination in efforts towards the advancement of women hinder progress, and the number of women in positions where decisions about policies, programmes and resources are made remain shockingly low.

Deeply rooted cultural attitudes represent as important a constraint as the discrepancy between political commitment to equitable participation of women in development expressed by governments, and the amount of resources devoted to this end. The value of a woman is based on the number of children she has or the roles she plays in service to the family. Women themselves are often unaware of their own basic rights, capabilities and needs, or are reluctant to pay the often considerable social costs of asserting themselves.

In the context of the family and the community, the socialization of children often serves to reinforce these cultural attitudes: boys and girls are perceived to have different roles and value in society. There is inequitable treatment of the two in ways that range from differential feeding and care, to choices about providing schooling and other opportunities. Sometimes such inequitable treatment is blatant and results in discrimination even in such fundamental matters as health care and nutrition. At other times the message is more subtle, for example, in the notion that boys should enter certain occupations, and girls, others. Often girls are not expected or allowed to enter any formal occupation, which condemns them to positions of economic dependence on men and leaves them unable to make informed choices about their own work interests and potential.

Where socio-cultural values are changing to allow greater inclusion of women in public and economic activities, those women who have managed to do so often encounter a new set of problems, such as difficulties in reconciling traditional values with contemporary roles and responsibilities. A lack of family and community support for her endeavors has many effects ranging from a strong sense of individual guilt to large scale social consequences. Too often, women continue to fulfill all of their traditional roles related to the household and family and non-formal economy (more than a full-time job in itself, particularly for women without access to household technology), in addition to full-time employment in the modern economy. Lack of support and sharing of family responsibility can severely restrict the time and energy women have available for non-domestic, or economic related activities.

### **Looking towards the future**

Although progress has been made towards greater recognition of the multiple roles that women play, measurement of the economic value of women's work (both domestic and outside the home), must be a top priority. It is important to demonstrate to the world the value of what women do - women themselves so often underestimate their own contributions.

In addition, despite the fact that inequalities have been noted for many years, the need is greater than ever for action to ensure equal pay for equal work, greater access to job opportunities, rights to own property and engage in all types of commercial transaction, access to technology and agricultural modernization.

One of the most promising changes has been the increase in literacy rates of women, and improved rates of school enrolment for girls, although more encouragement for girls to stay in school and achieve higher levels of education are required. Much can be done in schools, where opportunities for progress exist simply in the modification of school materials and curricula in order to make them free of gender bias that subtly perpetuate limiting stereotypes and self-concepts. With regard to health, boys must also be taught about nutrition, family health, and home economics from an early age.

The groups particularly emphasized the need for strengthening action in the following areas: equal pay for work of equal value, and greater access to job opportunities; implementing strategies to enable women to effectively participate in the process of socioeconomic development; appropriate social support measures, both formal and informal; access to labour-saving technology, at home and in the workplace; a higher level of sensitization of the community at large to the different values accorded to men and women; and participation of women in decision-making positions at all levels.

It is interesting to note that despite the varied approaches of the working groups to the question of women and development, all returned with one common, strongly expressed theme, namely that women themselves have for so long underestimated their own value that the need is greater than ever for them to develop and improve their self-concept and their self-image -to have confidence in their own ability to contribute and their right to benefit from development.

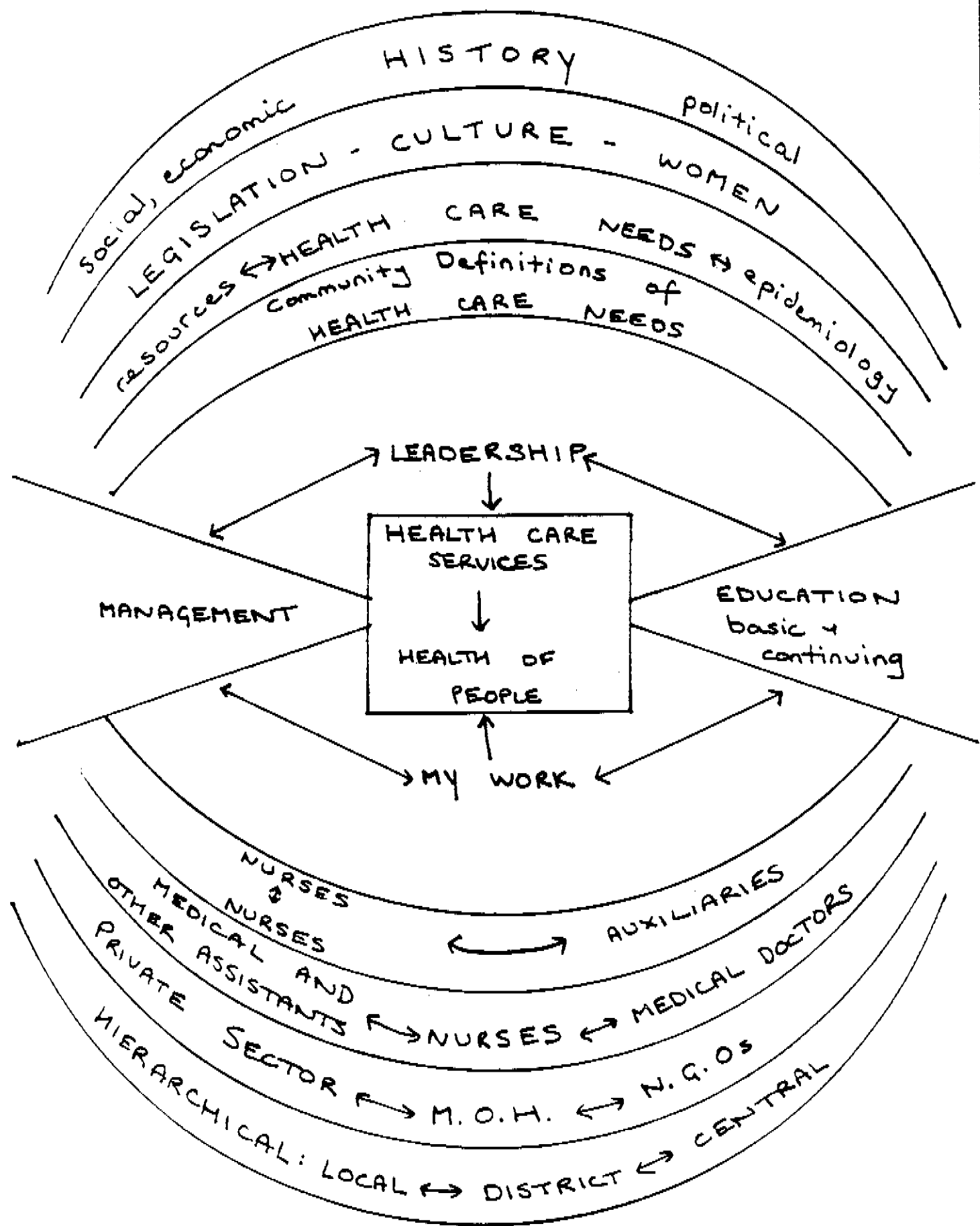
In order to move from the larger scenario of women and development to the more specific one of nursing and leadership, participants were presented a conceptual model (Diagram 1) which was used as the framework for discussions in groups. A summary of the points covered in the framework are as follows:

The development of nursing, as part of the history of a country, affects the way that nurses currently practice, as do the social, economic, political and cultural expectations of that country. Most nurses are women, and the status of women in a society will impact on the status of nurses in that society.

There are many factors which influence the work of nurses, both as individual practitioners and as part of a team. Clearly the organization of the health services in which a nurse is practicing will shape to some extent the nature of that practice, but in turn the health services are inevitably influenced by the demography and epidemiology of an area. In Southern Africa there are major changes in the epidemiological picture, because of the spread of HIV and AIDS: is the health service able to respond quickly and appropriately, and how can nursing best play a part in that response? How will nursing be affected?

It is clear, then, that there are pressures and influences which shape and perhaps sometimes limit or extend the work of nurses. Effective leadership demands that nurses are aware of these influences, and are able to have a vision for themselves: to see where they are going.

DIAGRAM 1



## **THEME II - ACHIEVEMENTS AND CHALLENGES IN NURSING**

### **ACHIEVEMENTS**

The participants identified significant achievements in both the nursing service and by individual nurses at many different levels of the health care system in each of their countries.

Nursing organizational structures were starting to improve, as was the nursing management system at all levels of the service in each country. The role of nurse leaders and their need for further development and encouragement was starting to be given positive value, and a number of countries were starting to give nursing a status of professional recognition. This to some extent meant an improvement in the public image of nursing, which had also increased an interest in the profession as an occupation.

Nurses were also starting to influence national policies: they were using University Departments of Nursing Sciences/Education to influence Government Departments of Education; strengthening contacts with Authorities of Nursing Services who related directly to Government Departments of Health; and also the Nursing Associations who had direct communication channels with Ministries of Health and relevant non-governmental organizations in most countries. The nursing profession had developed a good communication system among themselves, with their communities and with non-governmental organizations. For example, an inter-country nursing association, ECSACON, (East Central & Southern African College of Nursing) has been established, and there was a suggestion that all countries in this region could join together and find a way of having a common general nursing registration.

Nurses had developed successful mechanisms for transferring health information from policy level right down to effective grass root care programmes. This was one of the primary reasons that nurses, who had major responsibility for many of the primary health care programmes, e.g. the immunization programme, maternal and child health and family planning, could take credit for the success. Leaders in the nursing profession were promoting and encouraging teamwork among nurses, and also multi-disciplinary teams.

Nursing education is well established in each country and post-graduate courses are increasing, some at University level. These courses are preparing nurses for managing change, and to play a more active role in national health and development.

### **CHALLENGES**

Participants identified issues that they believed needed to be addressed more vigorously. The common issues that emerged were:

#### **Partnership between Service and Education**

There was the need for a better partnership between nurse educators and the nursing service. This was important so that the nurse educators prepared nurses who were able to provide the care that was needed by patients and wanted by the service organizations. Likewise the service needed to be kept in touch with both developments and constraints in the education system, so that their expectations were realistic.

## **Improving Patient Care**

Perhaps the greatest challenge for nurses was to maintain and improve the quality of patient care. The major difficulty associated with this is the raised expectations of consumers without an equivalent increase in the nursing resource. There were also new diseases, such as AIDS, which require a large proportion of the nursing resources and often take priority over other care. This has put great strain on the nursing profession which, to date, had always attempted to match the changing health needs despite limited resources. Clearly, in the future, nurses have to find ways of advising the public and the Government as to the level of nursing care that can realistically be achieved within the available resources.

## **Networking/Collaboration**

There is a lack of coordination and collaboration between non-governmental organizations, governmental agencies and professional organizations in areas and activities of mutual interest. This lack often results in duplication of activities and waste of scarce resources, both human and financial. Another factor impinging on coordination is the frequent reluctance or resistance to delegating and decentralizing on the part of regional and national level organizations or governmental agencies, which leaves groups on the periphery with little or no support, and insufficient information.

The individual nurse often faces a number of constraints that militate against greater participation which include: demands of multiple roles that limit time and energy; reluctance to participate for socio-cultural reasons; previous unsuccessful efforts to participate; perceptions that participation might translate to cost-sharing and; self-underestimation that comes from believing that what she has to offer is of little value.

## **Major Factors Affecting Further Progress**

### **1. Professional Issues**

- In some instances the well organized nursing structures have led to rather rigid bureaucratic systems with little flexibility in the promotion ladders, leading to inadequate career mobility. Unfortunately this system does not encourage competence to be rewarded through promotions: people are nominated to senior positions based on hierarchy. This has meant that some leadership positions are filled by people who do not have the skills to function in changing environments or to be innovative and creative. In such situations people tend to lose their self-confidence, find it difficult to delegate work to others, whether their peers or juniors, with the consequence of frustrated juniors lacking the necessary experience and opportunities to develop their own skills and/or careers.
- There is room for more rigorous attention to recruitment methods, induction procedures and clearer job descriptions which are explicit about specific functions and roles.

- Nurses are currently paid according to their qualification and the title of the position that they hold, and not by the content of their work or the actual work done. This point was demonstrated by the example of a matron of a hospital who managed a whole hospital, handling everything from nursing and ancillary staff management to the provision of care. The matron's authority and salary did not reflect her responsibilities, vast knowledge gained through experience, or the skills required to handle the management of a large workforce ensuring satisfactory performance of the organization. The matron's salary and status were less than that of young medical officers who had theoretical knowledge but very little experience, and often, less responsibility. Nurses are also expanding their clinical roles through further clinical responsibilities but their salaries are not being adjusted accordingly.

## **2. Relationships**

Nurses, all over the world, face a historical situation where their colleagues, the medical doctors, are the dominant partners. This is a very complex position which often leads to conflict: the responsibility of resolving the conflict rests with both professions.

There is also a dominance of doctors in the organizational structure, especially at the senior levels. This, plus the status and the nursing structures mentioned above, has led to nurses being inadequately represented in the decision-making arenas, not only about their own affairs but also in situations where they could make substantial contributions to the development of health policy as well as to the changes necessary for successful implementation of policies.

## **3. Suggested Strategies**

A number of structural and programmatic strategies to promote and improve the level of participation of nurses in the health systems were identified by the working groups:

1. ensure that formal and informal sectors have a common understanding of participation and create appropriate linkages between governmental and non-governmental organizations to support the profession.
2. facilitate access to and control of resources which motivate participation.
3. encourage political support and commitment to policies and mechanisms of networking among nurses at all levels.
4. take a "grassroots up" approach by providing adequate support to communities and the nurses working in the communities.

During the workshop participants expressed constant concern about the increase in the number of patients, more health needs identified, and less than adequate resources. There was a strong plea that nurses should not only have available relevant facts and figures, but also know how to utilize them in order to address the need for more resources through political lobbying, by using women's groups and their local politicians to do what they can to improve the situation.

### **Education**

Nursing could be strengthened by an education which includes the development of managerial and communication skills. This will lead to nurses having more confidence in themselves vis à vis other professional colleagues, and better skills for political lobbying. Higher education for a larger number of nurses will allow better analytical and negotiating skills in the profession and could, thus, lead to further recognition of the profession as a whole.

### **Qualifications, Ability and Workloads**

These should be recognized at all levels in the structure and rewarded by appropriate salaries where possible, or public recognition.

- There should be incentive packages for those nurses who have degrees or diplomas and/or excessive workloads.
- There should be more flexible entry gates to nurse training. It was suggested that nurses themselves could be more flexible in their attitudes towards admittance to the profession: they could experiment with more ways of finding and giving opportunities to those people who had the motivation to come into nursing but who had not reached the normal school standard for entering registered nurse training. A number of examples were quoted of nurses who were very successful, despite having no higher degrees.

### **Discussion**

The traditionally held image of nurses and nursing gave rise to much debate. There was agreement that the profession was staffed mainly by women and that this was a fundamental issue of culture and tradition that had to be acknowledged. A number of participants pointed that the work of the nurse was undervalued not merely because it was nursing but because most nurses were women and all work done by women, whether in developed or developing countries, received less attention than it should. It was agreed that nurses, as women, should not fear challenges and that they should value their history and contribution to health care.

It was also pointed out that nurses would not be valued by anyone else until they valued their work themselves. Further, nurses should also be helping other health professionals and the public to appreciate the centrality of nursing to all health care. One way of raising the status of nursing would be to ensure that graduate programmes for nurses give value to clinical care by having a clinical element in the programmes.

The group discussed a wide variety of strategies to remove barriers and promote the active participation of nurses in health care. In general, measures to improve the social and economic status of women would work to remove some of the barriers to more equitable participation in development. Role models such as influential women and political leaders have an important part to play in facilitating and promoting the participatory role of women. Health professionals also have a role in removing the mystique of medicine and approaching women as partners in health. Tapping the potential and actual force of grassroots women's organizations as a means of increasing women's participation should be developed.

At the same time, participants emphasized the fact that the participation of women is a resource not to be taken for granted, but requires investment and a desire to empower women - through skills, knowledge and practical measures such as appropriate time and labour-saving technologies that allow greater freedom for participation.

### **THEME III - VALUES/VISIONS (Personal, Professional, Organizational)**

In this module, the groups worked on the definitions and their understanding of values and visions. Values were defined as fundamental beliefs that impinged on human relationships; society functioned within the framework of these values and protected them. Another definition of values was that of innate principles which guide an individual in his/her daily life; these are not measurable, and depend on the situation. Visions were described as ideals, and one's personal and professional goals and ambitions.

#### **Values**

Despite some initial difficulty in identifying values, there followed a wide ranging discussion. This subject was bedded in the belief and pride that nursing is a profession, and the central core of health care. Other values mentioned were:-

- The quality of both nursing and health care services provision.
- That nursing makes a very important contribution to society by influencing health care and by respecting people as individuals: this applies as much to their patients and members of the community as it does to their seniors, colleagues and their junior staff.
- That nursing has boundaries and a code of ethics which incorporates the qualities of empathy, caring, maintaining confidentiality, commitment, patience and understanding, dedication and selflessness.

Also discussed were personal values, and these included:

- Respect for fellow humans regardless of social level or gender
- Empathy, honesty, independence, altruism and trustworthiness
- Friendship
- Positive attitudes to work, assuming personal responsibility, a role model and an agent for change for the better
- Maintaining one's personal integrity and remaining approachable

Participants found that visions and ideals were easier to identify and discuss than values. The corporate view of visions was:

- That nursing will be recognized by society as a successful profession which benefits society
- That as the nursing profession grows, issues will be discussed more objectively and widely
- That more community based care is delivered by nurses
- That nursing education develops nurses who are critical and analytical about their work
- That all nurse managers and leaders receive adequate preparation before appointment
- That systematic continuing education/in service programmes be available
- That training be provided in order for nurses to contribute to specific issues, for example, cost-effectiveness of health care provided by nurses
- That sabbatical leave be provided in both education and the practice areas
- That nurse leaders provide a role model for those joining the profession, and be united locally, nationally and internationally
- That nurse leaders network effectively leading to a better dissemination of knowledge about effective nursing practices
- That nurses can confidently influence health policies and contribute to national development and equity in Health Care
- That nurses will learn how to serve as effective advocates for their profession
- That the work of the Nursing Associations should become more professional, and that their officers be paid
- That health care should receive a bigger proportion of the national budget, and that there be an equal distribution of health resources between rural and urban areas. This should increase the financial resources available for the provision of adequate numbers of trained nurses and health workers to provide effective care
- That nurses be provided with adequate facilities (housing, transportation, etc.) in order to effectively discharge their responsibilities
- That nursing have greater influence at policy-making levels
- That a well-defined career structure be available to all nurses
- That more opportunities exist for higher education
- That the organization have a vision which focusses on the common goals of health care
- That health care organizations have a commitment to match the expressed health demands of the community with the provision of quality care which contributes to an improvement in the health status of the nation, an ethos of sharing information, clearly shared objectives, and participatory decision making
- That there be clear policies at all levels and for all aspects of the organization and its work and that these will be understood by all the staff in and consumers of health care. All policies should reflect equal opportunities
- That people within health organizations genuinely care for their staff and value their contributions to the overall achievements of the organization
- That organizations be led by a competent person(s)
- That the organization be open to audit and the public encouraged to become aware of their own role in meeting their own needs

## THEME IV - LEADERSHIP AND NURSING

In defining and discussing leadership, participants used the framework of Health for All by the Year 2000 - a vision founded on social equity, on the urgent need to reduce the inequality between the health status of people in developed and developing countries and in different parts of the same country. It was seen as a vision based on the principle that health and development are closely intertwined, and one that encompasses fundamental change in the way health is perceived, promoted, protected and delivered. It was agreed that leadership is vital for the processes and activities by which change can be brought about, however, the definition of leadership was not an easy task. Participants agreed that recognizing "leadership in action" or even listing characteristics that contribute to leadership could be easily done. But what is the combination of qualities and what are the circumstances that propel people to assume leadership in a given situation? Some of the assumptions about the "leadership tasks" that would facilitate the changes needed in nursing are given below:

Nurses should be **fully informed** about health for all and the strategies for its achievement, and **be able to communicate the concept to others.**

They should be able to **identify central issues** affecting nurses and their role in the health care system.

They should be able to **specify their own personal role** in resolving those issues which fall within the scope of their responsibility.

They should be able to **define strategic actions** to resolve these issues.

They should be able to **initiate** the process of change required and create networks of support for the implementation of change.

They should be able to **involve and mobilize others**, enable them by infusing a sense of purpose, commitment and a focus of action.

A synthesis of the group discussions on the definition of leadership included the following:

- a leader works with and through people to achieve an agreed upon goal.
- a leader is a person who is committed, capable, can guide, influence and motivate other people to develop their potential to contribute towards achieving the goals of the organization.
- leadership is an art, natural or acquired, of leading people in the organization to attain the stated objectives at a specified time.
- leaders recognize the value of supporting each other.

Leadership development was defined as the bettering and strengthening of abilities and effectiveness of both current and prospective leaders. This process was seen to centre on understanding why change is needed and how it occurs; understanding of the role of leadership in managing and motivating change; and an understanding of the importance of shared responsibilities. An important part of this process is the partnership of the community in supporting and facilitating leadership development. This enables leadership to emerge from within a group or community, and is far more likely to be sustained than that which is imposed from the outside.

### **Should the leader be a nurse?**

There was considerable debate as to whether it was necessary to have a nurse in the top leadership positions of nursing services and whether nurses make good leaders of nurses and other teams.

As the main function of a nurse leader is to ensure the provision of nursing in the fields of promotive, preventive, curative and rehabilitative care it was thought essential that the person in the position of leadership should have the knowledge that can only be acquired through the process of nursing.

One aspect of this knowledge was understanding the nature of the interaction that takes place between a patient or a member of the community and the nurse. This is invaluable when representing the views of the community and also when planning programmes of care.

A nurse also has the experience of the nursing workforce, understanding the intricacies of the different training programmes, the complexity of manning a twenty-four hour service of different grades of staff and the interaction that is necessary with others such as doctors, paramedicals, housekeeping staff and the local community.

Knowledge of nursing and health care, health care staff and the health needs of patients and the community makes nurses potentially an extremely powerful source of information for the development of community and health care policies and also successful implementation strategies.

### **Empowering others to assume a leadership role**

Participants defined numerous ways of preparing others to assume leadership positions. One is to express high but realistic expectations of people as this can encourage personal development. Open communication between managers and staff should be encouraged with feedback. Potential leaders need to be identified and their needs, abilities and limitations need to be realistically assessed.

Other methods of leadership training included continuing education, incorporation of training programmes in academic environments, and also training, informal and formal, in the work situation. Staff should be given opportunities to develop their skills in a supportive and constructive atmosphere. Mentoring of potential leaders in their present work should be developed further.

## **Discussion**

There was clear evidence that nursing leadership had made a difference to the health care of the populations in the countries represented at the workshop. The challenge now was how to continue to make and increase impact on health care with the resources that were available. The discussion showed a clear knowledge of what should be done but exposed problems in the application. The participants identified the need to strengthen certain areas such as adequate support, appropriate organizational structures, and human and financial resources.

Nurses were urged to communicate with all relevant organizations and individuals, not necessarily only those in direct hierarchical structures. This is very important in facilitating team building throughout the organization, and can identify resourceful persons who may not be in management or obvious leadership positions.

There was a clear message that the goal of health care should be kept central to all strategies and ways had to be found of assuming leadership without necessarily also having the structural control.

New ways of doing things were considered but more importantly, the considerable knowledge, power and the collective skills that the participants already had was emphasized. They urged each other to continue developing and implementing strategies of health and nursing care that would have a major impact on the health status of their populations, as well as provide professional recognition and satisfaction.

## **THEME V - ANALYSES OF STRENGTHS AND WEAKNESSES**

The purpose of this module was for each participant to identify their own personal strengths and the opportunities and the challenges they faced as they attempted to carry out their objectives related to improving the health of the people. This module built on the earlier work in which individual participants had identified the needs and attributes of leadership in nursing.

### **Strengths**

Collectively nurses were perceived to be a mass of professional women able to initiate and sustain the process of health development, and create a higher awareness of the benefits of health and education. Major successes were listed as:

- They had worked as a cohesive group and succeeded in reducing morbidity and mortality rates, and increasing immunization coverage.
- The leaders of the nursing profession had accepted and implemented the concepts of the Alma-Ata declaration (Annex 5), for example, in the training and supervision of community health workers. Nurses in the curative sector had kept pace with modern trends and developments with minimal outside support and resource increase.
- They had the confidence and encouragement of their staff, had developed good teamwork skills and were accepted by their multi-disciplinary colleagues.
- They are known to work hard, be open, available and assertive when necessary. Nurse leaders communicated with other leaders at all levels of health care and involved local communities in their own health care management.
- They encouraged a holistic approach to health care. For example, they worked with the patient and his/her family, caring for the sick and dying, consoling and counselling, and maintaining confidences.
- The experience of nursing contributed to the development of mature and competent women in society.
- A great many nurses had acquired adequate skills to empower future nurse leaders.
- Nurses had a collective responsibility and opportunity to change their direction towards a more positive approach to solving problems. Creative strategies could be developed to solve identified weaknesses. This could be enhanced, for example, by opportunities for further and/or continuing education at national or international levels.
- Intersectoral collaboration could be strengthened and used to back these strategies. Interdisciplinary seminars could improve mutual understanding and reduce interpersonal conflict. There is a long history of confused relationships between nurses and doctors. This should be addressed through the educational systems of nurses and doctors to change both the cultures so that each profession understands the need to complement each other's work.
- The existing and available nursing structures can be used to give information to the community and especially to women on subjects such as teenage pregnancy and AIDS.

## Weaknesses

While enumerating and discussing the positive factors that supported nurses and nursing, participants were only too aware of an equal number of weaknesses that debilitated the profession. Participants believed it was important to list these issues, and they were identified as follows:

- Nurses can hold important positions but too often have no real authority to make decisions.
- Nurses do not feel that their work is given sufficient recognition and they find this a demotivating factor. As women, nurses have not been able to overcome the cultural norms and the socialization process, which places women in a less important role than men.
- There was disunity among nurses themselves.
- The links between education and service were weak, with nurses having limited knowledge outside their own environment.
- There is lack of adequate orientation for newly employed and qualified nurses.
- The working conditions are very inadequate in many circumstances.
- Nurses have not been able to articulate their own or their patients' needs adequately in order to attract adequate resources. They have not produced robust and clear information which describes the scope and the limitations of nursing practice.
- Culture, history, political power and interdisciplinary rivalry have reduced the power of nurses
- The work of nurses is hampered by limited resources: human, financial, and material.
- The organizational structures are bureaucratic and actually tend to slow down progress because it takes a long time to make decisions. Further, there is no sustained career development.
- The salary scales are low relative to the responsibility handled.
- The community is not knowledgeable about nurses and nursing. The product of nursing requires a marketing strategy. The media should be used and the community should be encouraged to get to know and to be interested in their nursing service as they will be the beneficiaries.

## Discussion

Participants found that this module had worked very well and demonstrated the challenges of the subject and insight that had been gained during the previous four modules. Nurse leaders were encouraged to link with each other and also find several different fora for gaining support and constructive criticism in their roles.

The subject of interacting with the community was discussed in more depth than previously, and there was encouragement to work more effectively together and to use the community to act as pressure groups to achieve what they, the community, wanted from their nursing service.

Participants stressed strongly the suggestion that nurse leaders should be making it very clear to political leaders what nurses can do with the resources that are available, and what more could be done if they had more resources. Conversely, nurses need to have and use sufficient information to make politicians and the general public aware of the implications on the health status of communities if sufficient resources are not forthcoming.

## 5. FUNCTIONAL GROUPS

Participants decided that some part of the workshop should be spent in functional groups with the composition being based on similar levels and similar jobs. This would give the opportunity to discuss areas and issues of common concern, and ways of developing and improving their respective services.

The four groups were:

- nurses working at central level
- educationalists
- senior nursing officers, matrons
- nurses in primary health care services

After discussions in the functional groups, participants came back into plenary to present the salient issues that had emerged in the groups and to get feedback from the other levels.

All the groups were able to identify problems in their spheres of activity which reflected those already raised in other sessions. Once more the shortage of resources was raised, and the need to make nursing more attractive both to prospective students, and in order to retain staff.

The many practical problems which staff face may seem at times to be overwhelming, and it was recognized that anyone in a leadership role must be able to take a broad view in order to plan effective solutions. In particular, nurses at the central level were required to have a strategic overview so that they could diagnose and remedy problems accurately.

While recognizing the problems faced by staff at all levels, it was also acknowledged that there had been many achievements, and in sharing common concerns, it had been possible to share ideas and solutions too. The strength of inter-country collaboration was recognized.

Discussions in these functional groups proved extremely valuable in two ways: participants from the different countries were able to exchange information and ideas specific to their levels of responsibility/position, and, people working at different levels were sensitized to the particular factors affecting the performance of colleagues at a level other than their own. It was recognized that, too often, we are not aware of the constraints impinging on the work of people working immediately below or above our own levels.

## 6. COUNTRY PLANS - Discussion

The final phase of the workshop gave the opportunity for each country's team to work together to formulate a plan of action which would develop ideas identified in this workshop. Each plan was shared and discussed in plenary sessions.

It was perhaps not surprising that the obstacles to progress identified by each country had already been discussed in previous inter-country sessions. Nevertheless, it was a challenging exercise for each country to find realistic ways of overcoming these problems.

Two issues emerged as dominant, in that they were both mentioned by all the country teams: the first was the lack of integration between education and practice in nursing, and the second was the need for improved management skills in nursing. Clearly, both of these obstacles have far-reaching implications, and clearly illustrate the inter-dependence of factors influencing nursing and primary health care.

The range of solutions identified to overcome the lack of integration in nursing education and practice reflected the complexity of this problem, which at first sight may appear simple to solve.

The solutions suggested for overcoming this obstacle ranged from improving nurse education at all levels to improving collaboration between lecturing staff and clinical teachers. The difficulty lies in the impossibility of isolating one problem only as a cause. One reason for the failure of integration was seen as the drift away from clinical practice by well-educated nurses. Another is the poor communication between nurse educators and practitioners, and the inadequacy of clinical teaching.

However, collating all the solutions produces the following sequence: initially those people of a high enough academic standard have to be attracted to nursing, and in order to attract them there must be an image of nursing which affords the profession a high status in society. Secondly, the courses offered must be of a standard which, as the Swaziland team said, "meets technological and societal changes". Thirdly, clinical practice must be an attractive option for nurses to choose; it has to be adequately rewarded and the role of the clinical nurse specialist given the status it deserves. If these criteria are fulfilled, then it will follow that ward-based teaching will improve and standards of care will be raised.

All countries identified some or all of this progression, but recognized the difficulties in bringing about necessary changes which demand a multi-sectoral approach involving both educationalists and policy makers. Changing nursing's educational opportunities needs ministerial sanction, as does bringing about change in the terms and conditions of service at practice level.

It was recognized by all the countries that, in order to bring about changes effectively, better management skills were necessary for nurses. This included management at service level too, where resources were scarce and had to be deployed in the most effective way possible. To bring about change at ministerial level, and in policies, demands confident senior managers, who are able to articulate problems clearly and assertively at high levels. It was recognized that this is made more difficult by the low status often afforded to women in the participating countries. It was suggested that management skills could be developed through different learning opportunities, such as distance learning packages, or short courses, and through

workshops which offered the chance to problem-solve in a group. In addition to the educational changes suggested, it was felt by three countries that nursing's career structure should be strengthened, especially at the central level, where policies can be made and influenced. However, this situation is again illustrative of the complexity of obstacles to progress: better management skills are needed to convince the Ministries of Health that a nursing directorate is required, but will nurses be given opportunities and incentives to improve their management skills until there is a nursing directorate?

Two other important problems were identified, each mentioned by two countries. One was the shortage of nursing personnel, previously discussed during the inter-country phase of the workshop. The second was the difficulties in achieving the objectives of primary health care.

A number of suggestions were made to improve recruitment to nursing, and to retain qualified staff, such as placing nurses in jobs which they were trained for, therefore increasing their job satisfaction, and commissioning research on the utilization of nurse graduates. However, much the most persuasive suggestions were those to do with recruiting the most suitable candidates, and therefore having a strong and attractive image of nursing, and improving salaries, housing and transport for nurses to ensure their safety and security. A weak link in the effective organization of primary health care was identified as the lack of co-ordination between primary and secondary care. It was felt that this had its origins in nurse education, which did not include education for primary health care in basic training, and in the planning stages of primary health care strategies, which often excluded staff from secondary care. Both these problems demonstrate the need for an overview of situations, in order to identify strategies which will bring about change, especially when change is needed at several different levels. This once more indicates the need for improved management skills throughout nursing, in these countries.

### **Bringing about change**

Each country had not only identified problems, but also possible solutions and activities which could lead to change. A major theme to emerge during the plenary sessions, at which these plans were discussed, was how the changes would be monitored. Timetables were suggested by each country, but the point was made that short-term crisis needs often superseded the long term planning needs, and people's attention could be diverted. In addition, motivation, although high at the workshop, would not remain at this level, so progress would gradually become slower. However, it was also pointed out that motivation could be sustained in a number of other ways, such as meeting in inter- and intra- country groups to discuss plans, and by inviting people with expertise from Southern African countries to help with plans and evaluations.

Evaluation of progress was recognized as vital, because it allows all those involved in changes to appraise the effectiveness of their actions. Timetables are useful as an evaluative tool, but some outcome measures are also valuable, such as rates of immunization.

The role of WHO in both sustaining and monitoring change was seen as important. A number of suggestions on how best this could be done were made: follow-up workshops, regular contacts through reporting, dissemination of information, country visits and technical assistance.

## 7. CLOSING

The workshop was officially closed by the Honourable Minister of Health of Swaziland, Dr F. Friedman. She underscored the vital role of nurses in the delivery of health care, and the urgent need for all segments of the health services to recognize this fact. In stating this, Dr Friedman also urged nurses to be more proactive and to ensure the quality of nursing services. She wished all of the participants every success on their return, and hoped to hear, in the future, about individual successes and failures. The latter, Dr Friedman stressed, should not be demotivating or discouraging factors but should be used positively as learning opportunities.

On behalf of the workshop participants, the Director, Nursing Services, Namibia, gave a note of warm appreciation to the host country and its participants for their generous hospitality and excellent organization.

ANNEX 1

COUNTRY PLANS

LESOTHO

The main objective of the Lesotho team is to increase collaboration and co-ordination of public health and hospital nurses in PHC activities. The principal protagonists to achieve this objective are:

National Public Health Matrons;  
Chief Nursing Officers;  
District Chief Nursing Officers;  
National Public Health Matrons,  
Hospital and PHC matrons;

Funding will be requested from multi- and bi-lateral donors and Ministries of Health. The time frame will be July 1992 to July 1993. Evaluation will be based on meetings, workshop and activity reports and smooth referral systems.

The activities shown on the chart are in support of the stated objectives.

LESOTHO

| OBSTACLES  | STRATEGY   | ACTION   | BY WHOM                                       |
|--|--|--|---|
| Not very few Nurses at policy-making levels  | Strengthen representation of nurses at policy-making levels                | Increase number of positions for nurses at central level   | M.O.H.  |
| Critical shortage of nursing personnel resulting from high attrition rates and lack of man-power development | Develop appropriate mechanisms to retain nurses in the profession          | Improving working conditions e.g. incentives for anti-social hours; for nurses working in remote areas                                   | M.O.H. & Nurses Association                   |
| Inadequate number of well prepared nurses at all levels in the clinical area                                 | Improve/upgrade nursing education to a higher level                        | Training at institutes of higher learning by conventional methods or distance learning   | Individuals, employers and Nurses Association |
| Poor leadership and managerial skills at all levels in the nursing profession                                | Strengthen leadership and managerial skills                                | Training of senior nurses and practicing nurses in leadership and managerial skills  | M.O.H. & L.N.A.                               |
| Lack of career mobility in nursing   | Improve prospects for mobility and well-defined career structures          | To develop well-defined career structures within the nursing profession  | M.O.H. & L.N.A.                               |
| Low professionalism among nurses   | Improve the image of nursing   | Upgrading nursing education by educating nurses in institutes of higher learning   | M.O.H. and Schools of Nursing                 |
| Lack of autonomy of the legislative body   | Obtain more autonomy for Lesotho Nursing Council                           | Regular review of nursing legislation  | L.N.A and Nursing Council                     |
| Poor collaboration/co-operation between education and practice   | Ensure effective collaboration/co-operation between education and practice | Regular meetings/contact between education and practice personnel<br>Ensure effective supervision of nurse educators and clinical nurses | Nurse educators and practicing nurses         |

LESOTHO (contd.)

| Objective | Resource                             | Funding                | Time frame              | Evaluation                                       |
|-----------|--------------------------------------|------------------------|-------------------------|--|
|           | 1. National PH matron                | -                      | July and September 1992 | Meetings, minutes, reports                       |
|           | 2. C.N.O., N.P.H. matron             | Donors, M.O.H., W.H.O. | 1992/1993               | Workshop reports, Activity reports               |
|           | 3. Hospital and PH matrons           | -                      | April, May 1992         | Report or records                                |
|           | 4. Principals and C.N.O. and Co-opt. | -                      | June 1992               | Minutes, Improved collaboration and coordination |
|           | 5. DCNO                              | -                      | June 1992-93            | Smooth referral system                           |
|           | 6. National Public Health Matron     | -                      | June 1992-1993          | As above   |

## NAMIBIA

### 1. EDUCATION

- 1.1 Lack of physical facilities ---> approach Ministry of Health to consult with other ministries---> other/more classroom accommodation
- 1.2 Low academic background of applicants ---> improve image ----> make nursing more attractive. Career guidance by Nurses
- 1.3 Nurses with educational qualifications do not want to work in the clinical practice.
  - Discussion groups to motivate and change attitudes
  - Emphasize the status of the clinical nurse specialist
  - Pre-requisite for promotion to chief professor Nurse ---> additional post basic qualification.
- 1.4 Integration of teaching practice.
  - Reinforce in-service training programs for registered Nurses.
  - Lecturers to teach at bedside
  - More discussions ----> teaching and clinical persons

### 2. MANAGEMENT IN CLINICAL SITUATIONS

#### 2.1 Communication

- improve communication systems
- improve feed-back
- Ensure budget for telephone, fax and radio communication in rural and remote areas.

#### 2.2 Inadequate guidance and support of the newly qualified registered Nurse.

- Orientation period followed by research to determine critical areas to focus on.

### 3. CENTRAL LEVEL

#### 3.1 Preparation of leaders and supervisors for the clinical situation

- Internal workshops.
- Workshops and literature from external organizations
- Next WHO workshop in Namibia please!

**4. PRIMARY HEALTH CARE**

**4.1 Lack of communication and adequate curative services**

- Regular communication between PHC and curative services at all levels.
- Orientation of personnel in curative services regarding PHC.

**5. NURSING OFFICERS**

**5.1 Discrimination against women regarding conditions of service**

- Refer to Nursing Association

**5.2 Reports and memoranda**

- In-service education on written communication skills

**5.3 Support of Nursing Association**

- Reinforce the functions and advantages of the Associations at all levels.

## SWAZILAND

### 1. PROBLEM IDENTIFIED

Lack of collaboration and coordination between hospital nurses and public health nurses due to lack of full involvement in PHC programme.

### OBJECTIVE

To increase collaboration and co-ordination of public health and hospital nurses in PHC activities.

### ACTIVITIES/STRATEGIES

In planning stages of PHC activities/education, the nurse managers in hospitals and public health units and nurse educators should be involved.

### EDUCATION ON PHC

The implementors: Nurse leaders  
Nurse Educators

- Strengthen immunization at all levels through screening and immunizing babies in OPD, maternity and paediatric wards
- Establish and strengthen regular joint meetings of nurse managers in preventive, curative, and education services in order to discuss issues pertaining to education of students in PHC
- Upon admission of a child to hospital, a detailed history of PHC activities done on the child, e.g. immunizations, should be documented on card or, required activities should be carried out or a referral system between a hospital PHCU and other related sectors in the health care delivery system should be oriented and strengthened.
- A continuity of supervision of student nurses in the community utilizing the services of an identified public health nurse in the region. In peri-urban areas the nurses should be assigned by P.U. to areas of responsibility and a list of assigned nurses and their work schedules should be circulated.

TIME 1992/1993

FUNDING Swaziland government

INDICATORS Reports of activities

## 2. PROBLEM IDENTIFIED

Existing gap between nursing and education services resulting from mis-matched levels of education which adversely affect the quality of nursing care.

### OBJECTIVE

To provide equitable levels of education between nursing services and education in order to meet the technological and social changes with resulting changes in the quality of nursing care.

### STRATEGY

Formation of an SNA committee in collaboration with the CNO office to negotiate with Ministry of Health, Labour (MSD), Economic planning and Finance.

### ACTIVITY 1

Complete establishment of a faculty of nursing at the University of Swaziland in order to strengthen the education of nurses at both diploma and degree levels.

### ACTIVITY II

Encourage nurses to utilize distance learning opportunities.

Identify international institutions which provide education for nurses.

## 3. PROBLEMS IDENTIFIED

Existing nursing structure in Ministry of Health does not allow for mobility and career advancement.

### OBJECTIVE

To improve the existing nursing structure to meet the current demands and challenges and establish a nursing directorate.

### ACTIVITIES

- Review present structure and propose a revised structure to Ministry of Health
- Negotiate with Ministry of Health and Ministry of Labour

### RESOURCES

SNA team reps.  
CNO

## ZAMBIA

The main objectives of the team's action plan are:

1. Improve quality of care
2. Improve the management of nursing services
3. Accelerate the achievement of Health For All by the Year 2000 through effective participation of all nurses at all levels
4. Develop an effective career structure
5. To improve staffing levels (Nurse:Patient ratio)
6. To breach the gap between service and education
8. To empower nurses and women in particular to improve their social, economic and health status

ZAMBIA

| PROBLEM                      | ACTIVITIES   | RESPONSIBLE   | RESOURCES  | TIME FRAME   |
|------------------------------|--|---|--|--|
| Ineffective career structure | <ol style="list-style-type: none"> <li>1. Obtain and review existing nursing career structures intra- and inter-country.</li> <li>2. Prepare and circulate drafts of career structures for Zambian nurses for comments</li> </ol>  | C.N.O., Zambian Nurses Association, Ministry of Health  |  | April - Sept. 92   |
| Shortage of staff            | <ol style="list-style-type: none"> <li>1. Inventory of all nursing staff</li> <li>2. Commission research on utilization of graduates</li> <li>3. Proper placement of the nurses (job satisfaction)</li> <li>4. Proper screening of nurses going for further studies</li> <li>5. Review placement of specialized nurses</li> <li>6. Review and strengthen the bonding system to ensure that nurses practice in their areas of specialization</li> <li>7. Review enrolment policy into schools of nursing</li> <li>8. Strengthen referral system from Regional Health Centre to hospitals</li> <li>9. Review of salary structure and conditions of service in line with the proposed career structure</li> </ol> | <ol style="list-style-type: none"> <li>1. C.N.O</li> <li>2. P.N.O. and P.B.N.</li> <li>3. C.N.O.</li> <li>4. C.N.O (through manpower sub-committees</li> <li>5. C.N.O.</li> <li>6. M.O.H.</li> <li>7. M.O.H.</li> <li>8. M.O.H. (PHC unit)</li> <li>9. M.O.H., Z.N.A. and C.N.C.</li> </ol> | <ol style="list-style-type: none"> <li>1. M.O.H.</li> <li>2. M.O.H.</li> <li>3. Nil</li> <li>4. M.O.H.</li> <li>5. M.O.H. &amp; Cabinet office</li> <li>6. M.O.H.</li> <li>7. M.O.H.</li> <li>8. M.O.H.</li> <li>9. M.O.H., Z.N.A. and C.N.C.</li> </ol> | <ol style="list-style-type: none"> <li>1. Last week of April</li> <li>2. Jun-Dec 1992</li> <li>3. On-going</li> <li>4. On-going</li> <li>5. On-going</li> <li>6. On-going</li> <li>7. April-Dec. 1992</li> <li>8. Nov. 92</li> <li>9. Jan-June 93</li> </ol> |

ZAMBIA (cntd.)

| PROBLEMS                                  | ACTIVITIES  | RESPONSIBLE   | RESOURCES   | TIME FRAME   |
|---|---|---|---|--|
| Education and service gap                 | <ol style="list-style-type: none"> <li>1. Establish in-service/continuing education depts. and strengthen those in existence</li> <li>2. Revision of procedure manual, ward guidelines and policy manual</li> <li>3. Establish standards of nursing and develop code of ethics for nurses</li> <li>4. Strengthen ward affairs committees</li> <li>5. Review age clinical teaching and students</li> <li>6. Strengthen the capacity of clinical teachers</li> <li>7. Place nurses with post basic qualification in clinical practice settings</li> </ol> | <ol style="list-style-type: none"> <li>1. M.O.H. and C.N.O.</li> <li>2. G.N.C.</li> <li>3. Z.N.A., G.N.C., M.O.H.</li> <li>4. G.N.C.</li> <li>5. G.N.C. &amp; Nursing schools</li> <li>6. M.O.H. &amp; G.N.C.</li> <li>7. M.O.H.</li> </ol> | <p>M.O.H.</p> <p>M.O.H.</p> <p>Z.N.A.</p> <p>-</p> <p>M.O.H.</p> <p>M.O.H.</p> <p>-</p> <p>Z.N.A.</p> <p>Z.N.A.</p> <p>M.O.H.</p> | <p>On-going May-Dec 1992</p> <p>From June-Dec 92</p> <p>Jan-June 93</p> <p>from May 92 and ongoing</p> <p>August 1992 and ongoing</p> <p>consult NIPA</p> <p>From Sept 92 and on-going</p> <p>From May 1992 and on-going</p> <p>On-going</p> <p>May 1992 and ongoing</p> |
| Low participation of women in development | <ol style="list-style-type: none"> <li>1. To encourage nurses to participate in civic organization and development</li> <li>2. Reorganize nurses' work schedules to allow for participation in other developmental activities</li> <li>3. To strengthen integrated health services (supermarket approach)</li> </ol>  | <p>Z.N.A.</p> <p>C.N.O.</p> <p>M.O.H.</p>   | <p>Z.N.A.</p> <p>Z.N.A.</p> <p>M.O.H.</p>   | <p>From May 1992 and on-going</p> <p>On-going</p> <p>May 1992 and ongoing</p>  |

ANNEX 2

**WORKSHOP ON WOMEN IN HEALTH: NURSING LEADERSHIP FOR HEALTH  
AND DEVELOPMENT**  
**Mbabane, Swaziland, 3-10 April 1992**

**PROGRAMME**

**Day 1 - Friday 3 April**

- 9.00-10.00 (Plenary)
- Official Opening
  - \* Introductory remarks:  
Dr W.C. Mwambazi, WHO Representative, Kingdom of Swaziland
  - \* Keynote address:  
Her Excellency Mrs M. Dlamini
  - \* Musical Interlude by Students from the  
Institute of Health Sciences, Mbabane
  - \* Vote of appreciation:  
Mrs A. Singh Williams, WHO and Dr M. Hirschfeld, WHO
- 10.00-10.30
- Coffee/tea break
- 10.30-16.00
- Invitation to opening of Health Centre by His Majesty  
King Mswati III
- 16.00-18.00 (plenary)
- Brief Introductions
  - Process/Objectives/Outcome

**Day 2 - Saturday 4 April**

- 8.30-10.00 (Group work)
- Discuss Process and Objectives
  - Identification of main issues
  - Expected outcomes
- 10.00-10.30
- Coffee/tea break
- 10.30-12.30 (Group work)
- Achievements/Failures/Obstacles
  - Directions
- 12.30-14.00
- Lunch
- 14.00-15.30
- Group reports from previous session followed by discussion
- 15.30-16.00
- Coffee/tea Break
- 16.00-17.00
- Introductory session on reflexology

**Day 3 - Monday 6 April**

- 8.30-10.00 (Group work) - Values/Visions (Personal, Professional and Organizational)
- 10.00-10.30 - Coffee/tea break
- 10.30-12.30 - Continuation of previous session
- 12.30-14.00 - Lunch
- 14.00-16.00 (Plenary) - Group reports followed by discussion
- 16.00-16.30 - Coffee/tea break
- 16.30-17.30 - Leadership - What is it?  
- Its role in the Nursing Profession  
- How can you empower others to assume a leadership role?

**Day 4 - Tuesday 7 April**

- 8.30 - 10.00 (Plenary) - Group reports followed by discussion  
- Overview of main issues
- 10.00-15.30 - Functional Groups (with breaks for tea/coffee and lunch)
- 15.30-17.30 - Functional Group Reports followed by discussion

**Day 5 - Wednesday 8 April**

- All day - Country Team Work: Plans of Action (coffee/tea and lunch breaks taken at convenient times)

**Day 6 - Thursday 9 April**

- 8.30-14.00 - Country Team Work (coffee/tea and lunch breaks taken at convenient times)
- 14.00-15.30 (Plenary) - Presentation of country team plans followed by discussion
- 15.30-16.00 - Coffee/tea break
- 16.00-17.00 (Plenary) - Continuation of previous session

Day 7 - Friday 10 April

- 8.30-10.30 (Plenary) - Continuation of previous day's session
- 10.30-11.00 - coffee/tea break
- 11.00-12.00 - Closing Ceremony:
- \* Opening Remarks:  
Dr Q.Q. Dlamini, Deputy Director of Health Services,  
Kingdom of Swaziland
  - \* Musical interlude by Swazi participants
  - \* Guest speaker:  
Honourable Minister for Health, Dr F. Friedman
  - \* Musical interlude by Zambian participants
  - \* Vote of Thanks:  
Mrs Agnes Tjongarero, participant from Namibia
  - \* Musical interlude by Lesotho participants

ANNEX 3

**INTERCOUNTRY WORKSHOP ON WOMEN IN HEALTH: NURSING LEADERSHIP  
FOR HEALTH AND DEVELOPMENT**

**MBABANE, SWAZILAND, 3-10 APRIL 1992**

**Participants from Lesotho**

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**INTERCOUNTRY WORKSHOP ON WOMEN IN HEALTH: NURSING LEADERSHIP  
FOR HEALTH AND DEVELOPMENT**

**MBABANE, SWAZILAND, 3-10 APRIL 1992**

**Participants from Namibia**

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**INTERCOUNTRY WORKSHOP ON WOMEN IN HEALTH: NURSING LEADERSHIP  
FOR HEALTH AND DEVELOPMENT**

**MBABANE, SWAZILAND, 3-10 APRIL 1992**

**Participants from Swaziland**

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**INTERCOUNTRY WORKSHOP ON WOMEN IN HEALTH: NURSING LEADERSHIP  
FOR HEALTH AND DEVELOPMENT**

**MBABANE, SWAZILAND, 3-10 APRIL 1992**

**Participants from Zambia**

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**INTERCOUNTRY WORKSHOP ON WOMEN IN HEALTH: NURSING LEADERSHIP  
FOR HEALTH AND DEVELOPMENT**

**MBABANE, SWAZILAND, 3-10 APRIL 1992**

**Facilitators**

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**Observers**

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FORTY-SECOND WORLD HEALTH ASSEMBLY

WHA42.27

Agenda item 18.2

19 May 1989

STRENGTHENING NURSING AND MIDWIFERY IN SUPPORT OF STRATEGIES FOR HEALTH FOR ALL

The Forty-second World Health Assembly,

Recalling resolution WHA36.11 on the role of nursing and midwifery personnel in the strategy for health for all;

Recalling the discussions at the seventy-fifth session of the Executive Board, when the urgent need for an increase in the number of training programmes for teachers and managers of nursing/midwifery services was emphasized, together with the need to develop leaders to motivate and stimulate the necessary changes required to reorient nursing/midwifery education and practice;

Recalling the discussions at the Thirty-ninth World Health Assembly on the role of nursing/midwifery personnel in strategies for health for all and the conclusions that it was not possible to implement national strategies effectively without the participation of nursing/midwifery personnel; that there was an urgent need to strengthen nursing/midwifery education and practice in primary health care; that there was a need to increase the Organization's nursing/midwifery activities at all levels and to ensure the involvement of nursing/midwifery personnel in the development and implementation of health-for-all strategies;

Concerned at the present decline in numbers of nursing/midwifery personnel and recruits in many countries and the implications for the future;

Bearing in mind that the demand for nursing care will increase and the content of care will have to be expanded and partially changed in view of the aging population and life-extending technology, the expansion of activities in health promotion and disease prevention, including safe motherhood initiatives, and the effects of the AIDS pandemic;

Recognizing also that scarce nursing/midwifery skills must be used more cost-effectively;

Aware that little research on nursing/midwifery is being undertaken, and that there are few suitably qualified personnel available to carry out or supervise such research; that on the other hand, information and management systems need to be developed so that adequate and reliable information about nursing/midwifery is more readily available;

Having considered the report of the Director-General on the role of nursing/midwifery personnel in the strategy for health for all, and the comments of the Executive Board thereon;

1. URGES Member States:

- (1) to review their national nursing/midwifery needs and resources and to devise measures to avert shortfalls in the future;
- (2) to take the necessary action in developing strategies to recruit and retain, educate and reorientate, and improve the qualifications of nursing/midwifery personnel in order to meet national needs;

WHA42.27

page 2

- (3) to encourage and support the appointment of nursing/midwifery personnel in senior leadership and management positions and to facilitate their participation in planning and implementing the country's health activities;
- (4) to encourage and support the development of research on more efficient and effective methods of employment of nursing/midwifery resources, including training in research methodology;
- (5) to support both the reorientation to primary health care of all educational programmes for nursing/midwifery personnel and the expansion of continuing education of personnel;
- (6) to adopt or, where necessary, amend regulations and legislation to facilitate the involvement of nursing/midwifery personnel in all aspects of primary health care;
- (7) to provide the necessary supervision and support to personnel, especially those in peripheral areas, to enable them to contribute effectively to the promotion and protection of health, especially the health of the most vulnerable groups;

2. REQUESTS the Director-General:

- (1) to increase support to Member States to strengthen the planning, implementation and evaluation of the nursing/midwifery components of national health programmes, in particular the development, utilization and improvement of the qualifications of nursing/midwifery personnel;
- (2) to strengthen the nursing/midwifery components of all WHO programmes, increasing within available resources the number of nurses and midwives in senior positions at global and regional levels;
- (3) to intensify support for the global network of WHO collaborating centres for nursing development and, through these centres, promote the involvement of other institutions and agencies in extending WHO's work;
- (4) to promote and support the training of nursing/midwifery personnel in research methodology in order to facilitate their participation in health research programmes, including the development of information systems on nursing/midwifery;
- (5) to develop tools for monitoring progress in this field and to report to the Forty-fifth World Health Assembly on the progress made in the implementation of this resolution.

Thirteenth plenary meeting, 19 May 1989  
A42/VR/13

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# DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following declaration:

## I

The conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

## II

The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially and economically unacceptable and is therefore, of common concern to all countries.

## III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

## IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

## V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

## VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.



WHO

**Extract from:**

**Alma-Ata 1978, Primary Health Care.** Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Jointly sponsored by the World Health Organization and the United Nations Children's Fund.



UNICEF

## VII

## Primary health care:

1. reflects and evolves from the economic conditions, sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making the fullest use of local, national and other available resources, and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

## VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

## IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

## X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.



The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.