Leadership in Nursing for Health for All
A Challenge and Strategy for Action

Tokyo, Japan, 7-11 April 1986

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Japan International Cooperation Agency,
The International Nursing Foundation of Japan (INFJ)
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Meaning of Chinese Character:

A Chinese derived character – consisting of two forms: a hand and an eye. This character means observing and also nursing.
(Drawn by Sosetsu Mura)

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Leadership for Health for All
The Challenge to Nursing
A Strategy for Action

* Copies of this report are available, upon request, from the Division of Health Manpower Development, World Health Organization, 1211 Geneva 27, Switzerland.
Note to the reader

This document is a distillation of the ideas and concepts developed during the 1986 Tokyo International Encounter Conference on "Leadership in Nursing for Health for All". Its purpose is to highlight key Conference issues and present recommendations for action. These offer a practical way of producing a new leadership movement in nursing for the achievement of the Health for All goal.

An International Encounter on Leadership in Nursing for Health for All
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Disclaimer

This report contains the collective views of an international group of experts and does not necessarily represent the decisions or the stated policy of the World Health Organization.
Introduction

Forging Links Between Nursing and Primary Health Care

Nurses* are now aware that they can be a powerful ally in the coalition needed to promote Health for All through primary health care. Primary health care is an objective that has always been a fundamental driving force for them, a natural extension of nursing practice, especially in community health. Momentum is gathering behind the plan to achieve Health for All by the year 2000. So the pressure is on for a shift by nurses from their traditional roles to the assumption of greater responsibility in a much wider arena of action focussing on healthy people and healthy environments.

This document spells out the nature of primary health care in principle. It shows its links with the goal for Health for All and how nurses can reshape their role today to assume a natural, leading role in the whole process. It is intended to be used as a tool for questioning, research, analysis and action. Therefore it offers, to all nursing personnel, a resumé of the challenges facing the leaders of today’s nurses. It is an analysis of how to face those challenges. It outlines specific activities to be developed in practical settings. It should not be seen as a theoretical, fine-sounding declaration of intent. It is a handbook combining a grand design with down-to-earth ways of scrutinizing the status quo and then planning the future.

Health for All and primary health care mean both revolution and decentralization, demanding changes of every health professional at every level of the health system. Nurses are not exempt. They now have to be prepared to become agents of change. This is something their education to date has not traditionally prepared them for. They now have to develop a new health perspective. This is because Health for All, through primary health care, requires substantially different attitudes, levels of competence, knowledge, and skills from those which characterize traditional nursing. They also need to be more aware politically,** not so much of the confrontation of party politics, but of the way politics touch on health. Politics remain the vehicle of policy-making and of social change.

There was deep concern expressed at the Conference that since the first global meeting on Primary Health Care at Alma-Ata in 1978 there had been slow progress to date on Health for All and genuine primary health care. Should this slow rate of progress be allowed to continue, then an already unsatisfactory situation would deteriorate even further. Nurses can help change this situation.

Nursing personnel are one of the most valuable assets of any health care system, and represent considerable national investment. The harnessing and development of the skills of some 50 per cent of the world’s health personnel resources which they represent could ensure the most appropriate and the most cost-effective method of delivering health services to attain Health for All. Leadership in nursing is required at all levels of a health system, but it can be effective only with appropriate support. That support can be sought from government, from within nursing organizations, and from WHO.

The nursing profession now needs to produce the leaders necessary to unleash this potential driving force. It must expect to face resistance yet take up positions from where it can voice its opinions at policy and decision-making levels. The key elements in determining the future roles and responsibilities of nurses are the changes they can bring about and the influence they are able to exercise.

* Where applicable nursing includes midwifery personnel.
** Throughout this report, the word “politics” and “political” are used in the “health-political” and not the “political-political” sense.
Facing Dilemmas

Leadership for Health for All requires radical moves and it presents nursing with a number of dilemmas. The nursing culture is heavy with subordination without influence. It is burdened with obligation without power – even in directing, heading and controlling its own education, practice, research and management. Such an ethos militates against the emergence of positive initiative. There is a need for leaders who will convince their colleagues of the enhanced role of nursing. The majority of nursing’s current leaders must accept this, and change accordingly. The harsh reality is that they do not at present show those attributes required of leaders who can bring about successful change in health development.

There is a need to encourage a shift in the attitudes of the public as well as in those of health professionals. The cultural factors which militate against nursing’s adoption of a leadership role are many and obvious. They include the tendency of many communities to hold on to conservative attitudes towards health care. They prefer a medically-oriented, curative health care system, rather than an approach based on health promotion and sickness prevention.

Within the spectrum of care, the dilemma is that of achieving a balance between institution and community, treatment and prevention, management and cure. Nurses also have to equip themselves with the means to share knowledge and skills with individuals and the community, and to know how to delegate to people responsibility for their own health. That means mobilizing for public health action and collaboration for Health for All and All for Health.

1. A Time for Change: The Keynote Address

In the Keynote Address (1) to the Conference, Dr Halfdan Mahler, Director-General of the World Health Organization, spelled out the size and nature of the challenge. Nursing is a vital group for the success of Health for All. This demands a new set of values, involving fresh approaches and innovative responses from all the health professions. Only then can a means be found to bridge many unacceptable gaps and tackle intransigent problems. These problems are not only technical and managerial but touch key social, professional and economical issues and values because health is a goal for the whole of a society and an integral part of its development.

A health system should represent both the medical “care and repair” of the sick and the maintenance of health. That means making the spirit of self reliance at every level of society – for the individual, the family, local community, and nation – second nature.
Social justice and equity are often proclaimed yet the political will to achieve them is all too often persistently lacking. Every society must confront the dichotomy of organ transplants taking place while death and disability amongst young children is condoned when it can be avoided so easily with the minimum of technological resources.

The methods and techniques used to maintain health and treat illness are an integral part of the health services. Therefore they must be appropriate for the country concerned. They need to be scientifically sound, adaptable to differing local circumstances and acceptable to consumer and practitioner alike. They should also be maintainable within the resources of a country.

Health professionals still remain more attracted to high technology fields and heroic medicine rather than those dealing with human or social concerns where they may be able to contribute much more. There are growing numbers of unemployed doctors and nurses yet their skills are badly needed not only in the rural areas but in the deprived inner cities. Crucial to the strategy for change is ensuring social and quality control of the health infrastructure and technology, through a high degree of community involvement. This is the essence of the primary health care approach.

**Tackling Inequality**

Things have improved, of course, since 1978, when leaders of the world’s health community declared at Alma-Ata that the health status of hundreds of millions of people in the world was unacceptable. They then called for a new approach to health and health care to shrink the gap between the “haves” and “have nots”. Many countries set into motion a process of transformation of their health policies and health systems based on the fundamental principals embodied in the values of Health for All. This process has had the added benefit that countries everywhere are now much readier to be open and frank than in the past about their advances and setbacks when they meet in major public gatherings.

Concern about the slow rate of change must be partly balanced against the fact that there has been some improvement in the world’s health. More people are living longer in many developing countries, and fewer are dying unnecessarily early in life. But unacceptable gaps prevail – for example, only 40 per cent of the world population enjoys a life expectancy of 60 years or more; a large majority of the countries in Africa, South East Asia and the Eastern Mediterranean area (representing 45 per cent of the global population) have infant mortality rates higher than 50 per 1,000 live births. Forty-four countries of the world, of which 29 are in Africa, show infant mortality rates higher than 100 per 1,000 live births.

While impressive efforts have been made by some developing countries to improve their health infrastructure, health services are still failing to reach out to those who need them most, both in the rural as well as in the rapidly expanding urban areas. Globally, 1,000 million or more people have no access to adequate or safe water; 1,500 million or more people lack an adequate basic sanitation service; many millions of mothers are still giving birth to their children without any care during pregnancy or are unattended during delivery; and millions of people in rural areas remain without adequate access to essential health care and life-saving measures.

Health care systems in some developed countries have become astoundingly complex enterprises, conducted on a gigantic scale and at a staggering cost which does not yield corresponding returns in health. This has caused many developed countries to realize that, despite expensive and impressive health infrastructure and technologies, the emerging health problems of their people require a completely new approach which emphasizes individual self-reliance and commitment to “good health”.

What is now needed is a leadership that can help to construct a system that is practical and which reflects this new understanding of health. Such a structure must do more than produce great microbiologists, surgeons, teachers and occasionally managers. It must help to create a body of leaders among whom nurses will be an important sector because they represent the biggest group and the strongest link between the public and everyday care and health education.
Sensitivity and Dedication

Committed and dedicated leaders are now required, in sufficient numbers across the board, who are sensitive to social values. A passion to motivate and mobilize others and channel vital human energy in this fresh direction must be part of their activity at community level. Their leadership will be marked by a readiness to take up the cause of social justice for the poor, to adjust their own traditional values and approaches and be willing to take risks.

Such leaders also have their place in educational and scientific institutions. The search is on for women and men who can fully visualize the scope for improving the human condition. They will be willing to concentrate their intellectual energy on this task and be prepared to motivate others, especially future generations of health professionals, towards the new social values inherent in the Health for All goal.

Strong leaders are necessary, particularly for organizations that must undergo significant change. Not just good managers or executors, but people who are value driven. Leaders who know how to mobilize the will of others, leaders who provide motivation and direction, leaders who feel strongly about issues, leaders who are thinkers as well as doers.

This is what now stands before the nursing profession. It is a moment of choice. The decision must be made rationally and with a full understanding of the key concepts of Health for All and primary health care.

2. The Meaning of Health for All

I

"Health for All" means that health is to be brought within reach of everyone in a given country. And by "health" is meant a personal state of wellbeing, not just the availability of health services - a state of health that enables a person to lead a socially and economically productive life. "Health for All" implies the removal of the obstacles to health - that is to say, the elimination of malnutrition, ignorance, contaminated drinking-water, and unhygienic housing - quite as much as it does the solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines.

II

"Health for All" means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it.

III

"Health for All" demands, ultimately, literacy for all. Until this becomes reality it demands at least the beginning of an understanding of what health means for every individual.

IV

"Health for All" depends on continued progress in medical care and public health. The health services must be accessible to all through primary health care, in which basic medical help is available in every village, backed up by referral services to more specialized care. Immunization must similarly achieve universal coverage.

V

"Health for All" is thus a holistic concept calling for efforts in agriculture, industry, education, housing, and communications, just as much as in medicine and public health. Medical care alone cannot bring health to hungry people living in hovels. Health for such people requires a whole new way of life, and fresh opportunities to provide themselves with a high standard of living.

VI

The adoption of "Health for All" by a government implies a commitment to promote the advancement of all citizens on a broad front of development, and a resolution to encourage the individual citizen to achieve a higher quality of life.

VII

The basis of the "Health for All" strategy is primary health care.
3. Primary Health Care: The Alma-Ata Declaration

Primary health care is the strategy for achieving Health for All. It establishes the broadbased principles that give to people the right to health services where they live, work and play and also enables them to take on the responsibility of promoting their own wellbeing and that of their community.

Thus, primary health care:

I

Reflects and evolves from the economic conditions and 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;

II

Addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly;
III
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;

IV
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;

V
Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end, develops, through appropriate education, the ability of communities to participate;

VI
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;

VII
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.

Health for All—All for Health
4. The Nursing Spearhead: Leaders in Primary Health Care

The key role of nursing in implementing the essential changes in primary health care is clear. Nurses have always had a strong dedication and commitment to social causes and have shown an acceptance of and a readiness to change. The very nature of their work gives nurses an enormous advantage. They provide care at all levels and in all settings which gives them direct contact with the population. They are frequently the main link between individuals, the family and the rest of the health system and they form the largest sector of health workers in many countries.

Because of their everyday contact with people, nurses witness the ravages wrought by ill-conceived and inadequate health services on the population. They are eminently positioned to voice the feelings of the people whom they serve and to give them credibility and reasoned support and are often seen as natural leaders at the community level.

Nurses thus have a responsibility to lead the change. They need to identify the strategies and actions that will be required to exercise their full leadership potential. They need to look beyond the expansion of traditional nursing roles or mere cosmetic changes in the educational programmes to a deeper understanding of the philosophy of primary health care and a commitment to its values and goals.

Because understanding is the seed-bed for action, nurse leaders must:

- have a clear perception of the goal towards which effort should be directed;
- demonstrate a commitment and determination to reach that goal;
- be able to select, from a variety of options, those policies, strategies, procedures or objectives which appear most likely to achieve the agreed end; and
- inspire a level of trust and confidence which promotes motivation in others towards attainment of the goal.

Leadership may mean taking unpopular decisions. It requires courage and a clear-sighted view both of the issues and the techniques needed to tackle them.

Defining areas of action, eliciting and evaluating response, argument and advocacy are also part of the process. The complex task of implementing change demands that leaders for Health for All have a:

- **Clear understanding** of the Health for All Strategy and its broad principles;

- **Capability** to identify critical issues affecting the implementation of the Health for All Strategy and to focus energy on resolving them, and to convert obstacles into opportunities;

- **Confidence** born from the knowledge of having the relevant skills and experiences;

- **Capacity to motivate** others, especially other prominent colleagues and influential groups, to mobilize their commitment to the values of Health for All and to solve problems;

- **Commitment** to guide national policy toward social equity and to reduce health inequality and related socioeconomic inequity among people; and

- **Comprehension** of the health aspects of policies of other sectors and an aptitude to argue for health in an intersectoral setting.
The Right Prescription for H.F.A. Leadership

- Comprehension
- Capacity to motivate
- Commitment
- Clear understanding
- Capability to identify critical issues
- Confidence
5. Key Issues

The Conference detailed the immediate and long-term needs to give nursing the impetus and confidence to direct and lead change. It considered how future educational programmes might be structured and what changes are required in nursing curricula to create nurse leaders.

Any restructuring of the educational system will have to recognize the fact that there is a shortage of teachers with the appropriate grounding in primary health care. A basic need for teaching in this area has to be fulfilled, combined with a fresh approach to curriculum design. Only then will the education and training of nurses enable them to:

- work effectively with other sectors and other team members;
- provide the range of services necessary in the context of community needs;
- facilitate the development of appropriate technologies for effective primary health care services;
- provide relevant health information for more effective community involvement and participation; and
- address relevant social, economic and health policy issues affecting health development.

Today’s Nursing Leaders

As a step towards identifying avenues for action the Conference drew up a profile of a “typical” leader of nurses today. The portrait that emerged revealed strengths, weaknesses and latent abilities. If certain limitations could be removed, all could be turned to advantage, even while working within a well-established framework.

The picture showed that nursing leaders today have sound knowledge and skills relating to:

- common disease processes and other illnesses requiring medical or surgical intervention including the administration of drugs, other therapeutics and diagnostic agents and tests;
- basic administrative/management principles and practices involved in delegating, directing, supervising and evaluating the work of other levels of nursing/health personnel in the hospital setting;
- maintaining institutional records and information systems; and,
- the coordination of local patient-care services.

Nurse leaders have an ability to fit into a prescribed framework and follow the techniques and procedures of patient-centred care, “according to doctor’s orders”. They seem to acknowledge the demands of a bureaucratic structure and are able to survive and, possibly achieve some mobility, without “rocking the boat”. Both these attributes may be a weakness rather than a strength in the context of change for positive leadership.

The profile indicated that there were varying degrees of lack of knowledge and skills. These were in relation to:

- the basic sciences which form and support the practice of professional nursing;
- the “scientific” method and its application to nursing practice, including the nursing process;
- the organization and availability of health care facilities and resources;
- budgeting and financial management;
- a health care team approach and relationships;
- the new health values — the Health for All goal and the primary health care approach;
- a holistic, family-centred, community-based approach to health care;
- the sociology of the community;
- policy-making and planning processes, including political and government;
- the process of change and the role of leaders as agents of change;
- accountability: its pre-conditions and process;
- defining salient and visionary aims and mobilizing resources to achieve them;
- taking courageous and unpopular action; and
- exercising assertiveness and managing power.

Formulating the profile was extremely useful because it highlighted the factors that influenced nursing attitudes. These were portrayed as:

- a strong orientation to hospital nursing, with its emphasis on its medical and surgical aspects and on a hierarchical staffing structure;
- community nursing being regarded as a peripheral or semi-professional service;
- an unwillingness and absence of confidence to exercise legitimate power; and
- the adoption of postures of dependency and passiveness.

**A Quantum Shift**

A fundamental restructuring is called for to make Health for All and primary health care a reality. There is a need for new knowledge. Up to now the views, expertise and experiences of nurses and other non-physician health professionals, such as sociologists and anthropologists, have rarely been considered in organizational analyses of the Health for All movement. Such non-medical opinion, as well as the empirical “hands-on” expertise of the practitioners of everyday, person to person, health care which nurses have, is notably absent from prestigious scientific and intellectual groups concerned with Health for All. This reduces the breadth and range of ideas essential for comprehensive planning and policy development.

Health personnel planning and development has usually emphasized the numbers of personnel needed rather than the quality of those staff, whereas it must deal with both. The attributes of a leader — knowledge, attitude and skills — have rarely been identified, fostered and strengthened. Moreover, in this context, little attention has been paid to the composition of planning and decision-making terms: future working relationships can be enhanced by common foundation courses.

Although nurses often have the power of numbers to effect structural changes, they can do so only if they are sensitized, organized, politicized and mobilized. But they are hindered because the health personnel planning policies of some countries can militate against nursing leadership development. This is particularly difficult to achieve when there is no opportunity for nurses to gain satisfactory employment after qualifying. They then become “marketable products”, usually from developing countries. This also results in a brain drain between developed countries.

Some countries see nurses as an export commodity to earn foreign currency which when sent home can boost foreign reserves to pay national debts. Nor does national dependence upon foreign loan and aid facilitate the propagation and practice of the primary health care principle of self-reliance. Because of the conditions laid down by loan givers this can mean
that specific national targets or quotas are related to an external time-frame. The latter may result in certain programmes and activities being imposed or implemented without allowing adequate time to educate or prepare health workers. Similarly members of the public may not have the opportunity to become well informed and active participants in health care services.

6. Specific Strategies to Assume Leadership in Health for All

Nurses, because they are usually women and because of the nature of their primary and secondary education, have been traditionally assigned a passive role rather than one of initiative and leadership. Thus, society ignores their special skills in communicating with people, imparting to them information and knowledge about health problems and enhancing their capacity to resolve them. They have many assets: nurses teach and support other health community workers, they are successful in organizing communities and in facilitating people’s own involvement in health.
The Health for All movement offers nurses not only a tantalising challenge, but an opportunity to develop even more valued characteristics and strengths. They are already beginning to explore primary health care technologies and expand the way people use them. In a small but growing number of countries they are already seen as natural leaders at the community level. However, untapped potential far exceeds present performance.

Career structures must now allow flexibility for nurses to be innovative in their everyday work on a planned basis and to exercise leadership. This will prevent "burnout", the situation where initiative is stifled at an early stage and where potential leaders leave the profession in frustration. The structure must also provide opportunities to learn how to develop the professional confidence needed for effective teamwork and intersectoral collaboration.

Nurses should now shed their reluctance to move out of the security of institutional and hierarchical structures. Previously they have felt justified in refusing to do this because it meant taking on extended roles and responsibilities for which they had not been prepared and/or were not legally covered. Such limitations should be removed.

Leadership in Health for All can only be learnt by doing. Because nursing's power rests on its practice, the development of nursing leadership depends upon fundamental shifts in both service and education. There is a need to unify this vast potential social force, so that it becomes a virtual powerhouse of collective energy working to achieve Health for All.

**Taking Specific Action**

It is necessary to define the specific roles and responsibilities which leaders may be expected to play at each level of a health care system. A model has been evolved, detailed below, which can be adapted to each country's own unique circumstances, health problems, cultural patterns and resources. It is suggested that nurses take the list to check how the activities suggested relate to their own environment and that they also draw up a parallel action list.

The initiatives that should be taken will form part of an integrated effort at Community, Intermediate, National, and International levels. Certain responsibilities are common to the first three, while others are distinct and specific to each setting.

**At Community, Intermediate and National levels three common principles for action become evident. They are:**

- facilitating coordination and fostering links among nursing and with other relevant bodies;
- fostering networks of alliances with key individuals and groups, including media representatives and politicians; and
- identifying potential community health leaders and working towards their recognition and development.

**At Community level the responsibility of nursing leadership could be directed towards mobilization:**

- of communities to foster health development;
- of resources and their management, directing them to areas of greater need; and
- of intersectoral action for community health development.

**Other important activities are:**

- helping to foster self-reliance in health for the individual and the community, for example in identification of health problems, prioritizing needs, becoming aware of appropriate technologies, monitoring and evaluation of personal health;
- collection and dissemination of information relevant to community health;
- assessing and monitoring the quality of nursing care and the effectiveness of health services; and
- developing innovative primary health care strategies; supporting and evaluating their implementation.

The Intermediate level is that between Community and National activity. At this stage there is also a need for mobilization:
- of health workers and the public at large to a commitment to Health for All values; and
- of influential, special interest, and consumer groups, and communicating with representatives of the mass media to promote health.

Other important activities are:
- participating in policy-making and planning which also includes the allocation of resources;
- organizing priority nursing components within health programmes;
- evaluating the education and skills of nursing personnel, identifying and guiding the changes or reorientation required;
- contributing to and participating in policies related to health personnel, including nursing; and
- monitoring and evaluating health care services.

The third stage is leadership at National level where nursing leadership must play a policy-making role in:
- influencing the promotion of Health for All/primary health care;
- health programme and health personnel development; and
- allocation of resources, the assigning of priorities, the establishment of norms, and of information systems.

Other roles and activities may be:
- mobilizing support for Health for All from nursing and other professional groups;
- suggesting legislative and managerial changes to facilitate nursing development;
- defining and recommending changes required in nursing education, services, management and research; implementing these changes and evaluating their effect;
- assessing and utilizing research, particularly that which has implications for nursing’s contribution to Health for All; and
- taking a leading role in propagating the Health for All goal through seminars, meetings, conferences and articles in technical journals.

Such roles involve a recognition of the principle of accountability at all levels. This process will counteract the hierarchical structure in nursing which has for so long inhibited individual and collective professional growth.

At the International level nurses have to fulfill both personal and collective leadership roles to promote Health for All and primary health care. These could be considered lobbying roles in:
- exerting influence on policy-making bodies and in the formulation of resolutions which give
guidance, (for example, to WHO Regional Committees, to the World Health Assembly and UN Agencies);

– influencing international bodies, agencies, or groups which allocate resources to health services and/or education, e.g., bilateral and multilateral agencies;

– seeking membership of, or representation at, meetings of agencies concerned with international health development;

– promoting solidarity among countries by organizing an exchange of information, through intercountry studies and research, and networking for technical collaboration. This would help the formation of groups of health workers for primary health care in individual countries; and

– advocating the Health for All goal through meetings, conferences and articles in journals.

7. A Fresh Perspective for Today’s Leaders

If nurse leaders are to become visible, they will have to move out and establish lines of communication through a variety of channels to other professionals and the general public. The majority of leaders in nursing still operate intra-professionally, tending to communicate only with others like themselves, at meetings of nurses, through writing for professional journals or when debating nursing issues.

The obvious priority is to educate those nurses who are already in positions of leadership such as chiefs or directors of nursing services in ministries of health or health care institutions; heads/deans/directors of nursing schools, especially of those schools offering higher education which prepare teachers and administrators; nursing editors; major officers of nursing and nursing-related organizations; and influential nurses involved in drawing up regulations for nursing education and practice. Enlisting their support and changing their approach can be achieved more quickly than changes in the curriculum of basic education. Such action will have an immediate effect on policy.

Nursing education – whether higher or continuing – should be directed towards bringing about shifts in perspective. As the profile of contemporary leaders at the Conference revealed, nursing has certain ingrained perceptions. These will need to be challenged, dispelled or replaced with new ideas which will:

– create an attitudinal change from hospital/curative to community/preventive/health promotive values and an appreciation of Health for All;

– establish a broader knowledge base about health development and its specific issues, including the use of data, intersectoral collaboration, and teamwork;

– create an awareness of planning and strategic action to accelerate change; and

– enhance the learning of new skills such as those related to basic economics, policy development, statistics, research methods and communication.

One effective way in which to present this kind of educational experience is through multidisciplinary workshops, and by giving leaders of nurses direct experience of teamwork and learning-by-doing with other professionals.

Exerting influence

Nurses should be able to use effective strategies to manage situations and present their particular point of view. Techniques such as networking, creating alliances, negotiation, and management of conflict and confrontation should become part of the armoury of every nurse in a leadership position. Education in these skills should take place in a variety of settings –
during educational courses, through in-service training, in political workshops, political activities and action, in the course of work with legislative committees and professional associations, as well as in the family/community environment.

Because politics is the vehicle of policy-making and social change, some nurse leaders will have to combine the more gentle art of nursing with the rougher one of political activity. Nursing organizations, who have a responsibility to develop nursing and nurses, should promote and provide facilities and opportunities for potential nurse politicians. That includes flexible curricula, duties and time-off and ensuring their access to information. Education for political effectiveness needs to include the development of skills in public speaking, debating procedures, and handling hostile situations.

The development of communication skills is seen as an important source of influence, and value was placed on learning to use all forms of communication technology, e.g. television and radio, as well as newspapers and magazines. Although recent years have seen the emergence of nurses who contribute to the printed media in a number of countries, this trend is far from universal.

Other components of continuing education for today’s leaders of nurses need to be developed in the context of each country. The majority will probably include discussion of real-life situations related to Health for All in specific settings, as well as opportunities to develop skills necessary for effective group behaviour.

8. Educating Today’s Students

The nursing curriculum today has been influenced by certain preconceived notions, for example, that nursing is a female-dominated profession that generally adopts passive roles. This belief has had an adverse effect on professional development and on the practice and education of nurses. Leadership development has been limited, so there is an urgent need now for changes in the curriculum to combat such perceptions and promote more relevant thinking.

Courses should include ways of making students sensitive to these problems so that, at an early stage in their careers, they recognize the need to adopt appropriate strategies. Considerable emphasis should be placed on developing those traits which challenge and negate current female stereotyping. Thus assertiveness, risk-taking, independence and self-confidence should be projected as desirable and necessary for nursing leadership. The history of nursing, the lives of former effective leaders in the profession, and research and literature on the past efforts of women to effect social change in all areas of society, should also be included.

In many countries there is external control, often by non-nursing academics, of nursing education and practice. This poses continuing problems and the use of power and politics is central to rectifying this imbalance. Nurses need basic knowledge on how to achieve positions from which they can exercise power, and influence and change the system in which they work. Therefore students, practitioners, administrators (managers), educators (teachers), researchers – indeed all nurses – should learn the use of systems theories, political and power theories and the use of power and influence to achieve goals.

The Widening Horizon

A paramount requisite is that potential nursing leaders should receive their professional preparation under the auspices of institutes of higher education whose primary purpose is learning and education, not service. The community which exists outside the hospital world – with all its problems, facilities, possibilities and resources – should become their major, and most frequently used, territory to learn and practice their art.

The ability to discuss broad issues affecting health and development is essential if nurses are to be listened to and not just heard. Society’s growing interest in specific concerns relating to women gives nurses an excellent opportunity to lead such discussions from the high ground, precisely because they are experts from a predominantly female profession.
Formal educational programmes are crucial to the development of nursing leadership. These programmes should be assessed and restructured in the context of comprehensive national health personnel development policies and plans. Inevitably this must mean seeking out hidden talent and encouraging active leadership skills. Training centres should be identified which have the staff and facilities to create links with individuals, institutions and organizations to form resource and support networking at national, regional and inter-regional levels.

9. Public Affairs and the Practice of Nursing

Political and economic forces have created rapid social change and conflict and these are increasingly affecting health care issues and nursing practice. This trend requires nurses to be active in influencing policy for health, taking a ring-side seat in the arena of public affairs. Nursing leadership could be active in mobilizing and influencing governments, non-governmental organizations, and other health-related groups at all levels – local, regional, national and international – to set priorities, allocate funds and take appropriate decisions.

At work too, nurses should feel confident in leadership. The skills to achieve this can be acquired in various ways. This may mean initiating innovative modes of delivery of care and then following up with evaluation. For example, the early discharge of patients from both general and psychiatric hospitals now means evaluating different methods of providing home care nursing. In some countries nurse practitioner programmes have been initiated. In others
public health nurses have been given responsibility for preventive and curative care in relation to a specific group, e.g. elderly persons, or in relation to a specific level in the health service, e.g. clinics at district level. The ramifications of such assessments involve local politicians, budgets, and high profile public reaction – all essential areas in leadership development.

A critical factor is how to lead without alienating. A leader needs to be a model for other potential leaders, particularly in relation to Health for All and primary health care issues. Guiding others is the other half of the skill. To some this comes naturally but this activity should be built into the general process of education and provision should be made for today’s leaders to learn this technique. Workshops should include information on the personal and professional advantages of the activity, as well as offering techniques on how to guide others.

10. Regulatory and Legislative Reforms

Nursing practice and education are often governed by legislation which is archaic and out of step with the health needs of today’s populations. Implementing primary health care strategies necessarily calls for the re-evaluation of policies and this process should also include the revision of regulations which affect nursing. This kind of reform requires:

– an analysis or review of existing regulations in order to identify laws (especially those which hinder primary health care practice) which require amendment or abolition;

– nurses to be made members of the regulations’ boards or committees which govern their education and practice; and

– the development and enactment of regulations to facilitate the development and implementation of curricula and primary health care practice.

11. Resolving Internal Conflicts in Nursing

In order for nursing to demonstrate to others a new level of responsibility and imagination it will need to resolve some of its own internal conflicts. It is a paradox that, in the area of practice, the very diversity of nursing can be a strength and an advantage, but it is often an obstacle in the development of leadership.

The segregation of nurse leadership by level, clinical speciality and location tends to dissipate the awareness of the position of a leader and the ability to exercise power. If nursing’s potential influence is to become a reality, “common” leaders must be identified and supported. Such a “unified” approach will give greater impetus to efforts to negotiate and effect change.

Multilateral Activity

In order to close the alleged gap between service and education, new approaches could facilitate collaboration in the use of resources, the sharing of knowledge and experience and the development of joint endeavours.

The leaders of nurses increasingly need to become involved in multilateral contact such as that between education and practice, education and research, research and practice, and so on. While this process of unification through diversity is going on, leaders in an area of specialization should bring into their own professional groups representatives from a cross-section of health practitioners. This will help increase the cross-fertilization of ideas. This can be strengthened by making sure that networks operate inter- and intra-professionally.
Planning change for Health for All can be made more successful by:

- encouraging nurses to act as agents of change and motivating and rewarding them in the process;
- minimizing their isolation through dissemination of information about nursing and health development activities; and
- using and spreading knowledge generated by these agents of change.

12. Identifying and Preparing Tomorrow’s Leaders

A good leader knows when to be prominent, outspoken and charismatic, and also when to “lead from behind”. Potential leaders are sometimes not recognized because they adopt only the second of these approaches. Senior nurses have a responsibility to identify leadership qualities in nursing students and young graduates; they must also nurture those skills for individuals, teams or movements from the very outset.

Support for such continuous development, the provision of stimulating career structures and improvement in working and living conditions are vital elements in boosting nursing morale. This, allied with incentives to work in remote and difficult areas, and an awareness of partnership with other professionals and colleagues, will create leaders capable of influencing and stimulating change. These benefits will become evident not only in the field of nursing but also in the achievement of Health for All. Appropriate support for promising students and young graduates will unleash the potential, not only of a vast health personnel resource, but also of nursing’s future leaders.

13. Re-forging the Nursing Contract with Society

Over the past decade, many nurses have struggled to re-shape the social contract between nursing and society with at least two objectives: first, gaining greater public recognition of the significance of nurses in health and healing; and secondly, increasing the participation of nurses in creating knowledge, in restructuring institutional arrangements, and in shaping health policies and services.

These two aspects constitute a power base in themselves. They are the strategic building blocks for a re-fashioned approach to nursing leadership for Health for All.

Nursing is the occupational group best situated to make Health for All a reality. But it will not be able to make a full contribution unless this advantage is coupled with policies and activities designed to alter the balance of power and institutional support for nurses. The powerless cannot lead. Frustrated attempts to lead change only diminish the confidence and self-reliance of those who put their trust in a leader.

Studying networks of power and influence and the conditions under which they operate can yield valuable information to assist nursing in re-structuring and reorganizing itself. Alliances with such power groups could lead also to the coordination of research efforts with academic communities, professional, or special interest groups. One example is women’s organizations who investigate the strategies and tactics of women leaders working in both traditional and non-traditional female professions. The development of collaborative research consortia specifically concerned with leadership, should facilitate the collection, maintenance and distribution of data on nursing leadership, influence, and power. This could be achieved through consultations, curricula, workshops and newsletters.
Another important aspect of information collection and dissemination is the ability to involve the mass media, and make it aware of these new strategies for leadership, the changing role of nursing and the way nurses can guide others. Qualitative and quantitative data on the way they influence and lead others will include information on involvement in political, administrative or policy-making activities, as well as on specific changes being carried out within nursing. In turn, this will help to identify what knowledge, abilities and attributes are required to take a leading position in varying situations. It will help to determine whether a leadership style which is effective in one field of nursing can be repeated successfully in another.

14. Recommendations

The aim of the Conference was to trigger and sustain activities which would enable present and future leaders in nursing to achieve more rapid progress towards Health for All. Its premise was that the gap which exists between Health for All policy and its implementation could be substantially reduced if nurse leaders had a better understanding of the dynamics of change in the context of Health for All. This would help them to develop those qualities that would promote change and support leadership in nursing.

Leaders can be made. And appropriate education and relevant experience can improve leadership style and performance. The Conference identified some approaches which countries, nursing organizations and WHO could use to encourage the development of nursing leadership for Health for All. These include formal training within reoriented educational programmes and informal training at each service level of health care systems.

The following are specific recommendations:

I. To Facilitate and Ensure the Presence of Nurse Leaders at Policy and Decision-Making Levels

A. Countries
– include nurses as members of government bodies concerned with planning, funding, implementation, control and evaluation of health service and health personnel development programmes; as members of delegations to relevant international conferences and assemblies;
– establish, or increase in number, as appropriate, nursing posts in government service, particularly at senior levels of national health systems; and
– facilitate and encourage contributions to discussions on legislation and national health policy by nursing organizations.

B. Professional Nursing Bodies at International, National, Regional and Local Levels
– foster organizational activities to aid the process of selecting effective nurse representatives as members of policy-making, planning and other relevant bodies at all levels of the health system; and
– mobilize the cooperation of influential, lobbying and consumer groups and non-governmental organizations, and liaise with representatives of the mass media, in order to ensure nurses have a greater influence for Health for All.

C. WHO
– review the contributions nurses are making to relevant WHO programmes and activities at all levels; identify where and how nursing involvement needs to be strengthened or increased; take any urgent action required; and make appropriate long-term plans to accelerate the attainment of Health for All through nursing contributions to relevant programmes.
II. To Facilitate Investment in the Powerbase of Nurses, so That They Have Opportunities and Resources to Exercise Leadership in Health for All and Primary Health Care

A. Countries

– identify how nursing leaders may respond to national strategies for Health for All/Primary Health Care; initiate appropriate educational activities and learning opportunities so that a critical mass of such leaders, acting as role models and as guides to others, is mobilized at each level of a national health system;

– encourage and support the development of links between these leaders, educational institutions and organizations to form resource and support networking at all levels of the health system;

– facilitate and encourage young nurses, identified as potential leaders, to develop their attributes and abilities and to acquire a broader understanding of health development in a multidisciplinary context;

– give financial, technical and moral support to nursing institutions which are initiating curricula changes to, and/or the development of continuing education programmes for leadership for Health for All/Primary Health Care; and

– amend regulations and legislation which restrict the development of nursing leadership at practice levels.

B. Professional Nursing Bodies at International, National, Regional and Local Levels

– work towards solidarity of the profession by promoting cooperation and strengthening communications between nursing leaders, institutions and organizations;

– take organizational action to encourage and facilitate the development of leadership and political skills, including the application of research data to ensure appropriate changes in nursing education, services, management and research;

– confer, regularly and constructively, with influential and allied groups, e.g. consumers and other health workers, to mobilize wide support for Health for All/Primary Health Care;

– collaborate with universities and international development agencies to encourage nursing participation in new programme and research initiatives relevant to Health for All/Primary Health Care;

– work with women’s groups and other non-governmental organizations to implement the recommendations in the “Forward Looking Strategies for the Advancement of Women” adopted at the UN Decade of Women Conference (Nairobi 1985); and

– work for attractive career structures and better working conditions for nurses (including occupational health services) so that potential leaders are encouraged to remain in nursing.

C. WHO

– develop and promote leadership teaching/learning materials for use in workshops, seminars, etc., which could be useful as guides for action in planning for changes needed in nursing education and practice;

– use WHO publications and other media to publicize successful examples of nursing leadership in relation to Health for All/Primary Health Care, including the mobilization of communities, the use of appropriate technology and the encouragement of self-reliance;
— support annual meetings of Chief Nursing Officers with the aim of establishing effective resource networking and the monitoring of changes made in areas of nursing practice, education, and research towards the attainment of Health for All/Primary Health Care;

— support and publicize research, including evaluative studies of examples of nursing leadership for Health for All/Primary Health Care, and support and collaborate in studies on various innovative approaches to nursing contributions in primary health care;

— convene a multidisciplinary Expert Group to develop guidelines for continuing education to orient nurse leaders to Health for All/Primary Health Care; and

— make available a report on the meeting “Leadership in Nursing for Health for All” to the WHO Exeutive Board and Regional Committees, and feature leadership in nursing for Health for All in World Health Assembly Technical Discussions as soon as possible.

References


ANNEX I

Learning by Doing – Some Examples

It is heartening to see that a number of initiatives have already been taken to show how nurses can be leaders for Health for All. Gathering such information and publicising it, irrespective of success or failure, can be useful to other countries.

Zimbabwe

Because of the paucity of physicians in Zimbabwe, (of the 22,000 health professionals, 88 per cent are nurses and 5 per cent are doctors) nurses have had to lead community health teams. Before the government adopted the primary health care approach, nurses were predominantly hospital-based, and provided curative care. The few community nurses in the country were engaged in somewhat erratic, and therefore largely ineffective work. So community service was seen, not only as unglamorous but also offering little satisfaction. The radical changes in the health sector in 1980 led to the reorientation of all health workers. Since this nurses have found community health work, with its interaction with people, more fulfilling than their previous purely clinical work.

In addition to emphasizing leadership for those nurses already in service, the curricula of both nurses and physicians have also been reviewed. The creation of a department of Nurse Education in the Medical School means that future postgraduate nursing and medical students will study together. The team concept will become a natural approach at an early stage of their careers.

The government’s emphasis on rural development and promotion of community projects is considered to be a very important factor in having brought about changes in the attitudes and values of the nurses.

Lesotho

Senior nurses in Lesotho have been given a sound training in community health and their clinical skills upgraded before being deployed as local leaders in health centres across the country. They sit on community development committees, offer comprehensive health care and train junior nurses and village health workers.

Malawi

In Malawi, after appropriate reorientation, senior hospital nurses sit on Area and District Development Committees where they function as resource people for all health development activity. Other members of these Committees include politicians and officers from other sectors, e.g., agriculture and communications. The nurses are in touch with the communities they serve, understand their committees’ problems and are involved in identifying strategies to resolve them. So they have developed levels of confidence and motivation for community work which are good examples of effective leadership in implementing Health for All strategies.

Thailand

Experience in Thailand has also corroborated the Zimbabwean experience that community development, rather than health development, is often attractive, especially to people from different Ministries. Working together inter-sectorally towards a better quality of life for all can create a critical mass of sectoral leaders who, together, achieve a profound, long-term change in society’s development.
Using Incentives

It is at the primary level of the health system that motivation and incentives are particularly needed. In Kenya, annual awards (monetary and recognition) have been jointly provided, by leaders of nurses and the national Nurses Association, for the nurse who has worked best in a rural area for six years or more. Either the Minister of Health, or a high ranking professional, presents the award so it is given wide publicity and has consequently become highly regarded and competitive.

The Republic of Korea had originally despatched physicians to rural areas. It offered a wide range of incentives, including special academic credits to new graduates fulfilling their internship on rural assignments and the award of scholarships to medical students willing to serve in rural areas. But because the policies have been rather mechanical they have not created the much needed motivation and sense of commitment. A subsequent project, launched with the creation of the Korean Health Development Institute in 1975, has demonstrated the effectiveness of 2,000 nurses working in community health posts a decade later.

In the Vanguard of Change

Nurses in Kenya have initiated and conducted multidisciplinary meetings and seminars on a variety of subjects. The Danish Nurses Association, in 1985, arranged the first National Conference in Denmark on Health for All and primary health care. The latter attracted not only the country’s leading nurses, but professionals and representatives of various organizations, and ministries. This has effectively challenged other professional groups to follow the example.

Retired members of the Japanese Nurses Association have sponsored and organized a weekend relief system for the relatives of the elderly. This gives the relatives a respite at regular planned intervals.

In Kenya again, nurses have initiated projects for the elderly as well as the young and disabled; they have also set up nurseries for hospital nurses to breastfeed their babies whilst on duty. As a consequence of these and similar leadership projects, nurses have become a source of attraction and receive respect and attention when they speak on health-related issues.

Creating a Corps of Nurse Leaders

Denmark has established a corps of nurse leaders. For some years committees of nurse leaders have met at regional levels. The Chairpersons of these groups, numbering 16, have met twice each year with leaders from the National Board of Health and the Danish Nurses Association. Discussions have taken place on a wide range of issues and the corps has developed strategies for Health for All and primary health care. This has included local and regional workshops and national conferences.

Kenya also has a group of nursing leaders who meet with Ministerial officials on a regular basis.

Political Lobbying

Some nurses have achieved their objectives, and, incidentally, favourable publicity, either by political lobbying and/or by forming alliances with influential groups. In Yugoslavia, community nurses have won elections to three seats in government by obtaining the support of disabled people. Canadian nurses have exerted pressure, along with other groups, to influence their government’s policy on Health Insurance programmes. By working with two nurses who are members of the government and with representatives of other organizations, the Japanese Nurses Association has influenced Health Insurance legislation relating to nurse visitors. Changes in education, which required enactment by politicians, have been successfully achieved by Kenyan nurses who won support from the government machinery, and through lobbying their members of parliament.
## ANNEX II

### Strategies and Actions for Nursing Leadership Development

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<tr>
<th>Leadership Level</th>
<th>Leadership Role</th>
<th>Leadership Development Strategies</th>
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<tbody>
<tr>
<td><strong>Community Level</strong></td>
<td>Mobilizing communities for HFA.</td>
<td><strong>Improve skills in:</strong></td>
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<tr>
<td></td>
<td>Contributing to increased self-reliance in the community (involvement in health problems, analyses, health technologies, priority settings, and monitoring).</td>
<td>– Interpersonal relationships</td>
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<td></td>
<td>Mobilize local resources and support.</td>
<td>– communication</td>
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<td></td>
<td>Providing leadership (managerial and technical) to other members of the health and community teams.</td>
<td>– management</td>
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<td></td>
<td>Developing innovative PHC strategies; supporting and evaluating their implementation.</td>
<td>– epidemiological analysis</td>
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<td></td>
<td>Assessing and monitoring quality of care.</td>
<td>– training/teaching</td>
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<td></td>
<td>Facilitating coordination and fostering links between nursing and other relevant bodies.</td>
<td>– monitoring/evaluation</td>
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<td></td>
<td>Identifying potential nursing leaders and facilitating their development.</td>
<td><strong>Ensure:</strong></td>
</tr>
<tr>
<td><strong>Intermediate Level</strong></td>
<td>Participating in policy making and planning for health and development.</td>
<td><strong>Improve skills in:</strong></td>
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<tr>
<td></td>
<td>Monitoring and education.</td>
<td>– communication</td>
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<td></td>
<td>Participating in decision-making and allocation of resources.</td>
<td>– planning</td>
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<td></td>
<td>Organizing priority programmes – technical and managerial.</td>
<td>– management</td>
</tr>
<tr>
<td></td>
<td>Mobilizing influential and consumer groups.</td>
<td>– evaluation</td>
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<tr>
<td></td>
<td>Communicating with media representatives to promote health.</td>
<td><strong>Ensure:</strong></td>
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<tr>
<td></td>
<td></td>
<td>– equality and professional recognition</td>
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<td>– involvement in decision-making groups, e.g., development committees</td>
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## ANNEX II continued:

<table>
<thead>
<tr>
<th>Leadership Level</th>
<th>Leadership Role</th>
<th>Leadership Development Strategies</th>
</tr>
</thead>
</table>
| Intermediate     | Evaluating education/skills for nursing personnel and identifying changes/reorientation required and guiding these. Evaluating quality and structure of health care services. Facilitating coordination and fostering linkages among nursing and other relevant bodies. Identifying potential nursing leaders and facilitating their development. Contributing to policy-making in health and development. | Improve understanding of:  
- Intersectoral action in health and development  
- Power and decision-making structures |
| National         | Contributing and participating in health policy debates. Participating in decision-making on allocation of resources. Suggesting legislative and managerial changes needed for facilitating nursing roles and functions. Defining changes required in nursing education; guiding the implementation of these and evaluating their effects. Mobilizing support from nursing and other professional and influential groups. Facilitating coordination and fostering linkages among nursing and other relevant bodies to provide effective networking. Identifying potential nursing leaders and facilitating their development. | Develop understanding of:  
- Political processes in health and development  
- Social structure and society  
  - Intersectoral action in health and development  
  - Economics of health  
  - International scenario  
Improve skills in:  
- Communication  
- Policy analysis and planning  
- Economics  
- Management  
- Evaluation  
Ensure:  
- Involvement in policy and decision-making bodies  
- Appointment at policy and decision-making levels  
Achieve solidarity by:  
- Organizing networking of national nursing bodies, institutions and agencies  
- Arranging dialogues among national nursing bodies and other relevant groups  
- Fostering links with international groups |
ANNEX III

Desirable Characteristics of Tomorrow’s Leader in Nursing

Leadership in nursing will be the product of a visionary view of wellbeing and health. The inspiration such leadership offers will help shape the values of society so they blend with those inherent in the goal of Health for All.

This leadership will be a key factor in the success of the Health for All movement. It is based on certain attitudes, knowledge, skills and attributes.

**Attitudes** should be formulated by:

- a sensitivity to current social issues and a commitment to the cause of social justice to reduce health inequality and related socioeconomic inequity; recognizing that access to good quality health care, is not a privilege but the right of every citizen;

- a true awareness of how health and development are inseparable. This includes a clear understanding of, and commitment to, Health for All/Primary Health Care, its broad principles, values and goals, seeing health as a fundamental prerequisite of all human activity and health care as a critical component of a society’s development infrastructure; and

- an awareness that assertiveness is a positive and desirable behavioural trait, and is not to be confused with aggressiveness.

**Knowledge** emerges from:

- recognized expertise and credibility in one or more areas of nursing and the application of all stages of problem-solving (assessment, planning, implementation and evaluation) in providing holistic care to all age groups and in all settings;

- the use of systems theories, the political process and the attainment and management of power and influence in order to achieve goals;

- extensive communication activities including networking both within and outside nursing and the health sector; and

- principles and practices of management related to individual/group/team leadership and relationships.

**Skills in**:

- directing and helping others crystallize their perceptions of key social and health-related issues, especially the issue of equity;

- inspiring colleagues and others to make maximum efforts in a common cause, orchestrating their contributions and fostering their commitment;

- visualizing fully the scope for improving the human condition, using imagination and creativity to concentrate the intellectual and physical energy of others, especially future generations of health workers; and

- communicating and articulating the potential of nursing to contribute to the achievement of the Health for All goal.

**Personal Attributes** which:

- attract, influence and evoke confidence from others, such as integrity, humour, imagination, creativity, risk taking, courage, humanism, inter-personal skills and mentor and college relationships.
ANNEX IV

Nursing Values in Primary Health Care

At a WHO meeting entitled “Nursing in Support of the Goal of Health for All 2000” held in 1981, the following Declaration was made.

Primary health care is one of the social phenomena of our times, with a powerful potential for improving the quality of human life. This objective has always been a fundamental driving force for nurses and nursing. The provision of primary health care is a natural extension of nursing practice, especially as it applies to community health. It is an elaboration of the traditional roles and functions of nurses but at the same time it represents a re-ordering of priorities to correspond to the health care setting. More specifically:

– nursing in primary health care is addressed to the health needs of persons throughout the whole health care continuum – primary, secondary and tertiary – in homes, schools, health centres, clinics, hospitals, and all other settings of nursing care;

– in primary health care, nursing resources are allocated according to the health needs of the population, the greater proportion of them being allocated to care for those who were hitherto undeserved, and to areas where health needs are most concentrated;

– nurses working in primary health care are prepared and motivated to take their part in the assessment of the health of individuals, families and communities, including the recognition and treatment of prevalent diseases, injuries and disabilities, and to integrate the concepts and practices of self-help throughout the entire health plan;

– in the allocation of nursing resources to primary health care, priority is given to nursing practice in the domain of health promotion, health maintenance, and disease prevention;

– nurses working in primary health care are essentially generalists in that they are prepared to care for persons and groups of all ages, living under various conditions and with a wide variety of associated social and health care needs;

– nurses working in primary health care give priority to the care of those who are at greatest risk from the major health problems of the country;

– nursing practice in primary health care requires a willingness to take action as part of the health team, and to use other resources available in the community, to effect environmental changes that impinge on health;

– among the responsibilities of nursing practice in primary health care are training, support, and supervision of auxiliary nursing personnel and other community-based health workers; and

– effective nursing practice in primary health care is dependent on collaboration with a variety of health workers and other community-based personnel, and also with political leaders and groups in formal or informal association.
ANNEX V

Historical and Organizational Background to the Conference

In 1981 an informal global meeting was convened by WHO on "Nursing in Support of the Goal of Health for All 2000". Participants at that meeting put forward five strategies to be adopted if changes in nursing were to take place. The first and foremost strategy was the development, in different countries, of a corps of nurse leaders. They would be well informed about the Health for All goal and primary health care, and would serve as agents to stimulate and sustain change in many different fields. This need for leaders in nursing, attuned to new health development policies and processes, was considered critical if the nursing profession was to contribute towards the attainment of Health for All 2000.

The meeting was the beginning of a nursing initiative which, between 1983-1986, included a series of regional workshops about mobilizing nursing leadership for Health for All/Primary Health Care. They were organized by the International Council of Nurses (ICN) and also WHO in collaboration with the International Nursing Foundation of Japan (INFJ). There were also a series of yearly workshops involving senior nurses from countries in the Western Pacific and South-East Asia Regions. The development of effective leadership for change in nursing education and service, and of indicators to evaluate reoriented nursing curricula was analyzed. The Organization also began preparing nursing leadership materials for use by countries which will be field-tested before finalization.

In the Region of the Americas through the initiative and stimulation of the Organization, and in collaboration with the Kellogg Foundation, a series of workshops were held for national nursing leaders from several countries in Latin America.

In 1985, the Director-General of the World Health Organization launched a new initiative on Health for All Leadership Development. Its principal aim was to develop a critical mass of people throughout the world capable of assuming leadership in the Health for All movement – both in their own countries and internationally.

The Tokyo International Encounter was attended by 30 participants invited from 20 countries of all six WHO Regions. They included nurse leaders, senior health administrators, politicians, a social scientist, and a representative of an international nursing organization. Together they represented all four areas of practice, administration, education and research of the health field.

The Objectives of the Encounter were:

- to identify the actual and potential roles of nursing leadership to motivate the full participation of nurses in the Health for All movement;

- to define strategies to develop and facilitate the leadership role of nursing in directing nursing education and services towards the philosophy and attainment of the goal of Health for All; and

- to formulate recommendations relating the development and performance of the nursing leadership role within the framework of individual countries.
Conference Arrangements

The programme schedule was arranged in such a way that all participants had specific roles including the presentation of assigned topics either as members of a symposium panel or in roundtable discussions. All presentations were followed by plenary discussions. Topics discussed, following the Keynote Address of “Why Leadership for Health for All”, included a global perspective on present-day leadership for Health for All; actual and potential nursing roles for Health for All; and specific strategies to develop and facilitate nursing leadership. (Annex II)

Conference Officers

The following participants served as officers: Mrs E. M. Kiereini (Chair); Professor K. Kikuni (Vice-Chair); and The Baroness Cox (Rapporteur).

The Committee on Recommendations was composed of the following: Professor A. Baumgart (Chair); Dr M. L. Duxbury; Dr R. Elling; Dr H. Minami; Sir John Reid; and Dr G. Tadesse.

Speeches

At the opening ceremony H.I.H. Princess Chichubu of Japan gave the speech of welcome, and the opening address was delivered by Mr Zenko Suzuki, President, The International Nursing Foundation of Japan. Dr Halfdan Mahler, Director-General, World Health Organization, gave the Keynote Address.

Greetings were extended to all participants at the Conference by Mr Isamu Imai, Minister for Health and Welfare, Mr Yasuoki Urano, Parliamentary Vice Minister for Foreign Affairs, Mr Keisuke Arita, President, Japan International Cooperation Agency, and Dr Hiroshi Nakajima, Regional Director, WHO Western Pacific Region.
ANNEX VI

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*Unable to attend: Dr Awatif Osman, Director, Khartoum Nursing College, Khartoum, Sudan and Dr David Tejada-de-Rivero, Minister of Health, Ministry of Health, Lima, Peru.
ANNEX VII

Suggested Reading


