WHO/HRH/NUR/96.1
Distr. LIMITED
ENGLISH ONLY

GLOBAL ADVISORY GROUP

ON NURSING AND MIDWIFERY

Report of the Fourth Meeting

Delhi
12-14 December 1995

World Health Organization
Geneva, 1996

420
3/8/98

Report of the Fourth Meeting of the Global Advisory Group on Nursing and Midwifery

Delhi, 12-14 December 1995

Contents

1. INTRODUCTION 1

2. OBJECTIVES OF THE MEETING 1

3. OPENING OF THE MEETING 1

4. METHOD OF WORK OF THE FOURTH MEETING OF THE GLOBAL ADVISORY GROUP 3

5. PROGRESS IN DEVELOPING NURSING/MIDWIFERY SERVICES 3

6. REPORT ON A STUDY TO EXAMINE THE STRENGTHENING OF NURSING AND MIDWIFERY SERVICES 7

7. HEALTH CARE IN INDIA 9

8. ACTIVITIES OF GAG MEMBERS 9

9. HEALTH CARE REFORM 11

9. STRATEGIC PLAN OF THE GAG 13

10. CONCLUSION 20

Annex 1. List of Participants 21

Annex 2. Agenda and Schedule of Work 23

Annex 3. Strategic plan for nursing and midwifery development in SEAR countries (1996-2001) 25

Annex 4. Implementation of resolutions and decisions (EB97/13) Strengthening nursing and midwifery (EB97/INF.DOC./2) 28

Annex 5. Recommendations of the Third Meeting of the GAG and progress in implementation 41

Annex 6. *Being Strategic*, by G. Biscoe and B. Lewis 45

1. INTRODUCTION

The fourth meeting of the Global Advisory Group (GAG) on Nursing and Midwifery took place in Delhi from 12 to 14 December 1995. The multidisciplinary group was brought together to continue to address the complex issues in strengthening nursing and midwifery services in support of health for all. The list of participants, who were invited in their private capacity, appears in Annex 1, and the agenda and schedule of work appear in Annex 2.

2. OBJECTIVES OF THE MEETING

Within the Terms of Reference of the GAG on Nursing and Midwifery and on the basis of the opening presentations (discussed later) the objectives of the meeting were:

1. Review the work of the GAG since its inception.

2. Examine the present terms of reference of the GAG and, if necessary, propose modifications.

3. Review the proposed draft resolutions to be presented at the Ninety-seventh Executive Board in January 1996.

4. Prepare a plan of action for the GAG for the next four years.

3. OPENING OF THE MEETING

3.1 The meeting was opened by Dr Uton Muchtar Rafei, WHO Regional Director for South-East Asia, who welcomed the participants. He stated that he was especially pleased that the Director-General accepted the invitation from the Regional Office to host the Global Advisory Group on Nursing and Midwifery meeting. Dr Rafei recognized the close collaboration of the GAG with WHO regional offices particularly through the active involvement of the regional nursing advisers. He stressed that collaboration is essential to foster understanding of the issues confronting nursing and midwifery and of the sociocultural, economic and political contexts in which these issues must be addressed. Further, the GAG meeting provided an opportunity to contribute the South-East Asia regional perspective to the work of the GAG and, in the process, to benefit from its deliberations. He reported on the positive actions taken by Member States, the South-East Asia Region (SEAR) and all of WHO to the adoption of resolutions of the World Health Assembly with regard to nursing and midwifery personnel in

the strategies for health for all. All countries have revised and reoriented their nursing and midwifery training curricula and educational programmes in keeping with the Primary Health Care approach (PHC).

Dr Rafei announced that the Region has made a significant achievement in the initiation of strategic planning for nursing/midwifery development. The Regional Office is preparing a position paper outlining the prevailing issues concerning nursing and midwifery in the Region and WHO's response. This is intended to aid the promotion of an integrated approach in countries to nursing and midwifery activities, to enhance coordination among the relevant programme areas and to ensure clear, consistent technical advice and assistance.

An intercountry consultation was recently convened by the Regional Office and held in Bangkok, Thailand. It resulted in a regional plan which identifies key strategies for making effective use of the nursing/midwifery workforce. (Annex 3)

Dr Rafei observed that the countries of the Region are undergoing rapid political, economic and social changes which have an impact on the health of their populations. Countries are also experiencing an epidemiological and demographic transition featuring non-communicable and chronic diseases, in addition to a high rate of communicable diseases, HIV/AIDS, aging populations and environmental degradation. All of this takes place in the context of rising health care costs, dwindling resources and growing inequities in access to services. Potential solutions such as alternative financing and the greater involvement of the private sector are being debated.

He stated that despite these difficulties positive achievements have been realized in the Region. A comprehensive approach based on the realities of the country and focusing not only upon nursing/midwifery is required to bring about desired changes. The nursing/midwifery community must, therefore, work with others in filling gaps in services, especially for the most vulnerable segments of the population.

3.2 Dr Eric Goon, Director, Division of Development of Human Resources for Health (HRH), WHO headquarters, brought greetings on behalf of the Director-General and thanked Dr Rafei and his staff for accepting to host the fourth meeting of the GAG. He emphasised the importance of ensuring that the deliberations of the GAG be informed and anchored firmly by the experiences and realities of the regions and the Member States. Meeting in Delhi would provide such an opportunity.

3.3 Dr Hirschfeld, Chief Scientist for Nursing, WHO headquarters, extended her appreciation to the Regional Director for the invitation, the arrangements and the

warm hospitality. Special thanks were extended to Dr Sally A. Bisch and Dr Duangvadee Sungkhobol, SEARO.

She told the meeting of the importance of the GAG to nursing/midwifery development in the pursuit of health for all (HFA). Dr Hirschfeld reported that the Director-General and the regional directors have taken GAG's recommendations seriously. The recommendations have been sent to Member States and there has been follow-up. She agreed with Dr Rafei's opening statements, especially the need for an integrated, interdisciplinary and multisectoral approach to tackling the complex health issues.

4. METHOD OF WORK OF THE FOURTH MEETING OF THE GLOBAL ADVISORY GROUP

4.1 Dr Rafei nominated Dr Hiroko Minami as Chairperson and Dr Naeema Al-Gasseer as Rapporteur.

4.2 The Group conducted its work both in plenary and in small groups. Ms Gillian Biscoe, WHO Temporary Adviser, of the Department of Community and Health Services, Tasmania, facilitated the GAG's development of a strategic plan. Two professional visits were arranged by Mr T. Dileep Kumar, Nursing Adviser, Ministry of Health and Family Welfare, Government of India, New Delhi. The visits were to a local hospital and to a community centre, servicing urban slum areas. GAG members according to their interests observed nurses providing services in the hospital and in the community.

5. PROGRESS IN DEVELOPING NURSING/MIDWIFERY SERVICES

5.1 Dr Miriam Hirschfeld provided the GAG with a briefing on activities and the nursing/midwifery situation since the last meeting in 1994. She began by setting out the broader context within which WHO is currently functioning. The following points were raised:

- The entire UN system is being affected by the effects of the global recession which has resulted in shrinking resources. This is taking place while health needs are growing.

- Within WHO there have been budgetary cuts resulting in programme cuts and recent and expected reductions in staff. This has implications for the future work in strengthening nursing and midwifery.

- The relationships with traditional donors are changing as countries have reduced their contribution to WHO.

- There appears to be a move by donor countries away from multilateral to bilateral relationships.

- Nongovernmental organizations (NGOs) are emerging quite strongly, taking leading roles in health and other areas.

- There is a crisis, and new approaches and different strategies are being pursued.

Dr Hirschfeld suggested that the challenge for the GAG is to seek new approaches and different strategies which take nursing/midwifery beyond its current level. She stated that we need to find a different way to move forward in order to realize a "second degree change".

5.2 Dr Hirschfeld reported on progress in implementing resolution WHA45.5 on "Strengthening nursing and midwifery in support of strategies for health for all," adopted in May 1992. She also reported on the implementation of prior GAG recommendations. Three documents form the basis of the report:

1) EB97/17, *Implementation of resolutions and decisions.*
2) EB97/INF.DOC./2, *Strengthening nursing and midwifery.*
3) WHO/HRH/NUR/95.2, *Strengthening nursing and midwifery, 1992–1995: A progress report.*

The first two documents can be found in Annex 4; the third document is available from Nursing/HRH, World Health Organization, 1211 Geneva 27, Switzerland.

The recommendations of the Third Meeting of the GAG and their implementation is reported in Annex 5.

5.3 The Regional Nursing Advisers provided the GAG with detailed reports of the state of nursing in their respective regions, the changing state of nursing and future plans. As in their previous reporting, the Regional Nursing Advisers were unanimous in the view that the report and recommendations of the GAG continue to be helpful in reinforcing and guiding the policies of the regional offices. There have been significant efforts across the regions to develop national action plans. The need to balance nursing/midwifery personnel requirements (numbers and qualifications) with the needs of the population is increasingly being recognized

by ministries of health. The following are the common themes emerging from these reports:

- Investments in the health sector are not growing. In some regions there have been significant reductions. Countries are changing their health policies and strategies in order to manage within the budgetary constraints. Reform initiatives include decentralization, change in financing mechanisms, and greater participation of the private sector in the financing and provision of health care.

- In the reform efforts only a few countries have addressed nursing/midwifery issues systematically. However, the changes taking place within the countries provide opportunities for nursing and midwifery issues to be raised and addressed.

- Countries continue to face problems in respect to the numbers, deployment and working conditions of the nursing/midwifery workforce.

- There is an increasing demand for nursing/midwifery services. For example, the demand is growing for community/public health nurses who will take responsibility for the basic elements of primary health care (including basic curative care, health of children, pregnant women, family planning, school health, care of the elderly, rehabilitation services, care of the mentally ill, counselling on life style, home care for chronically ill and dying).

- In all regions, there is a need to develop regulatory frameworks, to expand and/or introduce systems of registration and systems to ensure quality of education and practice.

- Although nursing leadership has been developing in many countries, for instance through educational programmes and building stronger professional associations, there remains much work to be done in all regions. Where the professional associations are weak they must be strengthened, and where they are fragmented they must be united or coordinated. Leadership development at all levels has to be strengthened.

- The Regional Nursing Advisers indicated that strategic plans of action for nursing/midwifery development were being developed in many countries. Common directions across regions include a greater focus on the community. In the African Region this is expressed as

"Advocacy for quality care at village level". Research on nursing/midwifery practice in rural/urban areas has also been identified as a strategic direction. It is suggested that the research be action-oriented.

- Training is also taking place in the Region of the Americas for nurse researchers in methodologies for research in primary health care. Regions are also making greater efforts to involve nurses/midwives in health services research.

The Regional Nursing Advisers indicated that the opportunity to share their country experiences with the GAG and to get their feedback and that of their colleagues is a significant contribution to their work.

5.4 Professor Mo-Im Kim, Secretary-General of the Global Network of WHO Collaborating Centres for Nursing/Midwifery Development (Network), reported on the activities of the Network since November 1994. Members of the Network have undertaken a number of projects in education and training of nurses. The projects have addressed such issues as: quality management, staff development, continuing education, the development of primary care programmes for nursing/midwifery and the development of postgraduate programmes. A broad range of research projects has also been undertaken by members of the Network.

It was reported that the final version of the strategic plan for the Network has been prepared for submission to the Eighth General Meeting of the Network to be held in Bahrain in March 1996. In conjunction with this General Meeting, the First Network Conference will be held with the theme of "Nursing/midwifery: making a difference in health for all". The Network continues to work actively with the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM).

5.5 The GAG reiterated the valuable input by the International Council of Nurses and International Confederation of Midwives and the strong cooperation between them and WHO in the implementation of resolution WHA45.5. Ms C. Holleran, Executive Director, ICN, and Ms J. Walker, Secretary General, ICM, reported on the many activities of their respective organizations in support of strengthening nursing and midwifery. The following are examples of recent and planned activities. The ICM held a symposium for African nurses which was attended by 129 nurses from seventeen countries. Regional conferences and workshops were held in the European and Asia-Pacific Regions. Education and practice issues were the focus of these meetings. ICM will hold its next Congress in Oslo, Norway, in May 1997. ICN reported that a new Executive Director, Mrs Judith Oulton of Canada, has been appointed. She assumes the position

1 March 1996. Following a task force meeting in June 1995 on the impact of HIV/AIDS on nursing/midwifery personnel, guidelines are being finalized for use in countries. The International Nurses' Day for 1996 is "Better Health Through Nursing Research", in 1997 it will be "Adolescent Health" and in 1998 "Education for Health through Community Partnership". Both NGOs continue to participate in a number of WHO initiatives providing the Organization with valued contributions.

6. REPORT ON A STUDY TO EXAMINE THE STRENGTHENING OF NURSING AND MIDWIFERY SERVICES

Dr Linda Lee O'Brien-Pallas (Quality of Nursing Worklife Research Unit, Faculty of Nursing, University of Toronto, Canada), Co-Principal Investigator of a study to examine the strengthening of nursing/midwifery services, provided the members of the GAG with a detailed reporting of the study. The study, funded by the International Development Research Centre, Ottawa, Canada, has the following objectives:

1. Develop and test an instrument to monitor the extent to which strategies to support resolution WHA45.5 to strengthen nursing and midwifery in the strategy of health for all, have been implemented in countries throughout the world.

2. Determine the extent to which the strategies to strengthen nursing/midwifery have been implemented at the WHO regional and country level.

The GAG was instrumental in the development of the initial study framework.

The study was conducted between November 1993 and August 1995. Dr O'Brien-Pallas reported that the Nursing unit, WHO headquarters, sent 209 copies of a 64-item questionnaire in late August 1994 to the WHO regional offices, which forwarded them to the appropriate health authorities according to the WHO Official List of Addresses. A response rate of 75%, or 143, was obtained by August 1995 after follow-up mailings in March 1995.

Some of the key findings reported are listed below:

- Globally, there is consensus that nurses and midwives should receive a higher standard of education than that currently available.

- There remain imbalances in the number of care givers in their skills and in the way care givers are used.

- There remain unclear policies for deployment decisions.

- The respondents indicated that with respect to the strengthening of management and leadership for nursing and midwifery, emphasis should be on health policy and management issues.

- Both formal and informal mechanisms are being used to provide education and training in policy and management.

- General cuts in the overall health budget in many countries, the devaluation of currency (e.g. the franc CFA), political instability and a combination of other resource constraining events have led to a reduction in education and fellowship opportunities. Similarly, planned research activities have been delayed due to financial obstacles.

- Working conditions are varied across countries. Related closely with the availability of resources, working conditions, while having improved in some countries, require much improvement in others.

- The data suggest that nursing and midwifery personnel resources have increased in the majority of countries. Planning activities have been undertaken with various degrees of intensity. National action plans for nursing have been developed in 37% of Member States; 24% replied that they have developed a written action plan for midwifery.

- The importance of a focal point for nursing and midwifery in ministries of health has been stressed by the GAG in its reports. Eighty-seven of the 143 responding Member States indicated that there was a Chief Nursing Officer in the central government structure. Of these Member States, 44 reported the existence of a nursing unit at the Ministry of Health. With respect to Chief Midwifery Officers, the results indicated that there are 20 at the central government level.

- Globally, 54% of Member States indicated that resolution WHA45.5 has been distributed only at the ministry level, while only 16% of

Member States indicated the resolution was distributed to district level health authorities. Twenty-seven percent of Member States reported that resolution WHA45.5 had been translated into the country's official language(s).

Dr O'Brien-Pallas indicated that the responses were analysed by WHO region and by four economic categories (low, lower-middle, upper-middle and high income countries). In addition, a set of correlations have been conducted to examine the relationships between the elements of the resolution. The full report of the study is to be made available in the spring of 1996.

7. HEALTH CARE IN INDIA

Mr T. Dileep Kumar, Nursing Adviser, Ministry of Health and Family Welfare, Government of India, presented an overview of health care organization and delivery in India. He indicated that in the allocation of resources in the public sector, health gets the least priority. In the public health sector, nursing has not been a priority. Future plans, however, are to improve nursing education. It is planned to upgrade general nursing schools, attaching them to medical colleges or to colleges of nursing. In addition, the diploma programme is to be phased out into a graduate programme. In order to meet the health service delivery targets outlined by the government, it will be necessary to reduce the population:nurse ratio from 5000:1 to 2500:1.

Mr Kumar welcomed the members of the GAG and thanked WHO for its contribution to the strengthening of nursing and midwifery services. The GAG expressed its appreciation of Mr Kumar's presentation. A better understanding of the difficulties and complexities of various health care systems will help the GAG to carry out its work more effectively.

8. ACTIVITIES OF GAG MEMBERS

Between GAG meetings, members actively work to promote nursing and midwifery issues. The corresponding activities are carried out in various ways. These include the ongoing work of the members in their own countries, and their participation in national and international initiatives. The activities can be grouped under the following headings: policy development, education and training, fundraising, promotional activities, and planning. A sample of members' activities is provided below.

Policy Development:

- Work to influence the Government of Thailand to mobilize funds to support the nursing and midwifery development plan.

- Advising the Community Development Project regarding women's development and maternal and child health policy in Bahrain as a Member of the Advisory Committee of the Deputy Minister of the Interior .

Education and Training:

- Assisted in the development of a programme for midwifery training for nurses from Cambodia.

- Developed training programmes to strengthen nursing care in various areas of nursing, including critical care nursing and PHC nursing. These programmes are to be used in Bangladesh, Myanmar and Sri Lanka.

Fund Raising:

- Mobilized Japan International Cooperation Agency funding for nursing development in Cambodia, Egypt, Myanmar, Pakistan, and Viet Nam, and countries in Africa.

- Facilitated the mobilization of funds from the World Bank to assist training of nurses in home-based care for people with HIV/AIDS.

- Fund raising activities in support of nursing in Chile and Romania.

Promotional Activities:

- Briefed the Chief Nurse and her staff on the 1994 GAG meeting and the recommendations. This is intended to raise the awareness of the work of the GAG and other WHO activities.

- Discussed with the Head of International Affairs Division in the Ministry of Health and Welfare the inclusion of a nurse in their official delegation to the World Health Assembly.

- Worked with ICN to inform the Japanese Nursing Association of the activities of the GAG, who subsequently decided to allocate funds for a nurse delegate to the World Health Assembly.

- Contributed to the establishment of the Network of WHO Collaborating Centres in the Western Pacific.

- Organized a WHO Collaborating Centre Network meeting in conjunction with the Japanese Academy of Nursing Science Second International Nursing Research Conference.

Planning:

- Chair of the National Committee for Development of a National Plan for Nursing and Midwifery Personnel Development.

- Served as a resource person in the strategic plan for national nursing development in Bangladesh.

These examples reflect the work of only a few members of the GAG. They provide good indications of the contribution being made by the GAG.

9. HEALTH CARE REFORM

Dr Hirschfeld outlined for the GAG members the implications of health care reform initiatives in which most countries are currently engaged. The central focus of the reforms vary. Some countries have taken the policy direction of decentralization, others have chosen health care financing alternatives, while others are concentrating on changing the traditional organization of their institutions. There are a large number of groups with similar and divergent interests involved in health care reform initiatives.

The GAG argued that there is a crucial role for nursing and midwifery in the process of health care reform. It was agreed that one of the more important roles of the GAG is to promote the optimal development of nursing and midwifery within health care reform towards achieving health for all. To accomplish this, nursing and midwifery must interact with many groups. Figure 1 presents these groups from the perspective of WHO.

Interaction between these many groups can be in all directions. Figure 2 is a representation of the many places where nursing and midwifery must be involved in order to contribute optimally to improvement in health.

Nursing and midwifery should be involved at all levels of the health care system: the national, regional, district and local levels. Nursing/midwifery is involved in the home, schools, the workplace and on the streets. It was agreed that nursing/midwifery has many foci. They must be able to participate in the development of policy, and be able to work with groups, communities, families and individuals. Only with this understanding of the extensive role of nursing/ midwifery and its potential contribution will the necessary skills and competencies be developed and appropriate resources devoted to allow for the improved utilization of nursing/midwifery services.

Figure 1

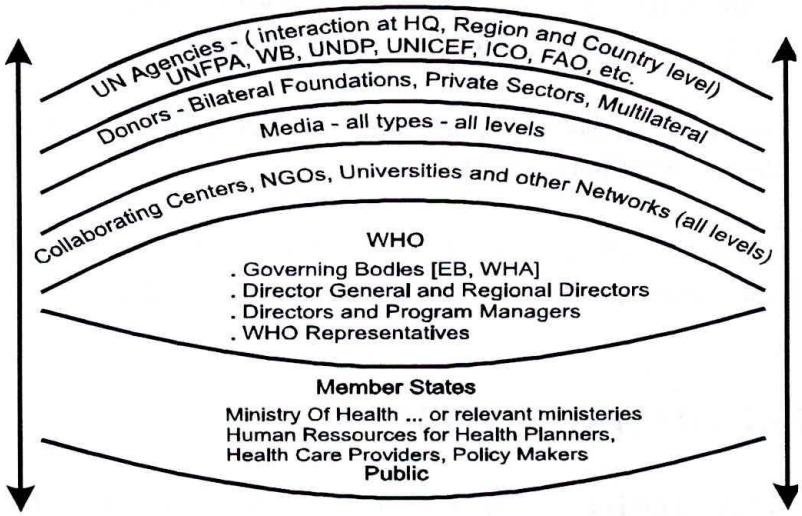
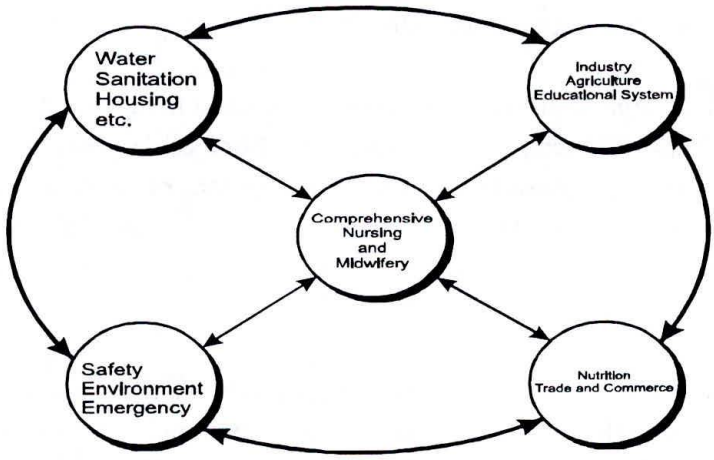


Figure 2



9. STRATEGIC PLAN OF THE GAG

Using a facilitated strategic planning process* the GAG developed a Mission Statement and strategic plan which reflected both resolution WHA45.5 and the global changes in health care.

MISSION STATEMENT

The Global Advisory Group on Nursing and Midwifery supports and guides WHO, in a climate of health care reforms, to enable optimal development of nursing and midwifery towards achieving health for all targets.

The GAG further determined that their strategic plan should reflect fresh and new thinking; it should thus be both visionary and pragmatic, with targets which are implementable and move nursing, and health for all, towards the future.

An issue identified by the GAG as key to success was understanding the changing environment of the 1990's. Globally, countries are addressing the key determinants of health and well-being. The degree of complexity is great as is the ability to both develop and fund appropriate strategies and services, including developing different funding models and mechanisms. The GAG applied the term "health reforms" to this overall strategic picture of global movement towards change.

The report of the WHO Expert Committee on Nursing Practice was used as a framework for the GAG deliberations.

As further input to its thinking, the GAG also referred to the draft Strategic Plan for Nursing and Midwifery Development in SEAR Countries, the product of the Intercountry Consultation held in Bangkok from 2 to 6 October 1995 (see Annex 3). The development of the SEAR Strategic Plan incorporated a rigorous analysis of contextual issues in health and in nursing, within the socioeconomic realities of SEAR countries. The SEAR Intercountry Consultation recommended that the SEAR Strategic Plan should be used as a framework for the development of country-specific national action plans for nursing/midwifery which are consistent with national health plans. The plan reflects a significant step forward

*This process is described in detail in Annex 6, *Being strategic*, by G Biscoe and B Lewis.

to bring about genuine change and strengthen nursing/midwifery in support of health for all.

The GAG Strategic Plan was therefore targeted at a level of strategic thinking which provided an overarching framework for the country-level strategic plan (the SEAR model) while embracing the contextual framework arising from the WHO Expert Committee on Nursing Practice report.

Within this overall picture the GAG analysed a range of data to provide the context for the development of its Strategic Plan. Key stakeholders were defined. Analysis of context and issues gave the strategic background for the development of Key Result Areas and strategies for their achievement.

In developing its Strategic Plan toward achieving the overal goal, nine Key Result Areas (KRAs) were defined by the Group:

KRA 1: Strengthen linkages with WHO Collaborating Centres for Nursing/Midwifery Development (WHO Collaborating Centres) and the Global Network of WHO Collaborating Centres for Nursing/Midwifery Development (Network).

KRA 2: Increase nursing/midwifery personnel in WHO at all levels.

KRA 3: Assure effective workforce planning for the delivery of high-quality care

KRA 4: Increase intersectoral collaboration

KRA 5: Explore possible role of the GAG in identifying funds for nursing and midwifery activities.

KRA 6: Collaborate with international, regional, national and local nursing/midwifery NGOs to create exchange of information/ communication and fora needed to develop increased contribution of nursing/midwifery to health care reform.

KRA 7: Review proposed resolution for presentation to Forty-ninth World Health Assembly in 1996.

KRA 8: Support relevant mechanisms for nursing and midwifery legislation to support health for all.

KRA 9: Refine GAG procedures and processes.

KEY RESULT AREAS & STRATEGIES

KRA 1: ***Strengthen linkages with WHO Collaborating Centres for Nursing/Midwifery Development and the Global Network of WHO Collaborating Centres***

Strategies:

1. Share GAG's Strategic Plan with WHO Collaborating Centres and the Network at the March 1996 Network Meeting in Bahrain.

   Action: GAG: Mo Im Kim

2. Assure that opportunities for implementation of relevant aspects of the GAG Strategic Plan are addressed in the renewal of the Network's Strategic Plan.

   Action: GAG: Mo Im Kim

3. Encourage WHO Collaborating Centres for Nursing/Midwifery Development to undertake health systems research and other relevant WHO collaborating centres to include nursing/midwifery questions into their health systems and research.

   Action: WHO/HQ: Dr E Goon Dr M. Hirschfeld, Mr O. Adams; and WHO/regions: Regional Nursing Advisers

4. Encourage WHO Collaborating Centres to be involved in defining nursing indicators affecting quality and safety of care.

   Action: GAG

5. Ask the Network to share the outcome of the Bahrain Meeting with GAG.

   Action: GAG and Secretariat of Network

KRA 2: ***Increase nursing/midwifery personnel in WHO at all levels***

Strategies:

1. Maintain nursing as a WHO priority programme.

   Action: GAG, WHO/HQ, WHO regions

2. Actively promote policy of giving priority to recruitment of nurses and midwives in WHO where appropriate.

   Action: GAG: discussions with Director-General and the Regional Directors.

3. Provide wider circulation of WHO vacancy notices to include health and education institutions.

   Action: WHO/HQ

4. Develop strategies for increasing secondments, appointments of associate professional officers, sabbatical leave, internships, etc., to strengthen WHO/HQ and regional nursing units.

   Action: GAG

5. Monitor the increased involvement of nurses and midwives in policy formulation.

   Action: GAG

KRA 3: ***Assure effective workforce planning for the delivery of quality care***

Strategies:

1. Provide comment and guidance on integrated human resource planning models as they relate to nursing/midwifery, including:
   - supply
   - demand
   - needs

   Action: GAG

2. Provide comment and guidance on comprehensive quality of care issues.

Action: GAG

KRA 4: ***Increase intersectoral collaboration***

Strategies:

1. Develop approaches for incorporating nursing/midwifery services in intersectoral activities.

Action: GAG

2. Monitor facts re nursing and midwifery input in intersectoral activities relating to HFA targets (e.g. sanitation, nutrition, environment, water, etc.).

Action: GAG

KRA 5: ***Explore possible role of the GAG in identifying funds for nursing and midwifery activities***

Strategies:

1. Seek different ways of raising resources to implement GAG strategies.

Action: GAG

2. Determine the GAG role in fundraising.

Action: GAG

3. Invite representative(s) of donor community to participate in the next GAG meeting.

Action: WHO/HQ

KRA 6: ***Collaborate with international, regional, national and local nursing/midwifery NGOs to create exchange of information/ communication and fora needed to develop increased contribution of nursing/midwifery***

Strategies:

1. Identify key people and organisations at all levels (local and global) and establish effective alliances.

   Action: WHO/HQ, GAG

2. Develop a policy framework for collaboration including mechanisms for joint statements as a result of joint planning activities.

   Action: GAG

3. Establish fora and alliances at local, national, and regional levels to:

   - develop and support nursing and midwifery leadership and management capacity
   - develop relevant regulatory mechanisms for nursing/midwifery education and practices (see KRA8)
   - monitor strategies for nursing/midwifery competency-based education programmes
   - establish joint approaches to key research issues.

   Action: GAG

KRA 7: ***Review proposed resolution for presentation to the Forty-ninth World Health Assembly in 1996***

Strategies:

1. Monitor passage through the Ninety-seventh Session of the Executive Board to the Forty-ninth World Health Assembly.

2. Monitor its implementation at all WHO levels and in Member States.

   Action: WHO/HQ, GAG

KRA 8: ***Support relevant mechanisms for nursing and midwifery legislation to support HFA***

Strategies:

1. Establish liaison mechanisms with nursing and midwifery NGOs to maximise effectiveness of all efforts (see KRA 6).

   Action: GAG

2. Establish liaison mechanisms with international organisations concerned with human resources and health legislative issues.

   Action: GAG

3. Explore the possibility of establishing a nucleus of expert consultants on nursing/midwifery legislation.

   Action: WHO/HQ

KRA 9: ***Refine the GAG procedures and processes***

Strategies:

1. Advise the Director-General on guidelines regarding membership: e.g. numbers, types of representation, tenure of members, rotation, tenure of office bearers.

2. Establish mechanisms for communication and interaction among the GAG members, WHO, and the Global Network between the meetings.

3. Recommend to the Director-General the establishment of sub-committees for each KRA to progress work prior to the next GAG meeting.

   Action: GAG

Where the action is to be initiated by the GAG, these issues will form the basis of GAG's next agenda.

ISSUES TO BE ADDRESSED

Based on the discussions in small groups and the plenary sessions, this strategic plan reflects a step forward to bring about genuine change and strengthen the GAG's impact upon nursing/midwifery development in support of health for all.

Among the many complex issues there is a clearer direction and a new clarity about strategies for its attainment.

The GAG envisaged:

a) using the strategic plan as an internal discussion document to guide the GAG's further work and advise the Director-General;

b) follow-up strategic planning sessions to both evaluate progress and capitalize on collective energy.

10. CONCLUSION

Progress achieved by the Global Advisory Group was significant. The outcomes of the meetings are clear and targeted and the result of synthesis of complex issues addressed through the GAG strategic planning process.

There was a high level of energy and commitment to move forward and address rigorously the strategies articulated to successfully achieve the Key Result Areas.

In the closing session, Dr Uton Muchtar Rafei stressed the importance of groups such as the GAG gaining an appreciation of the problems at country level. He thanked the GAG for its hard work and looked forward to the contributions that it will continue to make to SEAR. He emphasized the need for the GAG to have a long-term vision, especially in this period of rapid change.

The Chairperson, Dr Hiroko Minami, expressed the thanks of the GAG for the support of the meeting provided by Dr Rafei and his staff. The development of the strategic plan by the GAG will provide a framework that will allow it to respond to the broader issues of health care reform.

Annex 1

FOURTH MEETING OF THE
GLOBAL ADVISORY GROUP ON NURSING AND MIDWIFERY

New Delhi, 12-14 December 1995

LIST OF PARTICIPANTS

Members of the Global Advisory Group:

Dr Naeema AL-GASSEER, Chairperson, Nursing Division, College of Health Sciences, Ministry of Health, Manama, Bahrain

Ms Christina ACHUROBWE, Chairperson, Uganda Private Midwives Association, Nakivubo, Uganda

Dr Tassana BOONTONG, Dean, Faculty of Nursing (Siriraj), Mahidol University, Bangkok, Thailand

*Dr Ashraf HASSOUNA, Director-General, Community Development Programme of the Social Fund for Development, Mohandseen, Cairo, Egypt

*Dr K. KALUMBA, (Member of EB), Deputy Minister of Health, Ministry of Health, Lusaka, Zambia

Mrs Eunice M. KIEREINI, Chairman, WHO Regional Nursing/Midwifery Task Force, Nairobi, Kenya

Professor Mo Im KIM, Dean and Professor, Graduate School of Health Science and Management, Yonsei University, Seoul, Korea

Professor Hiroko MINAMI, President, College of Nursing Art and Science, Hyogo, Akashi, Japan

*Mrs Yvonne MOORES, Chief Nursing Officer/Director of Nursing, Department of Health, Richmond House, London, United Kingdom

Ms Julia PLOTNICK, Rear Admiral, Chief Nurse Officer, United States Public Health Service Department of Health & Human Services, Rockville, MD, United States of America

---

*Unable to attend.

Dr Judith SHAMIAN, Vice-President, Nursing & Program Committee Development, Mount Sinai Hospital, Toronto, Canada

Dr B.L. SHRESTHA (Member of EB), Director, Division of Epidemiology and Disease Control, Ministry of Health, Kathmandu, Nepal

*Ms Maria Mercedes Duran de VILLALOBOS, Executive Secretary, REAL, Universidad Nacional de Colombia, Facultad de Enfermeria, Santafé de Bogotá, Colombia

Representative of other organizations:

Ms Constance HOLLERAN, Executive Director, International Council of Nurses, Geneva, Switzerland

Dr Linda O'BRIEN-PALLAS, Associate Professor & Career Scientist, Co-Director, Quality of Nursing Worklife Research Unit, Faculty of Nursing, University of Toronto, Toronto, Ontario, Canada

Miss Joan WALKER, Secretary General, International Confederation of Midwives, London, United Kingdom

Regional Nursing Advisers:

Ms Aena KONDE, Regional Adviser for Nursing/Midwifery (HRN), Regional Office for Africa
Dr Sandra LAND, Regional Nursing Adviser (HSO), Regional Office for the Americas
*Dr Enaam Y. ABOU YOUSSEF, Regional Adviser for Nursing, Regional Office for the Eastern Mediterranean
*Ms Adele BEERLING, Acting Regional Adviser for Nursing and Midwifery, Regional Office for Europe
Ms Ainna FAWCETT-HENESY, Nursing and Midwifery, Regional Office for Europe
Dr Sally A. BISCH, Regional Nursing Adviser, Regional Office for South-East Asia
Dr DUANGVADEE Sungkhobol, Regional Nursing Officer, Regional Office for South-East Asia
*Dr John MILLS, Acting Regional Adviser in Nursing, Regional Office for the Western Pacific

WHO HQ Secretariat:

Dr E. H. T. GOON, Director HRH
Dr M. J. HIRSCHFELD, HRH/NUR
Mr Orvill ADAMS, HRH/PPM

Ms Gillian BISCOE, Temporary Adviser (Hobart, Tasmania, Australia)

Annex 2

FOURTH MEETING OF THE
GLOBAL ADVISORY GROUP ON NURSING AND MIDWIFERY
New Delhi, 12-14 December 1995

AGENDA AND SCHEDULE OF WORK

Tuesday, 12 December 1995

08:30-09:00 Registration

09:00-10:15 **Opening Session**:

- Inaugural address by the Regional Director, SEARO
- Welcoming address of the Director-General (by HRH/HQ)
- Address/remarks by Chief Scientist for Nursing, HQ
- Introduction of participants
- Appointment of Chairperson, Vice-Chairperson, Rapporteurs
- Announcements

10:15-10:30 Coffee Break

10:30-11:30 **Plenary**: Briefing session by Dr M.J. Hirschfeld on:

- Follow-up to prior GAG recommendations
- Report of the Expert Committee on Nursing Practice, July 1995
- Strengthening Nursing and Midwifery, 1992-1995: A Progress Report

11:30-12:30 **Plenary**: Presentation and discussion of country survey on monitoring implementation of resolution WHA45.5, by Dr L. O'Brien-Pallas

12:30-13:30 Lunch Break

13:30-14:45 **Plenary**: Presentation of situation analysis by the Regional Nursing Advisers

14:45-15:00 Coffee Break

15:00-16:30 **Plenary**: Continue discussion

Wednesday, 13 December 1995

08:30-12:00 Professional visits

12:30-13:30 Lunch

13:30-13:45 **Plenary**: Review of previous day's minutes

13:35-18:00 **Plenary and Group Work**: Past and future role of the GAG
Plenary, discussion and group work led by Ms Gillian Biscoe

- Discuss the GAG's future role in advising and supporting WHO nursing development activities at country, regional and global levels
- Develop a strategic plan of action for the GAG.

Thursday, 14 December 1995

8:30-12:30 **Plenary/Group Work** continued

12:30-13:30 Lunch

13:30-15:30 **Plenary/Group Work**: Finalize and approve the strategic plan of action for the GAG for nursing/midwifery development

15:30-16:00 **Closing session**

16:00 Tea/coffee

Annex 3

WHO SOUTH-EAST ASIA REGION: *DRAFT DOCUMENT*

STRATEGIC PLAN FOR NURSING AND MIDWIFERY DEVELOPMENT IN SEAR COUNTRIES (1996–2001)

An intercountry consultation was held recently in Bangkok, Thailand, (2-6 October 1995) to review the complex issues in strengthening nursing and midwifery in support of strategies for health for all to develop a framework for a strategic plan for nursing/midwifery development in the region. The participants were senior nurses in education and services from nine of the ten SEAR countries plus representatives of other disciplines who are in key positions in countries. This multidisciplinary group framed a Mission Statement to reflect underlying beliefs about nursing/midwifery and the strategic outcome required for nursing/midwifery over the next five to ten years. In addition, eight Key Result Areas and Strategies were identified to achieve the desired outcome.

The draft framework of the plan agreed upon at the meeting is being finalized to elaborate the specific actions to be taken, the time frame, etc. The Key Result Areas (KRAs) and a few examples of some of the strategies under each are provided below to illustrate the directions to be taken.

Mission Statement

Nursing/Midwifery in SEAR is a dynamic professional workforce providing relevant health services and influencing health development policy to improve people's health and quality of life towards health for all.

Key Result Areas

1. *Increased contribution of nursing/midwifery to policy development in all relevant areas*

   - Encourage education of nurses/midwives in policy development and analysis;
   - Acquire skills in negotiation, policy, dialogues and lobbying;

- Establish formal and informal networking with professional groups, politicians, administrators; and
- Meet with consumer associations for debate and information.

2. *Effective contribution of nursing/midwifery to achieving key national health targets*

- Identify 2–4 priority health targets;
- Create an awareness within the nursing/midwifery workforce as to its important role in assisting the achievement of key national health targets; and
- Critically examine roles and functions of nursing/midwifery personnel in each sector and at each level of the health care system.

3. *Improved quality of nursing/midwifery care*

- Establish standards for nursing practice;
- Implement a quality assurance system for monitoring, evaluation and overall quality management;
- Develop accreditation systems for nursing schools and the health care setting; and
- Develop a mechanism for performance evaluation of nurses.

4. *Improved planning and management of human resources in nursing/midwifery in the context of HRH development*

- Conduct situational analyses of HRH planning and management with special emphasis on nursing/midwifery;
- Identify priority areas for improvement; and
- Develop policies and plans of action for improvement of planning and management of HRH in nursing/midwifery.

5. *Capable nursing/midwifery managers*

- Establish action learning based management development programmes for senior and middle nursing/midwifery managers;
- Foster mentoring opportunities for nursing/midwifery managers and leaders both current and potential; and
- Create peer support networks for senior nursing/midwifery managers and leaders.

6. *Revitalized educational system for producing competent, confident and committed nurses and midwives*

   - Implement programmes which emphasize interactive teaching; and
   - Introduce/include in the educational programmes an approach which encourages a greater social/political awareness/consciousness in nurses to enable their better functioning as "citizen of the world".

7. *Relevant regulatory mechanisms for nursing/midwifery education and practice*

   - Obtain government approval to change or establish a regulatory mechanism for nursing;
   - Draft standards for nursing education and practice; and
   - Consult with key stakeholders.

8. *Effective networks and strategic alliances with key people and organizations within and among SEAR countries*

   - Identify clear objectives for networking;
   - Identify and secure resources for networking;
   - Collaborate with other professionals and/or groups who have already established networking mechanisms; and
   - Develop links with national health systems research or operational research institutes or units to incorporate nursing/midwifery research questions and issues.

Annex 4

World Health Organization
Organisation mondiale de la Santé

EXECUTIVE BOARD
Ninety-seventh Session

Provisional agenda item 6

EB97/13
6 October 1995

Implementation of resolutions and decisions

Report by the Director-General

This document presents progress reports on the implementation of resolutions and decisions of the Executive Board and the Health Assembly. The Board is invited to note the reports and to consider the draft resolutions contained in section XII.

CONTENTS

		Page
I.	Improving technical cooperation among developing countries (resolution WHA43.9)	2
II.	Monitoring of progress in the implementation of strategies for health for all by the year 2000: revised list of indicators (resolution WHA45.4)	4
III.	Strengthening nursing and midwifery (resolutions WHA45.5 and WHA48.8)	5
IV.	Revised drug strategy, including the role of the pharmacist (resolutions WHA47.12 and WHA47.13)	7
V.	Reproductive health (resolutions EB95.R10 and WHA48.10)	10
VI.	Occupational health (resolution WHA33.31)	13
VII.	Tobacco or health (resolution WHA48.11)	16
VIII.	Prevention and control of iodine deficiency disorders (resolution WHA43.2)	17
IX.	Infant and young child nutrition (resolution WHA33.32)	19
X.	Global strategy for the prevention and control of AIDS (resolution WHA42.33)	21
XI.	Development and implementation of the WHO worldwide management information system (decision EB96(3))	23
XII.	Action by the Executive Board	24

III. STRENGTHENING NURSING AND MIDWIFERY

1. This report examines progress in implementing resolution WHA45.5 on "Strengthening nursing and midwifery in support of strategies for health for all", adopted in May 1992. Since no systematic data on nursing and midwifery were collected before 1992, there is no firm basis for comparisons with the period before adoption of the resolution. There is now systematic data collection, providing a reliable basis to assess further progress.

2. The major thrust in the period 1992-1995 has been to strengthen the role of nursing and midwifery for effective and efficient delivery of basic health care services. With support from the Danish and Swedish Governments, a nurse and a midwife have been added to the staff of the Nursing unit. The Director-General has provided for a second secretarial post and additional operational funds. The unit's work has also been strengthened through the advice and support of the Global Advisory Group on Nursing and Midwifery.

3. A Headquarters Coordinating Committee on Nursing and Midwifery has been established to ensure that nursing and midwifery are also taken into account in policy formation and programme planning; a subcommittee reviews all new professional post descriptions to encourage adaptation of titles and educational requirements to include fields other than medicine. So far, 131 posts have been reviewed and 54 changed.

4. Demands on the Nursing unit have steadily increased as countries take steps to implement resolution WHA45.5. Special projects have included the development of information systems for management of health personnel, intercountry workshops on nursing leadership in health development and on research, and funding of three research projects on various aspects of nursing services in Member States. The plans and research tasks were favourably reviewed by the Advisory Committee on Health Research. The unit also collaborates with the International Council of Nurses, the International Confederation of Midwives, other nongovernmental organizations and the International Labour Organisation, undertakes extensive consultations and advocacy, and coordinates the work of WHO divisions as it relates to nursing and midwifery.

5. Since 1992, Member States have increased their requests for assistance from regional nursing units in further developing nursing and midwifery. Regional projects have concentrated on development of management skills among nurses and midwives; development of national action plans; strengthening of primary health care and safe motherhood services; nursing and midwifery education; reinforcement of the role of nurses and midwives in health policy and planning, and appropriate legislation. Work with the 31 WHO collaborating centres for nursing and midwifery development is aimed at improving the quality of nursing and midwifery practice, management, education and research in Member States.

6. Progress in strengthening nursing and midwifery in the 190 WHO Member States was evaluated in 1995 by a survey on the eight priority areas delineated by resolution WHA45.5; 136 Member States (61%) responded; 50% reported that since 1992, they had assessed future needs for nursing services; 36% had assessed needs for midwifery services; 48% and 31% had assessed the current deployment and utilization of nurses and midwives, respectively, and 43% had studied nursing and midwifery roles in relation to changing health care needs and to the roles and functions of other providers.

7. Countries which had completed assessments reported increasing demands for services, shortages of personnel and often inadequate or inappropriate use or deployment of personnel. However, a third (35%) had developed a written national action plan for nursing, and 23% a plan for midwifery. A third (31%) reported increases in research on the contribution of nurses and midwives to health care delivery. Others reported a variety of concrete measures to strengthen nursing and midwifery, summarized below.

8. In order to strengthen the leadership of nurses and midwives, over half (58%) of Member States reported increases in management and leadership training, and 44% had enacted or reviewed legislation aimed at ensuring high-quality nursing services and education (24% had done so for midwifery).

9. Changes in education are among the most important developments since the passage of resolution WHA45.5: 59% of Member States had reviewed the quality of basic nursing/midwifery education since 1992, and 52% had improved continuing education; 42% had strengthened postgraduate education; 55% and 42% had strengthened the primary health care content in curricula for nurses and midwives, respectively. A number of countries had made completion of secondary education a requirement for admission to nursing school, and 43% indicated that access to university education for nurses and midwives had increased. Only 22% reported increases since 1992 in the number of fellowships for basic and post-basic education. While nurses and midwives constitute approximately 50% of the health workforce, only 4% of WHO fellowships have been awarded to nurses and midwives.

10. Poor salaries and limited career opportunities are reported alongside shortages of nursing and midwifery personnel. While 35% of Member States report increases in salary and benefits since 1992, several countries note that because of financial crises nurses were not paid at all for months on end. Forty per cent of countries reported improved career opportunities, and 41% reported increases in the number of budgeted posts for nurses and midwives.

11. Various efforts to include nurses and midwives in policy development were reported: 49% of Member States said the contributions of senior nurses and midwives to policy had increased. Only 23%, however, had a nursing unit in the ministry of health and only two-fifths (43%) had a chief nursing officer at ministry level. However, some countries had a focal point for nursing or midwifery.

12. While the survey data show progress at country level, there is a need for far more action to strengthen nursing/midwifery development if this cost-effective workforce is to play a decisive role in improving the coverage and quality of health care services to people and especially to the populations in greatest need.

13. To conclude, since 1992 nurses and midwives have become more visible in WHO and recognition of their roles in strategies for health for all has increased. In spite of this, the overall number of filled WHO nursing/midwifery posts has decreased by 40% since 1991 from 47 (1991) to 28 in 1995. WHO has cooperated with many Member States to ensure progress in the areas covered by resolution WHA45.5. Much, however, remains to be done. In efforts to further develop nursing and midwifery, it is crucial to avoid fragmented approaches, which are likely to waste scarce resources without achieving desired results. A comprehensive approach will require the evaluation of health care needs, the development of national human resources policy and, within that framework, coordinated measures to ensure appropriate legislation and strengthen nursing and midwifery practice, education and management. Only then will the coverage and quality of health care services show genuine improvement.

14. A more detailed report on implementation of resolution WHA45.5 is provided in EB97/INF.DOC./2, and a complete report is provided in document WHO/HRH/NUR/95.2, available upon request.

XII. ACTION BY THE EXECUTIVE BOARD

The Board is invited to consider the following resolutions:

STRENGTHENING NURSING AND MIDWIFERY

The Executive Board

RECOMMENDS the adoption by the World Health Assembly of the following resolution:

The Forty-ninth World Health Assembly,

Having reviewed the Director-General's report on implementation of resolutions and decisions,[1] concerning strengthening nursing and midwifery;

Recalling resolutions WHA42.27, WHA45.5, WHA47.9 and WHA48.8 dealing with the role of nursing and midwifery in the provision of quality health care and education of health care providers;

Seeking to apply the spirit of the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1994), and the Fourth United Nations World Conference on Women (Beijing, 1995);

Concerned about the necessity of effectively utilizing health care personnel, in view of rising costs, and mindful of the cost-effectiveness of good nursing/midwifery practice;

Recognizing the potential of nursing/midwifery to make a major difference in the quality and effectiveness of health care services in accordance with the Ninth General Programme of Work;

Recognizing the need for a comprehensive approach to nursing/midwifery service development as an integral part of health development to maximize the contribution of nurses and midwives to achievements in the field of health;

Recognizing also that such an approach must be country-specific and be assured of the active involvement of nurses and midwives at all levels of the health care system, together with the recipients of health care, policy-makers, the public and private sectors, representatives of professional associations and educational institutions, and those who have responsibility for social and economic development,

1. THANKS the Director-General for his report and for the increased support to nursing in Member States;

2. URGES Member States:

(1) to involve nurses and midwives more closely in health care reform and in the development of national health policy;

(2) to develop, where these do not exist, and carry out national action plans for health including nursing/midwifery as an integral part of national health policy, outlining the steps

[1] See page 5 of this document.

necessary to bring about change in health care delivery, ensuring further development of policy, assessment of needs and utilization of resources, legislation, management, working conditions, basic and continuing education, quality assurance and research;

(3) to increase opportunities for nurses and midwives in the health teams when selecting candidates for fellowships in nursing and health-related fields;

(4) to monitor and evaluate the progress toward attainment of national health and development targets and in particular the effective use of nurses and midwives in the priority areas of equitable access to health services, health protection and promotion, and prevention and control of specific health problems;

3. REQUESTS the Director-General:

(1) to support countries where appropriate in development, implementation and evaluation of national plans for health development including nursing and midwifery;

(2) to promote coordination between all agencies and collaborating centres and other organizations concerned in countries to support their health plan and make optimal use of available human and material resources;

(3) to keep the Health Assembly informed on progress made in the implementation of this resolution.

World Health Organization
Organisation mondiale de la Santé

EXECUTIVE BOARD
Ninety-seventh Session

Provisional agenda item 6

EB97/INF.DOC./2
13 November 1995

Strengthening nursing and midwifery

The purpose of this document is to provide details to supplement the progress report on implementation of resolution WHA45.5, contained in document EB97/13.

INTRODUCTION

1. Resolution WHA45.5 on "Strengthening nursing and midwifery in support of strategies for health for all" was adopted by the Forty-fifth World Health Assembly in May 1992. This report contains details of the progress made in strengthening nursing and midwifery from 1992 to 1995.[1]

CURRENT SITUATION

Financial resources and support

2. With support from the Danish Ministry of Foreign Affairs and the Swedish International Development Authority, WHO staffing at the global level was strengthened by the addition of a nurse and a midwife. The Director-General also provided additional operational resources. Further, as a priority programme, nursing has been accorded a budget increase of US$ 100 000 for the next biennium (1996-1997).

3. The 1992, 1993 and 1994 programme budgets for global and interregional and regional activities varied greatly. While the figures for the African and European Regions did not reach a quarter of a million dollars in any of the three years and those for global and interregional activities remained at about half a million, that for the Eastern Mediterranean rose from about half a million in 1993 to just under a million in 1994; that for South-East Asia, which was just under a million in 1992 and 1994, exceeded a million in 1993, the Americas fell from over two million in 1993 to about one-and-a-half million in 1994; far the highest figures concern the Western Pacific Region, which went from under two million dollars in 1992 to nearly six million in 1993 and nearly 10 million in 1994. Some of the differences reflect degrees of success in obtaining

[1] The report is based on information from the Nursing unit and other divisions in WHO headquarters, reports from the nursing units in the six WHO regions, reports of the meetings of the Global Advisory Group on Nursing and Midwifery (1992, 1993, 1994), the report of the Study Group on Nursing beyond the Year 2000 (1993), the report of the follow-up Expert Committee on Nursing Practice (1995), background papers prepared for the Expert Committee, reports from the WHO collaborating centres for nursing/midwifery development, and data from a 1991-1992 survey of ministries of health and a 1994-1995 survey of Member States.

extrabudgetary funding for projects. Meanwhile, demands on WHO from Member States have steadily increased with their efforts to implement resolution WHA45.5.

4. In spite of their many differences, certain needs are common to all regions as shown by the increase in requests from Member States in response to the resolution for cooperation in further developing nursing and midwifery, management and leadership, policy and national plans of action; regulations and legislation; improvement of nursing and midwifery practice, requiring attention to the roles of all categories of health worker in relation to each country's needs; finally needs assessment and curriculum review for basic, post-basic and continuing education, and culturally appropriate learning material in the languages of the various countries. Since 1992, activities in the six regions have concentrated on meeting these needs. Of the WHO total budget for nursing and midwifery practice in 1994, 32% went on midwifery and safe motherhood activities, some 20% on primary health care, 18% on mental health and psychiatric nursing, 10% on the elderly, 9% on HIV/AIDS nursing, 9% on quality assurance and 2% on hospital care. In nursing/midwifery management, 39% went on development of national plans of action, 39% on capacity-strengthening, 11% on information systems, some 5% on needs assessment, 4% on health policy, planning and development, and 1% on legislation and regulations. In education, 63% went on continuing education, some 30% on nursing education, 4% on midwifery education and 2% on learning materials.

5. Global and interregional nursing and midwifery activities accounted for 3% of WHO's regular budget resources (4% of extrabudgetary), regional activities accounted for 13% (3%), and country-level activities for 84% (93%).

6. The programme staff work closely with the International Council of Nurses, the International Confederation of Midwives and other nongovernmental organizations, as well as with ILO. In addition to budgeted activities, WHO staff have ensured cooperation and been involved in consultations and advocacy in Member States and with donors and other international governmental agencies. The 31 WHO collaborating centres for nursing/midwifery development have also carried out a variety of projects in education, practice, management and research. Some centres have focused on developing nursing and midwifery in their own countries while others assisted less developed countries; many projects were collaborative efforts with nursing schools, nursing organizations and other collaborating centres. The centres' work is coordinated by a global network with a secretariat currently located at Yonsei University (Republic of Korea). Since 1992 the centres have reinforced and complemented the work of WHO. The challenge at regional level now for WHO is to continue to respond to Member States' requests for technical assistance without substantially increased resources. The challenge to collaborating centres is to increase their capacity to supplement the work of WHO.

Staff resources

7. The Global Advisory Group on Nursing and Midwifery (GAG), established pursuant to resolution WHA45.5, paragraph 4(1), has met annually since 1992. It has expressed concern about the reduction in the staffing within WHO (see Table). The overall number of nursing positions filled in WHO has dropped by 40% since 1991; meanwhile the workload has increased substantially in all six regions and at headquarters, and the cuts have stretched the staff concerned beyond their capacity for coping with it. The cuts in country posts also have a serious effect on WHO's capacity to provide support for the implementation of resolution WHA45.5 or any future resolution.

NURSING POSTS IN WHO IN 1995, (1991), [1989] BY REGION AND GRADE

WHO		D	P6	P5	P4	P3	P2	P1	Total
Headquarters	Posts filled	1 (1)		2 (2)[3]	2 (2)	1 (2)			**6 (7)[3]**
	Posts vacant				*3*	*[1]*			***3 [1]***
African Region	Posts filled			3	1 (8)[6]	5 (9)[10]	(1)[1]		**9 (18)[17]**
	Posts vacant			*(1)[1]*	*2*	*3 [4]*			***5 (1)[5]***
Region of the Americas	Posts filled				4 (6)[5]				**4 (6)[5]**
	Posts vacant			*[1]*	*1 (2)[2]*	*[1]*			***1 (2)[4]***
South-East Asia Region	Posts filled			1 (1)[1]	2 (4)[4]				**3 (5)[5]**
	Posts vacant				*(1)[3]*				***(1)[3]***
European Region	Posts filled			1 (1)[1]					**1 (1)[1]**
	Posts vacant				*1 (1)[1]*				***1 (1)[1]***
Eastern Mediterranean Region	Posts filled			2 (1)[1]	(2)[3]	1 [1]			**3 (3)[5]**
	Posts vacant				*1*	*1*			***2***
Western Pacific Region	Posts filled		(1)	(1)[2]	2 (2)[1]	(1)		(1)	**2 (6)[3]**
	Posts vacant			*2*	*1 (1)[2]*				***3 (1)[2]***
Total	**Posts filled**	**1 (1)**	**(1)**	**9 (6)[8]**	**11 (24)[19]**	**7 (12)[11]**	**(1)[1]**	**(1)**	**28 (46)[39]**
Total	***Posts vacant***			***2 (1)[2]***	***9 (5)[8]***	***4 [6]***			***15 (6)[16]***

The role of nurses and midwives

8. The policy orientations of WHO's Ninth General Programme of Work provide a framework for further global efforts to strengthen nursing and midwifery in the interests of improved health care. Within this framework, WHO will continue to encourage the inclusion of nurses and midwives in policy development, globally, regionally and at country level, to provide for the most vulnerable populations and most serious health problems, and to support Member States' efforts to recruit, train and deploy adequate numbers in view of the goal of health for all.

9. Nurses and midwives are a major target group for training and are ultimately the main implementers of many WHO programmes at country level. The importance of this role raises three major issues affecting planning for more effective health care services in the future:

(1) The assumption that training alone will ensure better services is known today to be false; even coordinated training activities do not enable the one nurse or midwife in the health centre or hospital ward to deliver integrated care, which depends further on availability of equipment, drugs and other supplies, and on transport and proper working conditions. A comprehensive and integrated approach must thus combine training with several other essential components.[1]

(2) It is not sufficient to produce high-quality teaching/learning materials unless they are available to health care workers at the point of service delivery in a language they can read and understand, which requires major efforts at country level.

(3) Nurses and midwives, rather than simple targets of training and instructions, must be involved in the overall policy and planning of health services so as to share responsibility for a system which supports comprehensive health care delivery, and for the delivery of integrated care necessary to reduce morbidity and improve health. This is a complex task requiring information and intelligent collaboration at all levels and in all sectors of the health care system as well as with other sectors and the population.

10. More and more countries find themselves in a situation where they have to answer changing and growing health care needs in a cost-effective way. While this is a very complex problem, there is no doubt that the effective deployment of nurses and midwives is an important part of the solution.

PROGRESS IN COUNTRIES (1995 SURVEY RESULTS)

11. In order to cooperate in monitoring progress in the implementation of resolution WHA45.5 in Member States, WHO and the Research Unit on Quality of Nursing Worklife, University of Toronto (Canada), devised a 64-item questionnaire. By August 1995, 136 completed questionnaires had been returned by Member States.[2] This report summarizes, by reference to specific provisions of resolution WHA45.5, the findings for Member States only (percentages relate to the total number of Member States); where appropriate, the

[1] Report of the Expert Committee on Nursing Practice, 1995 (in preparation for publication in the Technical Report Series).

[2] The complete methods and findings of the survey of Member States and territories are reported elsewhere (Hirschfeld MJ and O'Brien-Pallas LO, in preparation).

findings are compared to the findings of a 1991-1992 survey in ministries of health on shortages of nursing staff; nursing education; and quality of care.[1]

Assessments of needs and utilization (resolution WHA45.5, paragraph 2(1))

In a survey of ministries of health in 1991-1992 three-quarters of respondents had noted a shortage of nursing staff in the public sector and 57% had reported shortages in the private sector. Shortages were worst in rural areas. Many respondents had also reported insufficient budgeted positions for nurses, and had noted that the best-qualified nurse managers, educators and practitioners were leaving public service for the private sector, or for countries with better working conditions.

12. In the 1995 survey, 94 countries or nearly 50% of Member States report that they have completed an assessment of needs for nursing services during the period 1992-1995 and observe increasing demands for nursing and midwifery services, shortages of nurses and midwives, and often inappropriate deployment and under-use or inappropriate use of personnel.

13. Some Member States report that increased public awareness of the importance of health has brought higher expectations of nursing and midwifery services, some that job descriptions of nurses and midwives have been reviewed and updated and the roles of nurses more clearly developed and in some cases expanded. Some also note that regulations have been developed to support new standards for nursing specialties. A third (34.7%) of the countries have developed a national action plan for nursing in order to ensure a comprehensive approach to recruiting, educating and retaining sufficient numbers of nurses to meet changing country needs. Almost a quarter (23.2%) have developed a national action plan for midwifery.

Strengthening management and leadership (resolution WHA45.5, paragraph 2(2))

In the 1991-1992 survey, nearly half the respondents had found the quality of nursing management only fair - in the least developed countries, 71%.

14. In the current survey, 39% of Member States report increases in the number of senior nursing and midwifery positions at ministry level since 1992, and in 37.4% the number of such positions at regional, provincial or district levels increased. Several countries note that nurses/midwives hold more positions as planners and programme coordinators, and senior nursing staff are more involved in management and policy formulation.

15. Also, 58.4% of Member States report increases in the number of nurses and midwives receiving management training. In many, appreciably large numbers of nurses and midwives attended management courses, seminars or workshops locally or abroad. Some report enrolment of senior nurses in master's programmes in administration or management, and others, revision of basic nursing curricula to include management.

Enacting legislation (resolution WHA45.5, paragraph 2(3))

In 1991-1992 many respondents had noted that the legislation restricted practice and led to under-use of the capacities of nurses and midwives.

16. In the current survey 44.2% of Member States report that they enacted or reviewed legislation to ensure high-quality nursing services and education; 23.7% had done so for midwifery. This includes legislation on

[1] Hirschfeld MJ, Henry B, Griffith H. Nursing personnel resources: results of a survey of perceptions in ministries of health on nursing shortage, nursing education and quality of care. Geneva, WHO, 1993 (unpublished document WHO/HRH/NUR/93.4).

training and education requirements, introduction of equal-opportunity policies and new standards of practice for specialties, new policies on the utilization of nursing personnel, new regulations governing nursing and midwifery practice and education and the development of ethical codes and guidelines.

Strengthening education (resolution WHA45.5, paragraph 2(4))

In 1992, in many countries students might begin basic nursing education at age 13, 14 or 15, which is to be seen in relation to the information that in nearly half of the least developed countries many applicants could not qualify for nursing school because of poor general education. In the 1991-1992 survey, nearly half the respondents - and among the least developed countries, 86% - had thought the quality of their nursing schools unacceptable. Some 30% of respondents had reported efforts to increase fellowships and financial aid to nursing students as a way of recruiting more people to the profession.

17. In the current survey, many Member States report reviews of the quality of nursing education showing improvements; fewer report increases in the financial resources: just over a quarter (28.4%) had more resources for basic education than in 1992; another quarter report no change and 10% an actual decrease. About a quarter (26.3%) report increases in resources for continuing education, and slightly fewer (20.5%) report increases in resources for postgraduate education. Some countries increased resources as part of a comprehensive effort to end the shortage of nursing personnel; others received assistance from donors to establish new educational programmes.

18. Only 22.1% of Member States report increases in fellowships for basic education, and 21.6% report increases for post-basic education. But in almost every region the total number of WHO fellowships awarded to nurses and midwives decreased and, while nursing/midwifery personnel comprise about 50% of the health workforce in most countries, only 4% of WHO fellowships are awarded to them.

19. While the consequences of improvements in education are not immediately evident in practice, these changes are among the most important developments in nursing and midwifery since the passage of resolution WHA45.5.

Promoting research (resolution WHA45.5, paragraph 2(5))

In 1992, the report of the Study Group on Nursing beyond the Year 2000[1] noted that there had been little research on the efficacy of nursing care, especially in relation to the activities of other providers. Research workers thus face the major challenge of showing the link between an appropriate combination of nurses, physicians and other health workers and results in terms of care.

20. In the current survey 30.5% of Member States report increases in health services research on the contributions of nurses and midwives to health care, including research on clinical problems and health systems, and the development of collaborative research with other groups of nurses/midwives and with other members of the health team, as well as with WHO collaborating centres. They also report increases in the financial resources for research.

Improving working conditions (resolution WHA45.5, paragraph 2(6))

In the 1991-1992 survey, some respondents had noted that nurses worked 80 hours of night duty a week and others travelled four to six hours a day to and from work. Low salaries and poor and sometimes unsafe working conditions have been major problems for nurses and midwives in many parts

[1] WHO Technical Report Series, No. 842, 1994.

of the world. One country had reported that experienced nurses earned about one-fifth of the salary of teachers; 40% had reported that nurses' salaries were lower than those for similar occupations and a quarter that they were actually declining.

21. In the current survey, 35.3% of Member States report increases in salary and benefits since 1992. (However, the 50 Member States of the European Region did not answer this question because it was considered inappropriate for the Region; therefore, percentages need to be interpreted with caution.) In a number of countries government-employed nurses received either salary increases or cost-of-living adjustments. However, in many cases inflation cancelled out the increases. A few countries report that nurses were not paid at all for months on end because of financial crises. Improved career opportunities for nurses and midwives are reported by 39.5% of the Member States. In contrast, some note few opportunities for promotion and one reports that there have been no promotions for nurses for 15 years.

Ensuring adequate resources (resolution WHA45.5, paragraph 2(7))

In the 1991-1992 survey, a third of the respondents from developing and least developed countries had reported that they had too few positions in hospitals, and more than a third said they lacked positions in community health.

22. In the current survey, 41.1% of Member States report changes in the number of posts since 1992. While one or two countries note decreases, nearly all the changes were increases in budgeted posts, although many countries give as one cause of the shortage of nursing and midwifery services an inadequate number of budgeted posts. While this denotes progress, it is still far from answering the growing needs for primary, secondary and tertiary nursing services.

Including nurses and midwives in policy development (resolution WHA45.5, paragraph 2(8))

It has repeatedly been noted that the absence of nurses and midwives in high-level policy positions is an obstacle to the appropriate development of nursing and midwifery services. Yet only in a few countries do nurses play a full part in policy development and decision-making. Even in countries whose health ministries have large nursing departments, nurses must struggle to ensure that their voices are heard. There is, however, some progress.

23. In the current survey, half (48.9%) of Member States report that the contributions of senior nurses and midwives to policy development have increased since 1992. Most note that the changes result from new regulations to strengthen the contribution of nursing and midwifery, or from infrastructure development. However, only 43.2% report a chief nursing officer in ministries, and the great majority had no focal point for midwifery at this level.

CONCLUSION

24. Clearly, since 1992 Member States have made considerable strides towards strengthening nursing and midwifery at global, regional and country levels in support of strategies for health for all. Advances are reported in all the eight areas covered by resolution WHA45.5. WHO has succeeded in increasing attention to nursing and midwifery and their essential role in strategies for health for all, as well as in assisting Member States in this regard. In the six regions technical cooperation with Member States in developing national action plans and carrying out a variety of regional projects in nursing and midwifery education, practice, management and research has increased. The WHO collaborating centres for nursing/midwifery development have complemented the tasks described in resolution WHA45.5.

25. Much, however, is still to be done. The WHO Ninth General Programme of Work provides a framework for efforts to further develop nursing and midwifery and increase the contribution of nurses and midwives in strategies for health for all, in which it is crucial to avoid a fragmented approach wasting scarce resources by focusing, for example, on training needs without attention to the number of available posts, or on development of policy skills without involvement in policy formation. A comprehensive approach to the development of nursing and midwifery requires an evaluation of needs for services, the devising of national policy as an integral part of human resources policy, and coordinated action to strengthen education, practice and management as a part of health care reform.

= = =

Annex 5

RECOMMENDATIONS OF THE THIRD MEETING OF THE GLOBAL ADVISORY GROUP ON NURSING AND MIDWIFERY, Geneva, 28–30 November 1994

AND PROGRESS IN IMPLEMENTATION

The Director-General and the Regional Directors:

1a. Continue to stress to WHO programmes the need to recruit, where appropriate, nursing/midwifery personnel in order to utilize their expertise in contributing to accomplishing the goals and targets set out in the Ninth General Programme of Work.

- Job descriptions are being rewritten so that where a medical degree is not absolutely necessary other health professionals have an opportunity to apply for the job.

1b. Consider that a review of staffing and resources be undertaken to ensure WHO's ability to respond to the increasing demands for nursing/midwifery services within expanding activities at all levels.

- A review of the availability of nursing/midwifery personnel and their capacity to respond to the increasing demands has yet to be undertaken.

The Director-General:

2a. Urge Member States to develop nursing/midwifery country profiles that will assist them, WHO and other agencies in the identification of gaps in service provision.

- A number of Member States particularly in the European Region have been developing country profiles that can assist WHO and other countries in identifying gaps in service provision. The Department of Health in the United Kingdom provided a secondment to EURO to assist in this project.

2b. *Urge Member States to support nursing/midwifery attendance as a member of country delegations to regional committee meetings and the WHA in order to provide input into the setting of international and their country priorities for health development and public health action, disease prevention and health promotion.*

- The Director-General has circulated to Member States the GAG's recommendation in support of nursing/midwifery attendance as a member of country delegations to regional committee meetings and the WHA.

2c. *Support the development of specific indicators to reflect the progress of nursing/midwifery at all levels of service.*

- Joint work is being undertaken between Policy Planning and Management/HRH and Nursing/HRH in the development of indicators to reflect the progress of nursing/midwifery at all levels.

2d. *Support the development of guidelines to strengthen national capacity to develop relevant nursing/midwifery indicators.*

- This work has been initiated in conjunction with the above.

2e. *Ensure that nursing/midwifery be part of the official delegation to the Beijing International Conference on Women and to the Social Development Summit in Copenhagen (1995).*

- This recommendation was realized. Nursing/midwifery participated in preparatory meetings with respect to WHO's participation. Representatives of nursing/midwifery from headquarters, AFRO and SEARO attended the UN Fourth World Conference on Women in Beijing in September 1995..

The Regional Directors:

3a. *Provide a forum for chief government nurses/midwives, or equivalent, to share their experiences and knowledge and thereby increase their capacity to provide policy input to further the effective implementation of the Ninth General Programme of Work.*

- Meetings have been held during the last year in the following regions: Africa, the Americas, Europe, and South-East Asia.

3b. Consider the appointment of a nursing/midwifery committee to coordinate and provide nursing/midwifery input into regional policies on health for all and primary health care, and support the committee with funding.

- This recommendation is being implemented to various degrees in the regions.

3c. Encourage WHO representatives to ensure regional nursing/midwifery input into the development of WHO/country plans and, further, ensure that nursing/midwifery personnel be included in country assessment teams.

- This has started but it is necessary to find ways to support the WHO Representatives.

3d. Provide a separate budget line for nursing/midwifery to allow for a clearer identification of activities and closer monitoring.

- Budget lines for nursing/midwifery activities exist in some regions but it remains difficult to obtain comparable information across regions.

Annex 6

BEING STRATEGIC

by Gillian Biscoe and Brian Lewis

The health care system needs to focus on being strategic, not only on strategic planning. We need to develop a continuum where strategic plans are seen as an **input** to the **process** of strategic thinking with the desired **outcome,** being strategic, and health professionals and others within the system must be capable of being involved in planning the future and managing the present.

While this chapter is about strategic planning it is essentially about a paradigm shift in the way we view what we do in health service organisations. The major limitation of the focus on strategic plans is that once the plan is produced we believe that strategic planning has occurred. In the same way we believe that separate policy units are the best way to develop policy when in fact a good policy does not necessarily mean a change in behaviour or an improvement in service delivery that leads to improved patient care.

This chapter is structured in three parts:

- a framework for organisational success - that demonstrates the connections between various levels of planning and the operational delivery of services

- one strategic thinking model - that provides a conceptual framework, or map, to assist and guide the process of both strategic thinking and planning

- planning guidelines - that link strategic intent and operational reality including the connection with individual performance and development.

The logical sequence of information is from the macro to the micro. All of the ideas contained in this chapter are the result of practical application and experience in health service organisations rather than the intellectual pursuit of ever more robust theories. In short, all of what follows works!

(Inevitably much of the language surrounding these topics varies and can have different meanings. The important thing is not to prove who has the best set of labels but rather to identify words or "jargon" that leads to shared meaning and understanding.)

A Framework for Organisational Success

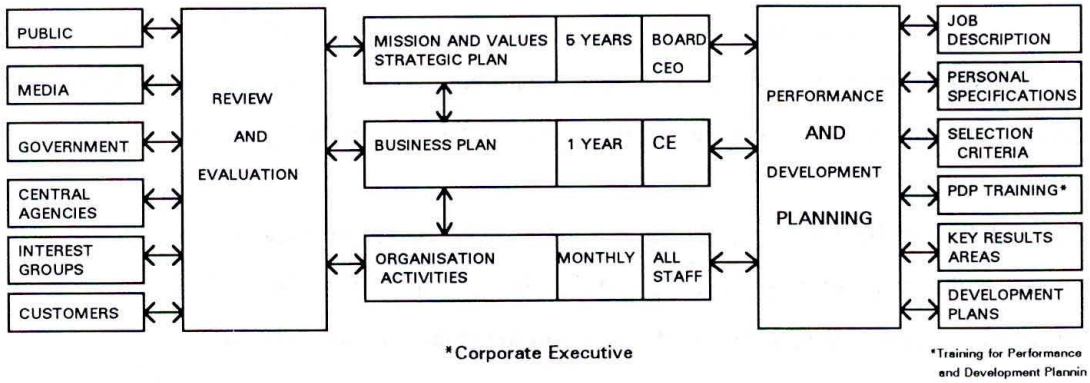
For many health service organisations, governing boards, health professionals, health administrators and managers, the recognition that their day to day activities are connected with organisational success is a novel one. This is not to imply criticism of the way health service organisations have typically been run but rather to acknowledge the reality of changing times with respect to reduced resources, increasing demand and a greater awareness of how organisations in the broader economy can be managed better.

Indeed, one of the great strengths of health professionals and health organisations has been their dedication and commitment to providing high quality care. Increasingly in recent times we have seen a focus on involving as many people as possible in understanding and responding to the needs of the overall organisation. This is particularly true in health where, for example, doctors tend to be the greatest cost generators and nurses are typically fifty percent of the workforce. So in management terms it makes sense to address both these groups, not to the exclusion of other groups, but to acknowledge that they are significant players in a very complex system.

One of the reasons it is important that moves to more managed health service organisations need to avoid explicit or implicit criticism of the past is that, for the most part, it has previously not been required of health professionals that they be involved in management. Our experience is that when system or organisation changes are introduced in a skilful and elegant way that acknowledges the contribution of health professionals and seeks to re-orient their activities to include a management perspective in a such way that builds on their strength and utilises their input then those changes can be most successful.

The following model was developed in response to questions from a group of health professionals along the lines of: "Why do we need to be involved in planning, what's the connection between what we do - delivering patient care - and the organisation's planning?". It is a model that we have refined over some years and continue to develop to make it increasingly useful for health professionals, health managers and governing boards to guide their thinking and ensure that their is a direct connection between organisational activity and organisational intent.

A FRAMEWORK FOR ORGANISATIONAL SUCCESS



Mission/Strategic Plan

The starting point for any organisation must be its mission or vision or statement of purpose or statement of intent, whatever label is applied. The important thing for a mission statement to do is to convey the essence of what the organisation is in business to achieve, not to describe its activities. Typically a mission statement will represent an end point that describes how the world will be different as a result of that organisation successfully achieving its purpose.

In many organisations, especially health organisations, mission statements are in practice "uncovered" or "discovered" not "created" or "invented". That is to say the underlying mission of the organisation exists and in many cases has existed for a number of years and it is a question of trying to discover or uncover that and articulate it in a meaningful way for staff, customers and other key people. A mistake that is often is made is to believe that mission statement development is a literature competition and not the foundation for any organisation. The organisation with the neatest or smartest or most memorable mission statement may not necessarily be the organisation with the most meaningful description of its purpose that conveys itself to staff and the public.

Typically a strategic plan will cover a time frame of about five years. The mission statement and perhaps a set of values or guiding principles that give expression to the organisational behaviour that is encouraged and will be rewarded to achieve this mission typically comprise the opening part of a strategic or corporate plan. Again, the label is not important so much as the meaning and

understanding it conveys so that when people refer to the five year plan they do so by the same label; for the purposes of this model a "strategic plan".

A strategic plan is most helpful if it outlines the broad strategic direction for the organisation, key result areas it wishes to achieve in, an analysis of the environment including competitors, future developments and assessment of the organisations current and future capabilities.

Accountability for the delivery of the strategic plan and progress towards the achievement of the mission is the responsibility of the governing board, chief executive officer and corporate management group - those who report directly to the chief executive officer.

Work Plan

The Work Plan or annual operating plan is a statement of what the organisation intends to achieve over the next twelve months, usually along financial years, in progress towards achieving the strategic plan. In crude arithmetical terms each Work Plan might represent twenty percent of achievement towards the strategic plan but it is important to note that the strategic plan is a rolling one in that after year one and the achievement of the first Work Plan and its objectives, a new five year strategic plan can be articulated.

It is important to emphasise this point as many people tend to think that the five year strategic plan exists in a finite time frame and after five years we then write our next strategic plan. All types of management and organisational planning need to be flexible and iterative and therefore necessarily require some tolerance for ambiguity. Indeed it has been said that only health service administrators would think that plans are for implementing! Plans are helpful to assist us in knowing what we are varying from.

More detail on Work Plans follows later but it is important to note the critical role they play in connecting the strategic plan and the operations of the organisation performed by all staff. As mentioned, it is not uncommon that many staff in large health service organisations are not aware of how what they do connects with the reason that the organisation exists. A planning approach that involves staff in all areas to develop Work Plans for those areas leads not only to greater knowledge but also to commitment to action and results.

Typically a Work Plan has an annual time frame and the accountability for the delivery of it rests with the corporate management group and those managers who report to them. Indeed, a helpful

definition of a manager in this context might be anybody accountable for the delivery of a Work Plan. Depending on the context this may include Directors of Nursing, District Nursing Officer, Charge Nurses and others. The development, monitoring and delivery of a Business Plan instils rigour into a system and encourages or forces those responsible for the performance of an organisation to consult with staff, seek their input and assist them to share in the overall accountability for delivery of services. It is not always an easy process particularly when introducing it but in the mid to long term the results both to "shareholder" interests and customer client/patient expectations is significant.

Operations

All the operations or activities or service delivery in an organisation **must** be a part of and contribute to the Work Plan of an area of the organisation. This is essential to ensure that not only are all activities geared to the planned purpose of the organisation but also to ensure that there are not activities being undertaken that are not required to achieve organisational success as specified in a mission, strategic plan and Work Plans for the organisation.

Embarking on a serious planning process, or building or refining existing planning processes, requires significant commitment from management and staff and is a major intervention in terms of organisational culture. The "theory" would have it that the missions and strategic plan are agreed by the governing body, the chief executive officer and the corporate management group who then transmit those intentions through the work plans together with other managers which then translates to each individual in the organisation having a "personal work plan" which we refer to as a Performance and Development Plan. In practice it must be a two way, top down/bottom up process.

Performance and Development Plan

The Performance and Development Plan or PDP is the way in which an individual gives expression to their job for the next twelve months and includes components relating to performance objectives, development needs associated with meeting those objectives, career development needs and personal development. Many organisations do not invest in this form of "performance management" and indeed those who do may choose not to develop systems and processes to cater to career development or personal development needs, but it is our experience that the minimum requirement for organisational success is for individuals to have performance

objectives and development needs identified to assist them to meet those objectives that are directly related to the annual Work Plan for the area in which they work.

The right hand side of the model identifies some of the inputs into a performance and development planning process and these may include job descriptions, person specifications, training in performance and development planning, identification of key results areas, personal development and career development. This list is not exhaustive, merely illustrative, and will vary according to organisational context.

A successful process of performance and development planning should start with the chief executive officer having a performance and development plan with the chairperson of the governing board or body. The corporate management group in turn has a performance and development plan agreed with the chief executive officer; they in turn agree with performance and development plans with the people who report to them and so on throughout the organisation. When the process works well each individual in the organisation can track how their personal efforts in fulfilling the requirements of their job makes a contribution through the Work Plan and the strategic plan to the achievement of the organisation's success.

An organisation's response to performance management is the loudest single statement it can make about itself and its culture.

PDP's, Work Plans and Strategic Plans are the essential elements of a performance management system.

Review and Evaluation

There is little point having a process of planning if there is no monitoring of progress against that plan. As mentioned earlier, the purpose is not to implement the plan as originally stated but rather to revise and amend the plan, for the right reasons, to ensure that it reflects any changes in the external environment or in the operational capacity of the organisation to deliver. Having a plan and writing it down means not only do we know what starting point we have agreed but instils discipline and rigour into organisational management.

The process of review and evaluation **must** be supportive and organisationally focussed and not be seen as a policing or audit role designed to catch people out. Therefore, it is important that all

plans but particularly work plans evolve during the course of a financial or operational year based on the input of those responsible for delivering on those plans - the staff and managers.

Successful organisations monitor their own performance and are never subject to scandals or surprises. Their planning and management processes are supported by a culture that encourages people to identify mistakes, correct them and modify planning to ensure that they do not occur in future. Many systems and processes in the broad area of "quality" are designed to assist in this ongoing management endeavour; to engage in the process of "always doing better" that requires the articulation of intended plans, standards, and indicators to measure achievement towards those standards.

There are an enormous variety of ways that organisational performance is reviewed and evaluated and some of those are listed on the extreme lefthand side of the model and include:

- **audit, both internal and external** : are increasingly extending beyond mere financial audits to cover a broader range of organisational performance indicators and audit functions within organisations are being seen as integral to organisational performance and not an "alongside" organisational function.

- **annual reports** : which should be a written report against the work plan which demonstrates that the plan was achieved, or that it varied and how it varied and what that means for the next year's performance and activities.

- **parliamentary scrutiny, or board scrutiny** : depending on whether the health service organisation is in the public or private sector. Indeed, in many cases organisations will be subject to performance evaluation from both boards and some higher authority whether that be Ministers of Government or stockholders or boards of organisations or parent or holding companies.

- **community** : which involves not only those customers or consumers of the direct services being supplied by the health service organisation but also the wider community which has an interest not only in the health well-being of its people but also in the financial well-being of the organisations that make up a part of the community and provide jobs, social stability and other important community elements.

- **media** : which in turn can be a reflection of public expectations and indeed influence public expectations. Not only can the media sensationalise one-off issues or cases that occur in the high profile health industry but they can also pursue ongoing performance issues of particular health organisations or parts of health systems.

- **co-ordinating agencies** : refers particularly to those health organisations in the public sector where central agencies such as Departments of Finance, Treasury, and other public sector-wide agencies are charged with monitoring the performance of individual organisations and their comparative performance against other organisations spending public monies. Traditionally, the health sector has been poorly served in being able to justify why expenditure should be maintained or, indeed, increased in this area when contrasted with other portfolios who can provide tangible performance measures for their own performance. It is no longer a compelling argument to say that health is "a good thing" and should therefore be funded; consistent successful performance against agreed plan is the most potent way for the health system to argue for its share of public sector expenditure.

Organisational Success

Health professionals and others working in the health care system will increasingly need to be more aware of their role in their organisations. Nobody in any organisation has a right to exist for one's own sake and the jobs, activities and services delivered by individuals need to be clearly identified and be integrated into the planning for any organisation.

As resources decrease and expectations increase the efficient use of available resources to meet agreed expectations through delivering high quality services becomes a moral imperative. As one chief executive put it "any health service inefficiency is an obscenity". Every individual needs to identify their place in the organisation and ensure that their contribution is connected to what the organisation exists to be or do. One way to do that is through an integrated system of performance management that includes the linking of individual performance and development, work plans, and strategic plans to the overall achieve of the organisation's mission. A way to do this is through the active consideration of the framework for organisational success, amended to reflect the unique position of each health service organisation, especially in respect of the inputs to the performance and development planning process and the nature of the review and evaluation that that organisation is subject to.

ONE STRATEGIC THINKING MODEL

There are endless strategic planning models most of which in our experience are too complex for the average health professional and health manager to either remember, apply or use effectively with others in the planning process. The outcome we are going for is to instil in our people the skill to think strategically. Once the strategic thinking process is installed as an integral part of the way we operate personally and do our business organisationally then we can indeed claim to **be strategic**. When you are being strategic you know that everything you are doing is directed towards what you intended to do.

What follows is a model for strategic thinking which is in two parts; firstly an overview that describes the model and secondly a process that provides some suggestions on how the model might be used especially in a group setting.

HELPING STRATEGIC THINKING HAPPEN - AN OVERVIEW

"Always remember that if you work at a wrong plan, you are neglecting the right plan; the plan that would accomplish results."

Let us say some things about strategic thinking. It is a process not an end. It is important so we know that everything we are **doing** is consistent with what we **wanted** to do. We can then be sure that our 'behaviour' matches our 'intention' - that we are doing what needs to be done.

For strategic planning purposes, **strategic** means purposeful or directed to an end. **Planning** means ordered, not random, progress with flags or milestones to measure progress against. However, the words **strategic thinking** are a more accurate label than strategic planning for they seem to represent **a way of being** rather than a way of doing. This reinforces the process as iterative, evolving and flexible. It also avoids the common pitfall of assigning that a **plan** means that **planning** has occurred.

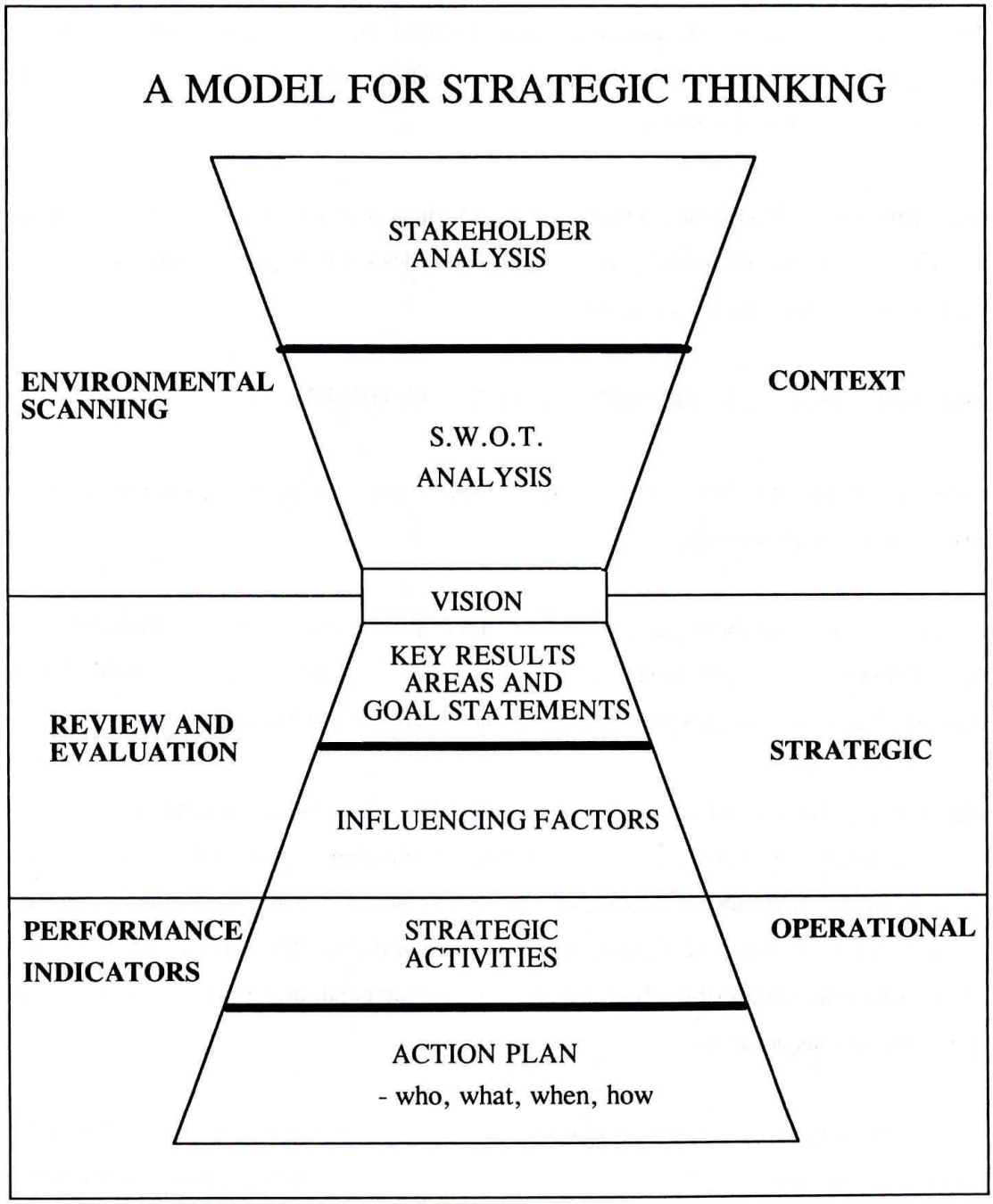
Strategic thinking is a guide to achievement, it is not the achievement itself. It is a map to chart progress. For example, a good corporate plan does not equal a good corporation, a good strategic thinking session is not a strategy - although both may help.

Mp·130 N97
05264

A Model for Strategic Thinking

This model is constantly evolving, being modified and enhanced.

(S.W.O.T. = strengths, weaknesses, opportunities, threats)



It has three main phases - context, strategic, operation.

Context	-	1 Stakeholder Analysis
	-	2 SWOT Analysis (strengths, weaknesses, opportunities, threats)
Strategic	-	1 Vision/Mission/Outcome Statement
		2 Key Results Area
		3 Influencing Factors
Operational	-	1 Strategic Activities
		2 Action Plan - Who, What, When, How

In using this model of strategic thinking it is useful to remember that the model, like the process, is an evolving one. The stages in the model merely provide useful beginning or reference points for strategic thinking. Most of the stages in the model need to be visited and revisited in the process of strategic thinking.

Draft Vision

Perhaps the most critical feature of strategic thinking, and indeed this model, is the statement of vision or mission or outcome a statement of what will be different. For this reason it is useful to begin strategic thinking with a "first run" of this statement. Particularly when working with groups this is a good way to see if we are talking about the same animal! At this stage the precise language of a vision statement is not the issue, but identifying the key features of what it is we are on about. These will usually appear as key words in peoples thinking about a mission or outcome statement. A favourite acronym is WBAWI, standing for "what business are we in". The key question to open up exploration of this vision is "what are we for" - a deliberately worded question to tease out the usual variety of perspectives.

When developing vision or mission statements for organisations it is a good idea to share and record values or guiding principles, usually as a separate set of words from the vision, that will support the statement.

One tool that is useful, especially at an organisational level, is the Values Grid.

Stated Values	Behaviour That Violates The Value	Behaviour That Supports The Value
•		
•		
•		
•		
•		

Identifying and agreeing specific **behaviour** that violates or reinforces the expressed value or guiding principle is not only important to model appropriately but also to ensure people understand what is really meant by the words. If people do not internalize and accept the ideas, then the words mean little to help change attitudes and action towards the desired end.

Stakeholders

Once the broad vision is established it is then appropriate to move onto "stakeholder analysis". Stakeholders are defined as those individuals, groups or organisations who have an impact upon, or are impacted upon by, what is we do. It is important to not only identify who the stakeholders are but also what stake they have and what assumptions we hold about them and that stake. The stakeholder analysis helps us to make sure that we do not miss the opportunity to enlist an ally as well as preventing us from being "shot down" by an unknown foe!

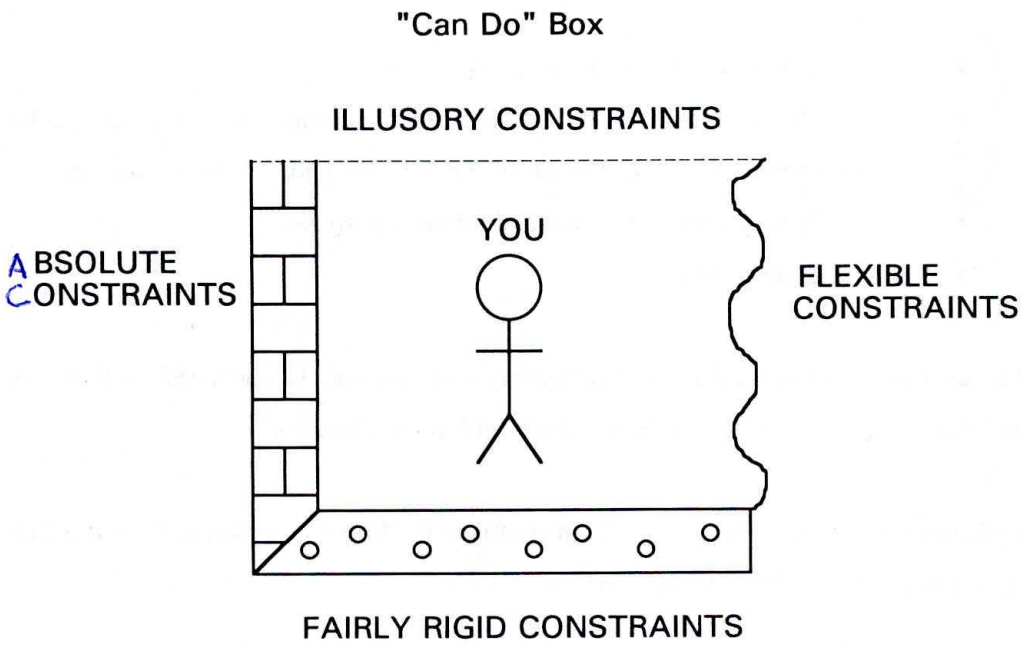
A common failing is to do the analysis but not develop a **strategy** for each stakeholder and assign a person or persons to manage the relationship with expectations of the stakeholder.

SWOT

The second part of the contextual analysis is the SWOT analysis. SWOT stands for strengths, weaknesses, opportunities, threats. If we assess our current situation in these four categories we get not only a "situation report" but also a best guess as to what the future may hold.

Strengths and weaknesses related to our current situation and are usually internal. Opportunities and threats relate to the future and are often external. The weaknesses and threats are those things

which may constrain us, and therefore need to be dealt with. A useful first "constraints analysis" is to use the "can do" box (See Figure 2).



This device is a way of adopting a more positive, "can do" approach to those issues that constrain us and not deprive ourselves of power by adopting a "can't do" approach. It is surprising how often those things that constrain us are actually flexible or even illusory constraints. How often do we constrain ourselves by imaging that weaknesses and threats are in fact absolute or fairly rigid? Having said that, it is important to be realistic.

Vision

Having completed an analysis of the context the next phase is to analyse the strategic nature of what we are doing. At this point we review the first run at our vision/mission/outcome statement. This enables us to refine and focus our intention and attention. Remember, at no stage is the process "finished", however it is important to specify more clearly what outcome we are going for and to document it. Now is the time to do that.

Outcome statements are often expressed as a verb - action statement. This can be misleading as we have no real way of knowing when we have achieved our outcome, as it is constantly "in progress"! Some helpful guidelines for vision/mission/outcome statements are:

- 25 words or less (one or two sentences).
- The statement should be expressed as a noun, something that can be measured as an end point (or put in a metaphorical wheelbarrow!).
- Specify what, for whom and for what purpose.
- Be inspirational

It should be the sort of statement that one might print on a banner above one's desk so that each day on arriving at work one might say "yes that's what I am working for".

You should also check how realistic your vision statement is. Can it be realised and is it within your scope of power to see that it is realised?

The statement does not have to be perfect at this stage but it should be as near to perfect as possible. The 80/20 rule applies here - that is 80% of the result can usually be achieved with 20% of the effort.

Key Results Areas

The next strategic stage is key results areas or KRA. KRA are those areas in which we must achieve specific things in order to reach our vision. As a general rule, the seven-plus-or-minus-two approach is useful as usually around five to nine goals can usefully be managed in relation to one outcome. Obviously this is guide only, but any fewer and something might be missed; any more and you may be attempting too much. In which case perhaps you have more than one mission.

In any event you need all and only those KRAs, often expressed as goals, the achievement of which will guarantee that everything you are working on is directly related to your vision statement and that you are working on everything that needs to be addressed.

Goal statements should:

- Contain an action verb eg to develop, to produce, to deliver etc
- Give an end point eg by 25 August 19??
- And give an estimate of resources within current budget, person hours, etc.

Influencing Factors

Having done the work on context and strategic levels of the model, the next stage is to step back and review progress in relation to goals. This is called assessing the influencing factors or helps and hindrances for each KRA. In relation to each goal statement we need to assess the positive, driving forces that will help us to achieve that goal and also to assess those negative, inhibiting forces that may hinder us in achieving that goal. This is, if you like, a snap shot of the present situation in relation to each KRA.

Strategic Activities

The next phase of the model is the operational phase. We now move into specific activities that need to be carried out in order to achieve each goal and therefore, through the achievement of each goal, the reaching of our vision. This stage is called "strategic activities". As an aside, it is at about this level in the model that many senior managers lose track of the strategic thinking process and are unable to identify specific actions necessary to actually achieve. The wisdom and expertise relating to the operational aspects of the model often lie in the middle and lower levels of organisations.

Action Plan

Once we have identified the specific activities necessary to achieve each goal we come to the final stage of the model - the action plan. This is the very specific information that we need to generate in order to actually get things done. The WHO, WHAT, WHEN and HOW. It is now that we identify who is responsible for what specific task or activity, when it must be done by and how it should be done. Obviously this stage of the strategic thinking process, as with most other stages, requires the input and involvement of those individuals or groups responsible for delivering on the plan. Performance standards and indicators to measure progress towards those can form a part of the action planning process.

Review

Throughout the strategic thinking model it is useful to revisit each of the parts. For example, in assessing the influencing factors you may find that a particular goal is not really viable and therefore you may need to reset your sights on your vision statement. Or, you may 'discover' some stakeholders that you had not previously identified. Obviously, you need to build all these enhancements and modifications into your thinking rather than say "but that wasn't a part of our original plan".

Strategic thinking is not a tool of management, **it is** management, regardless of what we are managing. It is the process of ensuring that everything we do is linked to what we exist for. If we do not think strategically, that is with an end in mind, then we run the risk of wasting resources on irrelevancies. We must constantly ask ourselves "Is what I am doing contributing to my overall purpose". If not, should you be doing it?

Strategic thinking, and indeed this model, can be applied to many areas - corporate development, strategic plans, project management, career and life planning, to name a few. The process of strategic thinking is foreign to many of us and it takes some time to get used to it. However, the benefits are well worth the effort!

Once we have mastered any model or approach to strategic thinking we then increase our prospects of addressing every issue strategically. With practice it becomes second nature to ask ourselves what are we trying to achieve, what do we need to get these, how will we make it happen.

HELPING STRATEGIC THINKING HAPPEN - A PROCESS

In our experience people understand the concept of strategic thinking and are helped by a suggested process to get started. The process of strategic thinking - to bridge the gap between theory and practice, understanding and application - may help in applying this model.

The process can be used by yourself or in groups. It will probably more usually happen in groups in which case it is useful to nominate a "process consultant" to manage the group's activities - to keep things on track, manage time, manage "air time", review and action plan. Different members of the group can take the role of process consultant.

Remember, strategic thinking is not a competition to develop the best plan. Documentation is only important as a representation of your thinking and, if appropriate, to communicate to others.

Strategic thinking means different things to different people. It is easier for some than for others and there is no one right way. The right way is the one that works for you. In addition to the stages and labels in the model, it may be useful to introduce two other categories under which you can store information. These might be labelled "Misfits", for all the information that doesn't easily immediately fit into any other category and "Not Knowables" for those things that are not knowable at this stage! Using these two categories can save a lot of time in discussing issues that are important but not urgent, and may distract from the immediate exercise of strategic thinking.

Strategic thinking can be a process of discovery and therefore it requires an approach that emphasises listening and questioning. You can expect some differences, some uncertainty and even more confusion. But remember, out of confusion comes understanding. Like many processes, it may be demanding and require commitment and energy. It should be a positive process with positive results.

> *"Choose to have fun. Fun creates enjoyment. Enjoyment invites participation. Participation focuses attention. Attention expands awareness. Awareness promotes insight. Insight generates knowledge. Knowledge facilitates action. Action yields results."*
>
> *Oswald B Shallow*

The following suggestions provide a rough map or guide to the strategic thinking process and through this strategic thinking model. Assume these instructions are for a group. It is best to use

newsprint/butchers paper. Timing will vary depending on the nature and size of the group. Remember, you can always come back to any stage.

1. **Draft Vision**

- Each write down a statement of what you understand you are here for, on about, in the business of, etc. Don't worry too much about the language of what you write, any collection or phrases and sentences are fine.

- Re-read what you have written.

- Exchange your statement with someone else and assess whether you have captured the what, for whom and for what purpose.

- Exchange papers again and count the number of words, whether it is a noun and assess its inspirational value.

- As a group, without too much debate, identify the common KEY words from all draft statements and documents then share draft statements and discuss them.

- Leave it now.

2. **Stakeholder Analysis**

- Individually, in sub-groups or as a whole group list all those individuals, groups or organisations who will have an impact upon, or be impacted upon by, what it is you are doing. "Brainstorming" can be a useful process.

- For each stakeholder list some words that identify what you assume their stake to be.

- Separate the KEY and NON KEY stakeholders and mark your papers accordingly. In determining the difference you may consider time frames, the nature of their stake, the numbers involved, the size of the stakeholder, the impact on your efforts if they are ignored etc. In addition to identifying whether they have high or low influence, also establish if they are for or against you.

- For each KEY stakeholder only, discuss the assumptions you hold as a group about the stakeholder.

- Expect this process to take some time, it is important to do it thoroughly.

- You must allow **all** group members some "air time" - they may well have a perspective you don't and it is essential that **all** stakeholders are considered.

- Discuss what strategies you should employ to manage each stakeholder.

3. **SWOT**

- Draw up a piece of newsprint with four columns headed strengths, weaknesses, opportunities and threats.

- Identify all the strengths, weaknesses, opportunities and threats that you can in relation to your draft vision and your stakeholder analysis. You may like to use sub-groups for each column.

Strengths

"What strengths does our organisation have, ie what does it do particularly well or possess of special value".

Weaknesses

"What weaknesses is our organisation currently experiencing (or likely to experience), ie what things is our organisation not particularly good at doing which may inhibit or limit us".

Opportunities

"What opportunities is our organisation likely to have in the near future, ie factors which may be utilised to deal with key issues".

Threats

"What threats is our organisation likely to face in the near future, ie factors which may jeopardise the likelihood of success".

- Using the "can do" box and its categories of absolute, fairly rigid, flexible and illusory, analyse the constraints. These will usually be your weaknesses and threats. Against each of them write a letter A, FR, F or I to indicate what category or constraint they are.

- Review your absolute and fairly rigid constraints. Can they be reclassified as either flexible or illusory. For absolute constraints - can its limiting influence be determined by us. For fairly rigid constraints - did we first see it as a constraint but now after more consideration believe it not to be.

- Review your flexible and illusory constraints just to make sure you have been realistic.

- You are trying to convert weaknesses to strengths, threats to opportunities and maintain both strengths and capitalise on opportunities.

4. **Vision**

- Return to your first draft vision statements and re-read them as a group.

- Confirm that you have identified all the key words.

- Individually, in small groups or as a whole group write a carefully worded statement or two that more specifically represents your intention. A useful technique is to image that it is some time after you have succeeded and to ask yourself what is different, what impact have we had. In this way you are describing an existing situation looking back, which may prove easier. Remember your vision statement should be stated as a noun not a verb, be about 25 words or less, contain a what, for whom, and for what purpose and it should be inspirational.

- As a whole group develop one statement that most of the group can mostly agree on for the moment. Apply the 80/20 rule.

- Check that it represents something that is within your scope or control. It must be challenging - but realistic.

5. **Key Results Areas**

- Identify the broad key result areas in which something needs to happen in order for the vision to be realised. This process can usefully be done in sub-groups to maximise the chance of a full coverage of key results areas.

- Review the list of key results areas for relevance, overlaps and quantity. You should aim for about five to nine. In sub-groups or a whole group write broad goal statements. These should include an action verb, and estimated end point and an estimate of resources.

- Apply the "all and only" test. Have you got all the goals and only those goals necessary to realise your vision. Yes or no.

- Review your vision statement for relevance and appropriateness.

- In the light of that review, review all goal statements.

6. **Influencing Factors**

- "Force Field Analysis" can be a useful process here for those familiar with it.

- For each reviewed goal list all the positive, enabling forces eg people, organisations, ideas, resources that will help.

- For each goal list all the possible negative forces that may hinder the attainment of that goal.

- Seek as much input as possible but don't fall into the trap of revisiting the past; look to move forward.

7. **Strategic Activities**

- This activity can usefully be done by sub-groups or individuals in the first instance. Develop more specific statements of what needs to be done to reach a goal. These may be those things necessary to ensure help and to overcome hindrances.

- Discuss your work as a whole group.

- As yourselves "If we do all this successfully will we succeed in each KRA?"

8. **Action Plan**

- List each activity on your newsprint and in columns identify WHO, WHAT, BY WHEN and HOW for that activity.

- This stage of the model requires patience to ensure completeness.

- This is a vital step for evaluating progress, success and where to look if things go wrong.

Now review the whole process!

For projects or enterprises of any substance it is unlikely that the strategic thinking process/model can be completed in one meeting. As for the artist, the fulfilment of the vision may take more than one sitting. You should also very carefully consider who needs to be involved and at what stages of the process. And if all those who ideally should be involved are unable to be, you must devise appropriate ways to enable them to share not only the vision but their role in the rest of the process.

Remember also that your strategic thinking must be congruent with your values, principles and philosophies - whether personal or organisational.

And always remember the old Turkish proverb "No matter how far you have gone down the wrong road, turn back" - if only far enough to pursue the right strategic approach that will achieve the desired results.

WORK PLANNING GUIDELINES

The work plan is a process of converting an organisation's strategic intent into operational plans to achieve that outcome or vision. If health professionals have never been involved in planning then knowing where to start is important. These guidelines have been developed by us to make business planning easy and relevant.

What is work planning?

It is an annual process that forecasts the performance of an organisation and provides a basis against which to measure that performance. It is linked to longer term strategic planning and thinking and to the performance of individuals in an organisation. A **work plan** is a common way to indicate that **planning** is occurring. It happens throughout the year, not just once a year.

It is not a new or additional thing to do, it is the way we do our work.

Benefits of work planning

Work planning has many significant benefits and any organisation, or part of one, that is not serious about business planning is not serious about being, or staying, in business. This applies to the largest corporation, government agencies, self-employed people and not for profit groups.

Good work planning enables an organisation to clarify its current position, plan for the next year's performance and monitor progress against plan, modifying as appropriate. The process enables individuals to establish their role in the organisation and what is expected of them in the upcoming year. It assists in the priority setting process and allows for open re-negotiation of targets during the year rather than the random and/or secret processes that must necessarily occur in the absence of a plan. The process is fluid and, contrary to common misconception, does not limit flexibility; rather it enhances it.

Good work planning provides the framework for shared understanding of the organisation's position, plans and prospects between all interested parties - boards, management, staff, politicians, unions, customers, shareholders etc. Access to some sensitive information is of course limited but there is arguably no reason why the work plans of all publicly accountable organisations should not be publicly available to the "shareholders" - the public.

When work planning is done well throughout each year then organisations can answer three of the questions most commonly asked by staff:

- What are we here for?
- Where are we going?
- Where do I fit in?

Authentic and meaningful answers to these questions can lead to increased productivity, job satisfaction and improved morale. The old sayings are true -

"If you don't know where you are going any road will take you there" and "If you don't know where you are going, how will you know when you have arrived?"

Work planning is a part of the way forward.

What is a work plan?

A work plan is a snapshot of an organisation at a point in time from a particular perspective. Nothing more. As time or the perspective alters so too would the plan. It can be a good idea to always think of the plan as "draft" as this can minimise the tendency to see the production of the plan as a substitute for planning and measuring performance.

Experience tells us that the more effort and expense that goes into the production side of the document - graphics, printing etc - the greater the tendency for it to be -

a) ignored
b) inflexible
c) irrelevant
d) criticised.

The less lead time required in production the more realistic the deadlines can be and they can be properly geared to the requirements of the work not of the printer's production schedule. Unless there is a clear and important marketing role for the document, it is best to concentrate on getting

the content clear, meaningful and owned by the people who generate the data input into the process and who will be accountable for delivering the results of the planning. Work plans should generally be well used work documents and not designed to win awards for artistic merit.

So, a work plan is a way of recording and agreeing on the best possible summary of the process to that point. It is common to use the financial year for planning purposes so you would expect to complete your snapshot before the commencement of each financial year. As the year unfolds you go back to the plan to agree any changes caused by performance, the marketplace, budget and for those in the public sector, political reality! In short, any significant changes to reality alters the plan so that the updated version continues to represent a recent and relevant plan. As the plan changes, so too will the activity of the organisation to reflect those changes. If you get a budget reduction you don't keep trying to produce the same outputs once you have already explored issues of efficiency and creative options. Remember if reality changes, change the plan to fit reality, don't expect reality to change just to fit your cherished plan.

Anyone with a title or role anything like "manager" should be clearly accountable for a work plan and for ensuring that all their staff input into its development, own and understand it and are clear about which parts of it they are personally responsible for delivering. A managers individual performance plan should contain an objective that say something like "to deliver the work plan".

A work plan is much more than a financial statement or a budget. It represents all aspects of the work.

Where does work planning fit in?

We have said that there is a lot of jargon in the world of planning and sometimes the same word is used to describe different things or different words are used to describe the same thing. It is not important to be **right** here, it is important to use consistent language that means the same things to the right people all the time. The following table represents the relationships and provides an overview of the planning process and is linked to the earlier Framework for Organisational Success.

Level of Planning	Timescale/Monitoring	Accountability/ Responsibility
Strategic Thinking	20 years plus	Board, Corporate Management
Strategic Planning	3 - 5 years	Board, Corporate Management
Work Planning	1 year	All managers
Operations	monthly	All staff

Each level of planning feeds in to the others. It is essential that information from the "operations", those doing the actual work, impacts on the higher level planning. At the end of each monthly reporting cycle the work plan is reviewed, at the end of each year the strategic plan is reviewed and all of this impacts on the longer term strategic thinking of the organisation. In public sector organisations ministers and other politicians may fulfil the roles of the board in relation to planning.

People other than those identified as accountable/responsible can be involved in any level of the planning process and it is common to involve outsiders especially at the strategic thinking level.

Making work planning work

There is no right or best way to do work planning or to produce the work plan. There are some common elements when the process and the plan work well. The process works best when -

- the people responsible for the work do the planning
- there is expert assistance available, both process and production, especially when people are new to work planning
- there is a relatively clear strategic direction for the organisation, preferably documented and understood
- time is allocated to the task of what is arguably the most important thing you can be doing

- it is ongoing and treated as essential by management, boards and politicians
- it becomes a part of how we do things around here
- it is linked to individual performance and people have their own performance plan or "personal work plan"
- the process is flexible and people are involved in any refining during the year
- rewards and sanctions are linked to performance to make the process real
- experience from the process influences the strategic thinking and planning of the organisation.

The document works best when:

- it reflects the process, and people can recognise their contribution and so own the plan
- it gets used, written on, dog eared, carried around in briefcases
- it is referred to regularly and people have the actual document when referring to it
- amendments and updates are agreed in writing or a new, updated version is produced and clearly labelled
- it is a reflection of, and certainly not inconsistent with, any strategic planning documents
- it adds meaning to the work of the people of the organisation and can be used for such purposes as induction, orientation and briefings
- it is written in plain language and is not so long that it remains unread, or worse, not understood.

The particular headings or format used is up to individual or organisational taste but it should have regard to the above comments. It should also enable reasonable consistency across the organisation so that staff moving throughout it don't need to learn a new approach each time. It should also be consistent with any reporting or management information requirements : that is the information management needs to manage, not what the computer can produce!

Work Planning Checklist

The work planning checklist includes the following items:

Environmental scan

An introduction which provides a brief summary and background to the work planning year. This might highlight key features of the environment, market trends and upcoming events such as elections. It should also include an analysis of the current strengths and weaknesses internal to the organisation and the future opportunities and threats external to the organisation (the SWOT analysis). It may also include an analysis of the market, of competitors and new products or services.

The introduction may also affirm commitment to the organisation's mission, values and broad strategic direction.

Activities

The activities of the organisation are the products and services it makes or provides - what the organisation actually does. This does not mean that the existing activities are merely re-stated but that the activities for the upcoming year accurately forecast the needs of the public and the marketplace and are within the capability of the organisation. As organisations become more familiar with planning it is in this part of the plan that can influence the future activities of the agency based on thorough analysis and through persuasive argument. This is instead of being subject to whim.

The activities of the organisation should be expressed as **objectives** - clear targets that allow all parties to understand exactly what will be achieved. Objectives should be SMART - Specific, Measurable, Achievable, Relevant, Timebound. "To deliver the same level of service, to the same quality standards with 3% less budget" is better than "To deliver services". As

circumstances change the objectives can be renegotiated and altered to reflect the changes. The should be changed in writing, especially if the time frames, volumes or quality standards alter.

Finances

At the very least the financial part of the work plan should include a statement of available funds and expenditure by month and a balance sheet.

The available funds and expenditure statement should provide an accurate forecast of those figures that reflect things like seasonal trends, payment delays, workload and other influencing factors and not merely be one twelfth of the annual figure. The budget contains all this forecast information and is the basis against which financial performance is measured.

The balance sheet provides a snapshot of the organisation's financial position at a point in time and should include all assets and liabilities. Assets may include accounts receivable, cash reserves, equipment, buildings, prepayments etc. Liabilities may include accounts payable, accrued charges, repayments, etc.

Assets

The assets of the organisation in this section refer to capital assets such as buildings and equipment. There should be a clear plan for maintenance and replacement as well as a depreciation policy. In the public sector there is a tendency to overlook a proper asset management plan and it is often the area to be targeted during financial cutbacks leading to deferred maintenance and ultimately devalued assets. Proper planning is required to protect these assets which are a key part of shareholder interests.

People

Almost every organisation says that people are its most important resource yet very few seem to reflect this in their work planning! The organisation must have clear policies, plans, practices and procedures for recruitment, selection, development, retention and employee relations. Workforce planning that predicts the labour market and forecasts the profile of the workforce required is essential. This then governs the selection and development strategies including succession planning to highlight key areas for attention. The overall human resource management strategy

should be linked to performance management that addresses performance objectives, development needs associated with meeting those and career development planning.

Management information

The management information requirements of organisations will vary enormously. What is important is for managers to identify "all and only" that information that adds value to the role. Data are simply that; they are not helpful information. The reporting and accountability requirements should clearly state who is responsible to whom and for what - and then report only on those things. Avoid the trap of collecting and publishing data just because you can. Report monthly against plan and highlight the exceptions which can indicate areas for staff and management attention. Ensure that management information and reporting are seen as a positive benefit to enhancing staff productivity and satisfaction as well as organisational performance.

Marketing

The marketing plan will typically include analysis and information on products, people, place, promotion, price, process.. It will analyse the "customers" of the organisation, their expectations and how best to educate them on the products and services as well as the realities of the environment. Just because an organisation does not sell things does not mean it doesn't have customers. Clear strategies are needed for each customer group and activities targeted to specific markets. Marketing is not advertising. It can be described as anticipating and meeting public expectations.

Public sector organisations need marketing plans and strategies too. Indeed the successful organisations have always done it, maybe under a different label.

"Pulses"

The "pulses" are the vital signs of an organisation, the key indicators of performance that let you know at a glance the organisation is alive. Particularly at the top management level it is essential to be able to quickly identify performance against plan and to highlight any problem areas without having to go through enormous amounts of paperwork and reports. Pulse identification can also be a guide to what is really important in an organisation.

Each organisation will vary as to which items need the most attention. Avoid the trap of ignoring categories - it is best to explore them anyway to be sure they are not relevant.

General

Any organisation, private, public or voluntary, must acknowledge the reality of an increasingly competitive world, shrinking resources and increasing demands for performance and accountability. An organisation not serious about its work planning is not serious about being around.

IN CONCLUSION

Being strategic is not merely a trendy catch phrase or interesting concept - for us. It is an essential ingredient for the successful profession, individaul or organisation. The broad, interlinked principles outlined in the Framework for Organisational Success, Strategic Thinking Model, Work Planning Guidelines are tools that are used to great effect by many of our friends, colleagues and clients. They are **not** a magic bullet; they are a help.

Specifying what outcomes you are going for in your own terms, and going for them is what being strategic is all about. "Being strategic" is helpful jargon for knowing what you want out of life, going for it and having fun doing it.

NOTE: Many people have contributed to our thinking, experience and practice in this arena and we thank them all. Specifically we would like to acknowledge (in alphabetical order):

Jane Bryson, Tony Cull, Tim Dalmau, Bob Dearden, Phil Hanford, Kevin Hardy, Roger Kaufman, Bernie McKay, Julia Vaughan Smith and the old Turk whose proverb we borrowed.

MP-130
W97
05264
COMMUNITY HEALTH CELL
LIBRARY AND DOCUMENTATION UNIT
BANGALORE