THIRD REGIONAL NURSING SEMINAR

Teheran, 16 - 21 November 1974

WORLD HEALTH ORGANIZATION
EASTERN MEDITERRANEAN REGION

EM/NURS/240
EM/THRD.REG.NUR.SEM./12
EM/ICP/HMD/002/RB (4402)

May 1975

ENGLISH ONLY

REPORT OF THE THIRD REGIONAL NURSING SEMINAR

Teheran, 16 - 21 November 1974

The views expressed in this Report do not necessarily reflect the official policy of the World Health Organization.

This document has been prepared by WHO Regional Office for the Eastern Mediterranean for Governments of Member States in the Region and for those who participated in the Seminar.

Participants and Observers who attended the Third Regional Nursing Seminar
(held in Teheran from 16 to 21 November 1974)
photographed with Dr H Mahler WHO Director General and
Dr A H Taba Director Eastern Mediterranean Region

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EVALUATION AS A BASIS FOR FORWARD PLANNING

I INTRODUCTION

The purpose of the Third Regional Nursing Seminar organized by the Eastern Mediterranean Regional Office of the World Health Organization was to bring together nursing leaders from the countries of the Region and to provide them, through workshop techniques, with opportunities to develop their skills in dealing systematically with nursing problems. By working on problems of importance to the participants themselves, it was hoped to demonstrate that a systematic approach is effective and can be adopted for a variety of problems and in a variety of cultural environments.

The decision to hold the Seminar in workshop format was made, in part, as a result of recommendations from previous seminars and, in part, as a means of encouraging nurses to consider how they themselves could effect improvements in the nursing profession.

Sixty-three nurses from twenty-two countries participated. To hold a workshop for so large and varied a gathering presented a challenge to the organizers. It was the first Regional Nursing Seminar to be held in workshop form in the Eastern Mediterranean Region and it marked a significant landmark in the development of the profession that it was possible to attempt such an undertaking.

It is intended that, within six months, there will be a follow-up of the Seminar by inviting the participants to respond to a postal enquiry concerning the extent to which they have found the systematic approach discussed in the Seminar useful in studying nursing problems in their own countries.

II PLANNING THE SEMINAR

Selected members of the Regional Expert Advisory Panel of Nurses met in Alexandria early in 1974. They planned the organization of the Regional Nursing Seminar as a workshop and volunteered to function as moderators for the small working groups.

The moderators met during the week preceding the workshop with two WHO consultants and with the two WHO Regional Nursing Advisers. Dr J. Cobin, a WHO consultant on workshop techniques, helped the moderators to prepare for their role.

This preparatory meeting in which Mrs Sh. Herovabadi, Assistant Director-General, Nursing and Midwifery Department, Ministry of Health, Teheran, acted as chairman and Dr Enaam Abou Youssef, Director, Higher Institute of Nursing, Alexandria, as rapporteur, made an important contribution to the success of the workshop. The moderators were well aware of the non-directive, facilitating aspect of their role, which would encourage full participation by all members of the group. The preparatory meeting permitted them to exchange practical ideas for promoting such participation and to draw up with Dr Cobin, plans for group work, including objectives, activities and evaluation criteria for each day.

By way of definition and over-simplification a workshop is a meeting of people where:

1. They work together in small groups.

2. What is worked on is derived from the people who are present.

The reason for working in a small group is that it gives everybody present an opportunity to participate actively - not just to listen, but to contribute.

Members can get to know each other easily and this results in easier exchange of ideas, better inter-personal relationships and hence more productive thinking.

In a real sense, every person taking part in a workshop is a resource person for everyone else. Each participant has certain unique experiences which have produced certain special qualities. These qualities and experiences represent a resource that should be available to others The resource does not depend for its value on the position held by the individual, or the number of college degrees held, in a workshop, everyone has a contribution to make, if it can be discovered and linked to the needs of others

During the Seminar, the moderators became the Seminar steering group working with the WHO consultants and the staff. This group met briefly each morning to review the previous day's work and as necessary at the end of the day to deal with any immediate business. The programme of the Seminar is given as Annex II The working programme was balanced by an equally stimulating social programme

The final report of a workshop is more difficult to prepare than that of a course, a more traditional type of seminar, or a series of lectures So much of the "content" of a workshop is the very process itself, the way in which the participants become involved and apply themselves to a series of tasks designed by those conducting the workshop, by co-operative efforts of participants, moderators and resource persons.

In this particular workshop, papers presented each morning provided guidelines for the groups to use as they found appropriate to their needs. These papers appear as Annexes.

The following table summarizes the process of the five working days of the Seminar as planned by the Steering Committee

OBJECTIVES	ACTIVITIES	EVALUATION
DAY 1 Plenary Session Introductory speeches - Details of workshop procedures		
1. To become acquainted with each other 2. To share expectations of Seminar 3. To clarify own participation 4. To become familiar with moderator 5. To review daily Seminar activities	1. Select one other member and for five minutes learn as much as possible 2 Write expectations - anonymously, give to moderators Write opinion of day's activities anonymously 3 Explanations and discussions led by moderator 4. Learn to find persons to help with personal concerns, i.e. travel, finance, etc.	Moderator must 1. Note that each participant has become familiar with other group members 2. Read reactions to day's work by participants
DAY 2 Plenary Session Presentations - Need for systematic planning nursing services		
1. To identify ideas that seem clear 2. To identify ideas that need further clarification 3. To prepare list of broad nursing problems 4. To select group members for work in sub-groups on subject of common interest	1. Discuss information from plenary session 2. Request resource person for clarification where necessary 3. Use "brain storming" technique to prepare list of problems 4. Select subject of interest and discuss with 2-3 others aspects of problem which can be studied 5. Discuss in whole group aspects selected and critically question each other 6. Write opinion of day's activities	1. Review written problems answering question "why important to know the answer" 2. Read reactions to day's activities - give to workshop organizer - Dr Cobin 3. Assess contribution and participation of group members

OBJECTIVES	ACTIVITIES	EVALUATION
DAY 3 Plenary Session· Evaluation versus Measurement		
1. To identify ideas understood by all 2. To identify ideas not understood 3. In sub-groups to define specific objectives for problem identified, in light of day's presentation 4. To analyze objectives of each sub-group critically	1. Discuss information given- 15-20 minutes 2. Work in sub-groups one hour to write objectives for study of problem selected 3. Share objectives identified with other group members 4 Write opinion of day's activities anonymously	1. Review of each sub-group's objectives by Dr Cobin 2. Reading reactions to day's activities 3. Moderators to assess group participation
DAY 4 Plenary Session: Research as a method of tackling problems		
1. To identify ideas understood by all 2. To identify ideas needing clarification 3. To determine nature of data collection and analysis appropriate for subject selected for study 4. To determine areas where consultation of resource persons are necessary	1. Discuss information given 2. Request consultation to clarify misconceptions 3. Work in small groups to identify data and methods for collection 4. Prepare outline for subject selected. Objectives - data - collection - analysis 5. Share presentation with group for critical analysis 6. Write opinion of day's activities including reaction to sub-group work	1. Read reports of work of sub-groups 2. Read reaction to day's work 3. Moderators to assess group participation
DAY 5 Plenary Session: Nursing studies as a factor in effecting change		
1. To identify areas clearly understood 2. To identify areas needing more clarification 3. To apply principles of change process to subject studied 4. To share with other groups ideas from past four days	1. Discuss information from plenary session 2. Seek clarification from speaker of ideas not understood 3. Determine process of change in subject studied (a) Statement of application of study (b) Define barriers to implementation (c) Determine areas of compromise (d) Plan who will do what (e) Plan time-table of proposed events 4. Share ideas with own group 5. Re-assemble in new groups and exchange ideas	1. Read group report of change process 2. Read individual reactions to day's activities 3. Read Final Group Report

III OPENING CEREMONY

His Excellency, Professor A. Pouyan[1], Minister of Health of Iran, inaugurating the Third Regional Nursing Seminar in the name of His Imperial Majesty Shahanshah Arya Mehr, said there was no need to emphasize the importance of the Seminar. It was a quarter of a century since the inception of nursing in the Region. Now was the time to evaluate past achievements and lay the foundations of the future nursing programme securely on the basis of community needs. The expectations of society to-day required that nurses should base their practice on sound scientific principles. At the same time, they had to remember the humanitarian aspects of their service and provide for people, sick or healthy, the empathy and warm sharing of problems which are fundamental to all good care.

On behalf of the World Health Organization, Dr A.H. Taba[2], Director of the Eastern Mediterranean Region, thanked the Government of Iran for the kind and elaborate arrangements and for the hospitality shown. He also welcome representatives from many agencies.

His presentation provided the keynote of the week's work. He emphasized the general concern felt by all health care planners that the great majority of the populations of the world were without access to the most elementary of health care services. Nurses must become involved in attempts to correct this.

There was in medicine and in nursing a need for relevance in education and service. More than ever was it important not to copy another country's patterns.

In nursing, as in other human activities, planning should be based on a genuine knowledge of the existing situation and on future needs.

To try to achieve this, nursing should be considered as a system involving all levels from the health aid or village worker to the most senior nurse administrator or academician. It must include not only education but the part played by nursing in the total health care delivery system.

He concluded by outlining three major areas of investigation for nurses.

1. What do we have and what do we want?

2. How are nurses used now and how should they be used in the future?

3. The need to ensure the relevance of nursing education programmes

Dr H. Mahler[3], Director-General of WHO who was visiting Iran when the Seminar was in progress, addressed the participants on the third day of the Seminar.

His presentation dealt with the need for all health professionals to look carefully at their system of education and service to ensure that out-dated professional caste values were not preventing new approaches to delivery of health care and the use of auxiliary personnel.

IV DAILY ACTIVITIES

The first day was devoted to the opening ceremony, to introductory speeches and to explanations of workshop procedures.

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1 See Annex I for full text
2 See Annex II for full text
3 See Annex III for full text

1. First Plenary Session

In the introductory speech Miss E. Leedam, WHO Regional Adviser on Nursing Development, considered the evolution of the nursing profession from its role of assisting physicians to its present one, which in its educative, preventive and rehabilitative aspects were clearly those of an independent profession.

The range of care now given by nurses needed a well-organized nursing system, encouraging the education and utilization of nurses as well as the supporting legal and administrative structure to enable nurses to carry out their responsibilities.

The challenge to the nursing profession today was that it should play its part, with the rest of the health professions, in making health care available to all and not merely the few who reach the hospital doors.

Miss T. Agah, Acting WHO Regional Adviser on Nursing Development, then summarized the development of nursing in the Region, as seen through the recommendations of previous seminars.

She asked the participants to consider to what extent, in their own countries:

(a) There were Nursing Divisions in the Ministries of Health

(b) There was Legislation and Registration for Nurses

(c) There were Nursing Associations or affiliation with International Council of Nurses.

In the past, assistance had been requested from WHO in establishing Regional Post-basic Nursing Education Programmes on a variety of subjects. However many countries now had their own programmes and the specific needs were changing.

A previous recommendation that WHO should hold a Regional Workshop on how to conduct nursing studies had resulted in this Seminar.

Group work

At the end of the morning, the participants divided into groups and spent an hour or more getting to know each other, clarifying their expectations from the Seminar, and establishing a pattern through which they would work for the remainder of the week.

2. Second Plenary Session - Need for Planning

The need for systematic planning of nursing services within the framework of national health planning and in the context of national development planning was stressed by Dr Ziai[1], Medical Director, Reza Pahlavi Medical Centre, Teheran, and Miss Simpson, WHO consultant, in their respective papers. Both emphasized the importance of keeping in mind the needs and wishes of the recipients of care and of planning for rural as well as urban communities and for health promotion as well as for care of the sick.

A reliable information system was seen to be crucial to good planning. Ad hoc studies and results of research were two sources of information. Only a minority of nurses would be involved in studies but all nurses need to be able to sift out the real nature of their problems, define the problem precisely, set objectives, define criteria of success and understand sufficient of the process of systematic study to be able to use the results of research carried out by research workers effectively.

The first step in conducting any study was a clear definition of the problem. All subsequent steps proceeded from this. A clear concisely worded problem statement served as the guide for outlining objectives, selecting the design, choosing the methods of data collection and analyzing the findings of the study.

[1] See Annex IV for full text

Group work

The problems were identified through a "brain storming" session when ideas were written down as they occurred to the participants. These were then grouped into those with a common focus, and the groups divided into sub-groups to work on the subject which had most interest for them.

In their sub-groups, the participants began the task of defining their problems in such a way that the rest of the stages were clear. This proved more difficult than many had anticipated Amendments to the original statements were found necessary as the different stages were reached.

3. Third Plenary Session - Systematic Approach to Problems

In her presentation Dr Cobin, WHO consultant, dealt with evaluation versus measurement. Evaluation was a value judgement on a situation or series of facts. It was made more objective by using clearly defined criteria or measurement.

In deciding on what data were to be collected for their various studies, participants must know what they wanted to achieve as a result of the study, and what measurements they would accept as indicating that their purpose had been accomplished.

Group work

Participants found the work on this day most frustrating. The values they wanted to measure, good nursing care, non-nursing duties, relevance of education programmes, factors to encourage recruitment of staff for rural areas all seemed elusive when subjected to the rigid demands of measurement. The scope of some of the subjects originally selected by the participants was narrowed to a more easily defined and researchable subject.

4. Fourth Plenary Session - Methods of Data Collection

Miss Simpson, WHO consultant, described the progression of research from descriptive/analytical/diagnostic studies to experiments with evaluation and on to wider field trials, also with evaluation. She then outlined the steps in the research process relevant to a single study.

There were three stages. The preparatory stage when the problem area is identified, a search of the literature relating to the subject and the science conducted, the problem defined precisely and the objectives stated, decision taken about the population or sample, the methods of data collection and processing, the instruments designed and a pilot study carried out. She emphasized the importance of this preparatory stage and of consulting a statistician or other expert early if help was going to be needed.

In the data collecting stage information could be obtained from verbal, written or observed material or documentary research could be carried out on existing material. Completed schedules needed to be edited and the information coded.

The third stage was that of data processing and the preparation of tables, charts, diagrams and written material for the report. The findings of the study had to be integrated into the existing body of knowledge and conclusions drawn.

Group work

Discussions of data collection and analysis become more meaningful when a study is actually conducted, but the groups were made aware of pitfalls and difficulties encountered from the experience of some of the members who had undertaken studies. By this stage most of the groups had identified a problem which could be studied, and knew the type of data

which should be collected. Some of the groups were well on the way to having a completed outline of a study.

5. Fifth Plenary Session - Planning for Change

Miss Simpson spoke of the use of studies as the change factor which could keep nursing practice in harmony with changing social conditions and increased scientific knowledge. She reminded the participants of the natural reluctance which people feel to changing established patterns of work or living, and suggested some ways in which those affected by change could be consulted and involved in decisions on innovations.

Group work

It was soon apparent that discussions on how studies could be utilized in effecting change merely touched the tip of an iceberg and that this subject would require a workshop of its own.

Exchange of ideas

The participants were naturally interested to know what had been discussed in groups other than their own. It was decided by the Seminar Planning Committee not to have the customary plenary session with reports from each group, but to re-arrange the participants into new groups so that there would be a representative or representatives who would report on and discuss the work of the group he or she represented. This "scrambling" worked smoothly and everyone was able to participate in the presentations and resultant discussions.

V REPORTS OF GROUP WORK

Three of the groups looked at educational problems, two at manpower planning and one at utilization of nursing personnel. The week's work was intensive within each group.

The issues selected by the participants for examination ranged widely. Recruitment for nursing schools, for assistant nurse schools and for rural areas were all considered by one or more sub-group. The admission of men and of married women to nursing schools also came in for consideration. Education programmes were looked at in relation to curriculum content and the licensing examination. Problems of evaluating student performance attracted one sub-group, whilst another looked at ways to make head nurses more aware of their teaching role. The preparation of nurse teachers was again seen as an urgent problem. The preparation of nurses for complete health service work was examined. Salaries and conditions of work and activities of nurses in hospital units and in maternity and child health units, were each selected by one or more sub-group for consideration.

From the material available from the groups it was difficult to select studies which would be representative of the week's work. However, it was decided to include three, one from each of the major areas, Education, Manpower and Nurse Utilization, and these are given in Annex XVI.

VI EVALUATION

1. From Participants

The groups expressed anxiety about the shortness of the time available for the tasks presented to them and during the first two to three days there was some confusion and difficulties with the method of examining problems. These cleared gradually and were replaced by a general enthusiasm for the opportunities offered in the small groups. The facilitating function of the moderators was particularly appreciated.

Papers presented in plenary session are not an essential part of workshop techniques but in this instance the papers appear to have fulfilled a useful purpose in providing concepts and systems from which the participants could extract material to meet their individual needs.

At the final reporting sessions it was clear that the concept of systematic approaches to nursing problems had been accepted and tentatively tried out by most of the participants on problems of direct importance to themselves.

2. By Steering Committee

The Steering Committee under the guidance of Dr Joan Cobin evaluated the performance of the participants as an indication of how well the Seminar succeeded in its objective. This evaluation (given in full in Annex XV) showed that the participants had developed the attitude that a systematic or scientific approach to studying nursing issues was useful. It also showed that the participants work well together within a workshop form.

VII CLOSING SESSION

Speakers at the closing session reviewed briefly the work of the week and expressed the general feeling of enthusiasm and appreciation for a learning experience which it was hoped would exert a lasting influence on the approaches to nursing problems in each of the countries of the individual participants. Mrs K. Mowla, Rapporteur, presented a summary report and the recommendations.

The generous hospitality of Iran, the host country, had provided not only excellent working conditions but had balanced the professional programme with delightful social events

Mrs Khoury presented an invitation to hold the next Seminar in Kuwait.

H.E. Dr A. Amini, Under-Secretary for Technical Affairs, Ministry of Health, Teheran, representing H.E. Professor A. Pouyan, Minister of Health, and Dr A. Robertson, WHO, Eastern Mediterranean Office, brought the meeting to a close.

VIII RECOMMENDATIONS

As a result of the Seminar, the participants felt they could return to their countries with fresh enthusiasm and a desire to tackle their problems in a scientific systematic manner, but that this Seminar provided only a beginning. They recommended that:

1. Nurses, governments and WHO should continue to give full attention to recommendations of previous seminars, where these have not yet been implemented.

2. Further seminars in workshop format should be planned regionally and nationally to look at the nursing problems objectively and with a systematic approach to find ways for effective changes and improvements.

3. In view of the importance of total community involvement in nursing programmes, nurses should seek to identify new approaches to local problems, and to extract from the experience of other countries practices which could be modified and adapted to meet local needs. Within their own countries individuals should form groups for discussion on nursing problems thus strengthening systematic approaches to matters of local importance. Such groups might profitably be multidisciplinary.

4. There is need for resource groups to assist in identifying areas where studies are needed to determine what changes might ensure provision of quality care. Members of a Regional Nursing Advisory Panel could form such a group.

5. Traditional biases towards hospital-based practice need to be identified and a new dynamic approach to health problems inculcated in nursing education and practised in the community.

6. Within the nursing care system of the countries of the Region, training in future should include auxiliary professional and post-basic educational programmes. Opportunities should be provided to permit movement of personnel from one category to another, building on their existing knowledge and experience.

7. Although some countries of the Region are now able to meet their own needs and provide assistance to others, there is still a need for WHO guidance in developing new attitudes and inculcating new concepts to achieve the more dynamic approach to nursing care which will meet total community needs. WHO could assist by providing educational opportunities and expert advisers, and by identifying resources within the Region which could be utilized to meet the specific needs of the member countries.

ANNEX I

ADDRESS BY PROFESSOR A. POUYAN
MINISTER OF HEALTH, IRAN
AT THE INAUGURATION CEREMONY OF THE
WHO THIRD REGIONAL NURSING SEMINAR

Distinguished Guests,
Ladies and Gentlemen,

I have the honour to inaugurate in the name of His Imperial Majesty Shahanshah Arya Mehr the Third Regional Nursing Seminar held with the collaboration of the World Health Organization and the Ministry of Health.

There is no need to emphasize the importance of this Seminar which is held for evaluation of nursing services in the national health programmes.

Taking into consideration that a quarter of a century has passed from the start of nursing in this Region, now the time has come that in the light of knowledge and perception gained by nurses in their profession, they must evaluate the past activities of nurses by precise and scientific criteria and standards and put the foundation of their future programmes on the basis of community needs.

It is my personal belief that promotion of health and curative levels of every country have a direct impact on the quality of the nursing services performed.

Researches carried out prove, that disregarding the other facilities, the development and progress in the health and curative programmes cannot be achieved or would be impossible without the educated, understanding, interested, and dedicated nurse to the profession.

It is indeed very fortunate that today the knowledge of nurses has reached a level that for the progress and promotion of their profession, the evaluations made are based on facts and the future of nursing is planned and founded on scientific principles. In the world of to-day no other approach could succeed.

In view of the increase in public knowledge, the expectations of to-day's society necessitate that the nurses also should base their profession on sound and scientific principles.

Due to development and expansion of democracy in the world, particularly in our Region, and increase in the value of human beings and their awareness of their rights, it is important that the nurses, together with other health and curative groups, should make a qualitative and quantitative review in their profession.

I, particularly, wish to draw the attention of this specialized group, who are the representatives of twenty member countries, and experts from other countries, to a vital and fundamental point which has always been of utmost importance for those benefiting from nursing services. I am expecting that you who are experts in nursing services will make every possible endeavour to institute and develop philanthropy and devotion in the nursing profession in nurses, specially in young nurses, and propose tactics and methods to assist the practical teaching of this to the students and create this noble feeling in their hearts.

You are the people who should give satisfaction to communities and provide peace and tranquillity forthem not only through the scientific methods but by means of humane criteria. People sick or healthy, always expect that kindness, affection, sympathy and philanthropy are the fundamentals of a nurse's duty, and in fact a real nurse is the one who in addition to

nursing science and knowledge, is a real human being, who faced with people, specially with sick people, could put herself in their place and grasp their feelings.

In addressing you in this manner I have no intention to guide or advise you, but to emphasize my inner and heartfelt wishes and those of the society, in these undeniable facts which I have always hoped would be realized.

In conclusion, I wish to thank Dr Taba, WHO Director, Eastern Mediterranean, experts and participants from countries of this Region as well as those who in one way or other have made special endeavour to make this international gathering fruitful I hope that the participants in this Seminar will be able to perform their duties with success and complete their mission with which they are entrusted with satisfaction and be able to profit from their continued endeavours in promoting the quality and quantity of nursing in this Region.

I also hope the honourable guests enjoy their stay here from scientific and cultural points of view and be able to further strengthen and establish friendly relations between the member countries and carry back to their countries happy memories from Iran.

Thank you

ANNEX II

ADDRESS BY DR A.H. TABA
DIRECTOR
WHO EASTERN MEDITERRANEAN REGION
at the
OPENING SESSION OF THE
THIRD REGIONAL NURSING SEMINAR

Your Excellencies, distinguished participants and observers, dear colleagues,

It is a great pleasure for me to take part in this Opening Session of our Third Regional Nursing Seminar.

I should like to take this opportunity of thanking the Government of Iran, through your Excellency the Minister of Health, for the kind and elaborate arrangements made for the Seminar, for the hospitality already shown to us, and for the part that all this will play in making this a successful meeting.

I should like to welcome on behalf of the World Health Organization, all the participants, who come from almost every one of our member countries in this Region. We are very pleased at the way in which each country has responded by sending such a senior group of nursing professionals to share in our joint deliberations.

It is also a testimony to the importance attached by all concerned to the role of nursing within our health services today, that so many other agencies have sent representatives to this meeting. I should particularly like to welcome those who represent, as observers, the United Nations Development Programme, UNICEF, UNESCO and other members of our United Nations Family, who in so many different countries work jointly with us in a variety of projects which are aimed to improve either the quality of Nursing Education or the quality of Nursing Services delivered to the people.

We meet at a time when, more than ever before, all countries and especially those people responsible for the planning and delivery of Health Services, are increasingly conscious of the serious deficiencies in Health Services everywhere.

In the Eastern Mediterranean Region, as in so many countries all over the world, at whatever stage of development they may be, we are deeply conscious of the fact that the great majority of our populations, whether they be dwellers in rural villages, or in the less well-off sections of our rapidly expanding cities, are without any access to the most elementary of health care services.

To correct this is the first task of all of us and the nursing profession has a vital part to play in this.

Nursing, in this Region, has come a very long way in recent years. It is because it has done so well in the recent past that it is desirable that we should all sit down together and discuss how it can become better.

I personally am gratified with what has been achieved in nursing in this particular Region. And yet I have an uneasy feeling that, in some countries, nursing may be developing away from what is really needed.

There is some tendency for nursing to develop something like a separate identity of its own, and while this is to some extent a good thing, we do need to try to do everything we can to make sure that the education for nursing which we develop in our Region, and the pattern of nursing services which are built upon that education, genuinely do match the needs of the people.

In another connexion, I have many times stressed the need for relevance in the education and training of our doctors. There are patterns of medical education which have been imported from the outside, modelled on the patterns used in other societies in times gone by, which are being perpetuated here in the Eastern Mediterranean Region to the detriment of the best possible care of the people.

Nursing shares with medicine the danger of slavishly copying other people's patterns. I think that, perhaps because nursing has not yet gone quite so far as medicine, because there are proportionately less nurses, and because the educational institutions which are preparing nurses are newer and younger, it may be easier for you to adapt your patterns of education to the reality of need than has sometimes proved to be the case in medicine.

However that may be, I think it is very suitable indeed that the title "Evaluation as a basis for forward planning" has been selected as the subject of your meeting.

When we use the word evaluation, we mean, quite simply, that it is necessary to know where you are before you decide where you are going, just as it is also necessary to define the direction in which you need to go.

In Nursing, as in all other human activities, it is desirable to base planning, as far as humanly possible, on a genuine knowledge of the existing situation and of future needs.

Nursing development must be seen in the continuum of time. The past has influenced the present, and a study of the past helps us to discern proper directions for the future.

Several of our countries which had no nurses at all, only a relatively short time ago, now have nursing schools of their own training different levels of nursing personnel. We have about 200 nursing schools in this Region, and nurses from countries of this Region now contribute not only to the improvement of the health services of their own countries, but to nursing deliberations and to the planning of nursing services throughout the world. But in the final analysis, the success, or the failure, of nursing must be measured in the context of the quality of the health care given in each individual country.

I do not share the belief that "Nursing is the same the world over", any more than that medicine itself should be "the same" in every country. Each individual country requires to prepare its own health personnel in the ways that most closely match its own health needs.

If nursing is to be evaluated, how is this to be done? I think to begin with we have to think of nursing as a system, comprising all levels of nursing personnel from the health aid or village health worker to the most senior administrator or academic. Nurses in the field are part of this system, so are nurses who teach in classrooms and those who plan curricula, so are the nurses who work in sophisticated city hospitals, and the nurses who work in village health centres.

The nursing system must be concerned not only with education, but also with the incorporation of the product of education, the nurse herself, or himself, into an effectively operating health service. This means the preparation of nursing personnel at each level, who think of themselves as part of a wider team. I hope you will bear this in mind as you work during the coming week.

Then there is the problem commonly called the "shortage" of nursing personnel. There probably is an overall shortage of nursing personnel, and indeed I think we could say that there certainly is. But frankly we do not know the extent as accurately as we should. None of the countries of this Region can in fact say exactly how many nurses it has, and in none is there any proper system of registration or licensing, maintained in an up-to-date manner There is an urgent need to remedy this.

The answer to the "shortage" of nurses, is not simply to "train more nurses". There are countries which cannot afford to employ the number of professional nurses they have already trained. Is the answer then to train more auxiliaries? Yes, in part, but that is not the whole or the final answer. For auxiliaries cannot function optimally without proper supervision and support. And if whatever shortage there is, is primarily a shortage in community health services, then training more nurses to work in the highly specialized atmosphere of urban hospitals will not be the answer. There is an urgent need for a more effective definition of the reality of the nursing shortage, for measurement and manpower planning, as a prime prerequisite for the effective evaluation of where we stand and where we should be going.

Another problem I want to mention is the question of whether or not the nursing personnel that we do have, at whatever level, are being most effectively utilized in the context of the needs of the health services, and of their own capabilities. We urgently need simple studies of nursing utilization which show what is going on and how it can be improved.

Finally, I want to talk for a moment about the need for the revision of nursing curricula. You, as nurses, are at least as aware as we doctors, that all is not well with the quality of our educational planning. Far too much time is spent in nursing schools of all kinds in thinking about such things as "hours of instruction" or "number of credits". Far too little time is being spent in the careful definition of relevant educational objectives, and in incorporating the new technologies of education into our learning programmes.

I hope that in the workshop sessions of this Seminar you will pay special attention to these three issues. I will repeat them very briefly:

1. The need to measure what we have and what we need.
2. The need to understand much better how nurses are presently utilized, and how they should be utilized in the health services for the future.
3. The need to incorporate into our educational planning, the most up-to-date educational methods; to define realistic and relevant objectives and to design learning programmes which will achieve them.

In closing let me again remind you that there is only one purpose for nursing; and that is to make a contribution to the improvement of the health care of the people.

Nursing, you know, is about caring. Caring in the widest possible sense. Caring for people who need to be protected against illness, and caring, as a member of the wider health team, for those who have already become sick.

It is because I know how far nursing has already come in this Region, in a very short time, that I am confident that the nursing profession can meet the challenges which face it now.

With open minds, in an atmosphere of enthusiasm for the accurate measurement of need and the accurate definition of relevant objectives, I am sure that together we will be able to discern new patterns of nursing care.

I am sure that these patterns, while they will retain for nursing its proud position as a profession in its own right, will also ensure that nursing forms a truly integral part of an overall health system designed to meet the needs of all the people.

I wish you a very enjoyable and stimulating week and I look forward with the greatest interest to reading your recommendations.

ANNEX III

ADDRESS BY DR H. MAHLER
DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION
at the
THIRD REGIONAL NURSING SEMINAR

Good morning. Thank you for giving me the opportunity to make what I hope will be a few provocative remarks.

As somebody once said to me, in WHO you don't move if you can help it, if you have to move, you move slowly; if you are pushed, you move in a circle; and if you are cornered, you hold a seminar. Still, I believe that, if seminars are really aggressively innovative, with everybody letting down his or her hair, they can serve a very useful purpose, so long as they do not develop the kind of bureaucratic sterility some say is often a significant feature of work in a large organization. I have been told that this Seminar intends to have the right kind of aggressive creativity, without which I do not think we shall be able to do much about the miserable state of the world's health as it is today.

Miss Turnbull knows that I suffer from an obsession about the caste system that prevails in the health field. I have always believed that the system whereby both the physician and the nurse become ridden with caste notions has conceivably done more harm than anything else to the process of bringing health care to the people. I wonder whether, if we were to re-fashion the world and its health services today, ask ourselves what the priorities are, and provide care not only to the exceptional few but to the whole population - not only, and I repeat not only, to achieve the elimination of frank disease but also to take care of the positive health of the total population - we would then create the same kind of system as we have today, with the same classes of so-called doctors, so-called nurses and so-called this and that? I doubt it very much indeed. I fully believe that, if we were to identify what the health problems are and then ask ourselves how we should go about creating the necessary agents to have an impact on those problems, we would at all costs avoid the class system that now exists, whose narrow professional interests very often - I would almost say constantly - stand in the way of bringing to fruition the possibilities of modern technology because they fail to inculcate the proper human attitudes. I think the most important question today is not only to have good technology with which to attack priority problems but also to be able to generate the right kind of attitudes. I believe that, if you were to look at the kind of health problems that exist and were to make a pyramid of them, you would see that the very large base of the pyramid - amounting, I would even say, to more than 90 per cent of the problems - could be taken care of with a very simplified standardized technology of prevention and treatment that could be taught and learned within a remarkably short time by anybody who has the right motivation.

If you are prepared to accept that statement, which I am ready to prove and at least think I have proved in a particular field, it will be worthwhile to take an example. Whereas in my little country it took about five to six years to make a tuberculosis specialist, WHO has shown that within a couple of weeks we can train anybody who has gone to primary school to become as good a tuberculosis specialist as the professor in Paris or in Copenhagen. And, speaking for myself, I would in many instances rather have my family treated by an auxiliary than by many a professor. So I think that if we are able to do that, and really and truly take away all the fringe knowledge, the knowledge that we for our own professional reasons are adding to the curriculum and incorporating in our teaching/learning system, we would really be able to start delivering health care to the last citizen of the most impoverished country in this world within a remarkably short time. Now, if our training pyramid were really related to our problem pyramid we would give priority to training those people who can take care of more than 90 per cent of the problems, rather than doing it the other way round, starting with the tip of the pyramid and making it the most wonderful thing in life to be able to tackle the most obscure complication of the most rare disease. We have within our medical

profession, as within our nursing profession, a kind of worship for the ability to deal with the tip of the pyramid, and therefore, in a way, we have turned the whole thing upside down, although this has been perhaps more in the case of physicians than in the case of nurses.

There is a third pyramid in the way we construct our facilities, hospitals, health centres, and so on; precisely the same thing occurs, because we cater for the tip of the pyramid and train our personnel to take care of the tip. We build the most sophisticated establishments first, which consume 80 to 90 per cent or more of the total health expenditure. So there is total perversion. There is perversion in the way we look at health problems, there is perversion in the way we train our people, and there is perversion in the way we build our facilities in order to cope with the problems. What is even worse, these various kinds of pyramids mostly have no relationship to each other, so that training is in isolation from health problems and facilities are in isolation from the other two.

I think that, fortunately, the health services are getting into such a situation of crisis at present, as I said yesterday evening, that they will no longer be permitted to degenerate in this way. I would say that over the next ten years all of us who have the privilege of working in the health field will see some very drastic changes in our attitudes, our thinking, and our actions. If we are not ready to change, if we are not really ready to come up with a new type of innovative imaginative approach, sweeping away a lot of the taboos and restrictions surrounding our caste-ridden health care system - including quite particularly those within the medical and within the nursing profession - and if we are really not able to develop quite a new conscience in relation to taking care of man's health in the broadest possible sense, I do not think that we will be tolerated in the long run by the population, and thereby not by governments either. So, I think, we are in a tremendously fertile period for change, and all of us have a very specific kind of responsibility to become agents for change. But I feel all of us have built into our system so many traditional reflexes that we tend to go on and on with the same thing and just do not seem to be able to break away.

Now, I hope, in such a seminar as this you will have the necessary courage to question really and truly the very foundation of what we have been doing. I know that we all have to live with the past; I am not saying that all of a sudden you can build a barricade between the past and the future. But it is somehow useful to ask yourself: supposing we were not in the state we are in today, in which all of us have been forced to evolve within a set pattern, supposing we were to do everything over again, where would we go, what kind of people would we use? I think that this is the crux of the whole thing. This is at the root of the conflict, for instance, between the medical profession and auxiliaries, which is still a glaring problem in most countries. Of course you can say that in the rich countries - my own little country, for example - who cares because after all the country is affluent enough to produce some nurses and some doctors and some people are getting some services. But even in affluent countries, if you look at the facts about mental health, for example, a large part of the adult male population are taking tranquilizers to go through life. I would call this a very bad testimonial for the efficacy of the health services. If the facts are so, it just shows that we have totally forgotten the preventive side, have totally forgotten that we are concerned not only with sick people who are moving into hospitals but also with everybody's ability to realize his potential in the environment in which he is living. It is this concept which, in my opinion, the nursing profession has always understood better than physicians.

Unfortunately, we who are entitled to call ourselves physicians have been instrumental in creating a kind of gap between ourselves and our closest collaborators, the nurses. If we had been able to have a much more productive dialogue together over the last 25 years, the health services would look quite different from what they look today. I think it is important that we are breaking down these barricades and that we are getting together in this famous health team we have been talking so much about and of which there are so few signs in most countries I know of. Although the health team receives a lot of lip service, truly there are still arrogance and inferiority complexes on the part both of nurses and of physicians. Who has the inferiority complex depends on which countries you are in, in some places nurses are

more arrogant than physicians, and in others physicians are more arrogant than the nurses. But in all countries this kind of divorce between the two professions has very much prevented the dialogue through which I think we should be able to get down to brass tacks.

What kind of people are going to be trained in order that everybody may be able, as I said, to realize his full intellectual, mental, and spiritual potential in the environment in which he is living? This involves no less a problem than what constitutes health. If we go on to the next century thinking only about big disease palaces, considering our most dignified function to be that of being able to take care of the most complicated things in a very sophisticated machine environment, then I think we are really missing the fundamental objective of our professional task. As I said, nothing can be more sad than that half or even two-thirds of the existing population of the world could today, without many problems, enjoy a truly remarkable health care system on a per capita expenditure of two to three dollars, if these two to three dollars were used in the right way, with the right attitude, in the right spirit, and according to the right priorities. What happens is that these two to three dollars are in fact the per capita expenditure on health in the large majority of countries, but they are spent not so much in the interests of the population as in the interests of the professions. Now, if the professions are using that money in order to further their professional prestige, obviously what is left for people is very, very small; you would need to take a microscope in order to see how little the proportion is.

We are faced with a strange world, where one cannot help but feel very pessimistic because we have not been doing better, because we could do better with the resources we have today and with our concept of training masses of auxiliaries. We could truly be a very remarkable community force, those of us who have the privilege of working in health, and we could make a major contribution to development. After all, let us not overlook the fact that if you treat health in isolation from development you are utterly missing the boat. Here again is a challenge to the nursing profession, because I think you have seen, better than the medical profession, that it is not medical supertechnology that is changing the health status of people, but the ability to work with man for his overall development. Nutrition, hygiene and housing are certainly more important for health than any of the most refined medical technology you can apply after years of training. I feel that nothing will happen in many countries, unless together we can make it absolutely clearly understood that not only do we do what we have to do as a team of physicians, nurses, and members of the other health professions, but that we also have to weld this team very closely together with the other social and economic development teams; and then we in the health field can be accused of not having made a vital contribution to the confidence of people in their own development. Let us not overlook the tragic fact that in most developing countries today people do not have the confident feeling that they themselves or their governments can truly improve their lot. Health is fundamental. Not only has it been scientifically proven that health has a very powerful influence on people's confidence in development, but I also think it is clear from all the studies that have been made in Africa, Asia, and Latin America that health is a moral imperative, that people are virtually prepared to sell their wives or their jewels to buy some kind of health care. In other words, I think there is proof enough that health can be a very powerful lever for overall development. This is our marvellous challenge; it is not only being involved with a few diseases, it is this marvellous feeling of being involved with development, of making the world a more decent one to live in. I think that this feeling of being members of a total development team is what we have lacked so badly in the past. Therefore I appeal to you, because I have always, in the projects where I have had the privilege to be working, had a very aggressive and positive dialogue with my nursing colleagues, and I think they have meant a lot to me in my professional life with their hardnosed, realistic approach to getting things done when I was flying aloft on clouds of idealism. I hope that you will feel that this is one of the great challenges to you and that you will not shrug your shoulders about what we can do with the other kind of health professions but truly make a contribution towards teamwork, internally between the health professions and externally with the other development professions.

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If this Seminar can take some steps in this direction it will really be tackling some of these basic issues that have to do with attitudes. I am sorry if it sounds as if I were speaking more as a priest or prophet than perhaps anything else, but a change in attitudes is really fundamental if we want to improve the health of people throughout the world

Thank you very much for listening to me.

ANNEX IV

ADDRESS BY DR M. ZIAI
MEDICAL DIRECTOR
REZA PAHLAVI MEDICAL CENTRE
TEHERAN, IRAN
at the
THIRD REGIONAL NURSING SEMINAR

Let us start by defining what is education in general? I think one has to be very careful in separating education from training, education from vocation. As far as I can see, education has not changed since the time of our great physicians of history. Education means an interest in the society around us, a sense of curiosity to see the problems, and to be able to go to the right sources in order to find solutions to these problems. Avicenna was a great physician because of possessing these qualities of an educated man. He was interested in the acquisition of new knowledge and added to that of his day; he also learned from what was left behind by his predecessors.

Instead of trying to educate our students, we try to put a great deal of knowledge and information into their heads. These have little value per se or relation to the tasks expected of them in their future positions. Why is the situation like this? It is because of the assumption that one needs a great deal of background. This word background is repeated all the time.

I have to give you examples constantly from medical education as I know so little about your profession; it is a pity, but I don't. It is because I myself have gone through a poor educational system. When the medical student comes to medical school, the first thing that he sees is a cadaver. He has come to the medical school with certain sensitivities such as love to help his fellowman. The dissection room is where the dignity of man is completely lost. It is assumed that the complete knowledge of the structure of the human body is going to make him a better physician. Let me be frank in saying that such knowledge has seldom, if at all, helped me as a paediatrician. I was never taught the difference between the size and characteristics related to livers of a one-day old and a one-month old and a one-year old and a ten-year old and a seventy-year old person. That would have been more important than the exact structures in the cadaver. These false assumptions are constantly brought to our attention if we stop and think and if we are not careful we will get lost.

There is a great deal of knowledge in the world and no brain anywhere is big enough to absorb all that is known in medicine. We must separate useful from useless information. The higher we get into the educational system, the more important it is to develop the ability of problem solving in individuals. The more important it is for them to understand the society which they are trying to serve. The higher they get, the more important it is for members of the team, especially the leaders of these teams, to understand one another.

I must confess that as far as I can see, nursing and medical professions, the closest of all professions, are getting further and further away from one another. In fact they are in competition with and provocative to one another. Both are trying hard to gain their status, and one status symbol is acquiring degrees such as Ph.D., M.D., or super-specialization in medicine - that is a hoax. It so happens that in our country there may be more cardiac surgeons than people who know anything about nutrition. And that is sad.

Now why is the situation like this? I think the greatest reason is our inability to see the problems and plan our educational programmes for supplying the needs. Also, our prejudice against change and experimentation. We have, and very rightly so, copied what has been done before us. This is true of Western as well as developing countries. Western countries are quick to realize that the efforts of the solutions found in the past may not necessarily apply

to the present day situation. So they are rapidly in the process of experimentation and change. This is not very easy to accomplish, and the traditional view of health and education are constant barriers and obstacles. When we in developing countries try so desperately to copy these already out-dated models, with less in the way of materials, possibilities and teachers, and whatever else is needed to implement our programme, the results are catastrophic.

One other problem in medical care and education is that nursing and medicine are going parallel to each other with little chance of inter-section in the way of getting together, so they are in competition. A physician does not understand a nurse; and a nurse does not understand a doctor. How can they therefore assemble together and solve problems together? Another obstacle confronting these people is that they cannot change from one profession to the other. This is looked down upon. It is thought that if a nurse wishes to become a physician, it is a great sin. I don't think so. I think a human being is free within reason to do whatever he or she desires to. And our educational systems must be so designed as to be flexible enough to provide this opportunity.

I want to give you an example of this, and this is the situation of the nurse practitioners in the United States. I am sure all of you are familiar with these programmes. Because of the shortage of paediatricians, for example, a large number of nurses have been converted into something else, which is called "nurse practitioner". This has had good results, but at the same time it is regrettableto see someone going through an educational system, spending funds of public or private organizations, and then looking back and seeing that a great deal of what she has learned during these years has been useless knowledge. Why? Because of the assumption that this is "background".

Let us get away from this background knowledge. Let us find out what is important, and what is not. What is the common denominator in health. I believe this must be established on the basis of functional analysis. In every area of health there are common denominators. This includes the front line auxiliary, as well as the super-specialist. I am not against degrees, but I think degrees must be obtained with justification, on the basis of what the acquisition of this knowledge or degree is going to do for people's health. But what is this degree going to offer the individual - what capacity, what extra capacity? The status symbol has been a great handicap in this regard. I suppose the prevalent feeling is that if the nurses should go on to obtaining a Ph.D. degree in nursing, they become necessarily better leaders. I don't agree with this and assume that most of you don't either.

We talked about common denominators for professional health workers. Can this be accomplished? Yes. If we place our emphasis on useful knowledge and first decide what a person is trying to accomplish in his or her profession, then there are certain tasks that this individual will have to be able to perform. We immediately see then that the lower the educational level of this particular individual, the more technically orientated this person would have to be. That means if you have a front line auxiliary in one of our sixty thousand villages throughout this country, this person has to be involved in family planning, in maternal and child health, in the treatment of diarrhoea, in vaccination, in giving health advice and in environmental sanitation. This is a combination of prevention, cure, nursing, being a social worker, and so forth and so on. Yet all of this must be flavoured by an understanding of the society in which this particular person is going to serve. That is almost asking for the impossible, isn't it? A person with very little information is placed in a village because there will never be sixty thousand physicians to cover the distantly located villages in Iran. It is wrong for people to say that no-one has the right to treat people unless he has a M.D. degree. That is prejudice. How can they? With our mountains, deserts and difficult communication systems in this country, with snow, rain, cold and hot weather; how can you? And even if we train sixty thousand physicians, one for every village, what is the physician going to do there? This expensive product living in a village with some twenty people will eventually rot. His knowledge will be decreasing constantly; he is going to be unhappy, and I think the money spent on his education would be a complete waste.

It means that we have to accept the concept of auxiliaries and delegate responsibilities to them. And it means that the more removed this auxiliary is from the centre, the more knowledgeable, the more understanding, the more problem solving this person has to be. It is again asking for the impossible, isn't it? I think it is not as impossible as all that. On the basis of functional analysis, one can determine what the priorities are and the particular services that an auxiliary would have to render. Intelligence in my vocabulary is not necessarily related to the level of the person's education in so far as obtaining degrees is concerned. An illiterate person in a village may be a very smart individual. And if we are capable of teaching him or her the proper things, this person will become very useful.

I will stop at this point and tell you about a very interesting experiment that we have conducted in this country. Some of you may have already heard about it. About a year and a-half ago, we felt that there was a great need for the training of frontline medical auxiliaries in remote areas of the country. We chose thirty-one girls and boys, almost half and half, in a very deprived area of Iran, where there was a population of about 400 000 people with virtually no access to health care. These were nomadic people. The particular groups introduced potential candidates to us and out of some 300 of them, thirty-one were selected. They went through a course of nine months' duration, which we think now is perhaps a little too long. They learned the elementary aspects of prevention and cure, and then they were sent to their own communities where they had originally come from.

The results of what those people have been able to accomplish already I claim, are greater than those of my own humble efforts during the seventeen years that I have been back in my country desperately trying to do something. These people have changed the lives of people and the societies around. They have cleaned up their villages, they have given treatment to patients suffering from common and recurrent diseases. If we want to change one of these people from one area to another, we meet with tremendous resistance, which by itself, is the best argument against those who say that people do not accept auxiliaries. They do. With this type of beginning, i.e. a person of little classic education, but natively intelligent, we can accomplish a great deal.

Why was this possible? Because we made a preliminary analysis of the priorities such as the importance of knowledge about prevention and treatment of diarrhoea, sanitation, especially the role of water, fighting against flies and mosquitoes and other pests, rats and bed bugs and so forth and so on. These are more important than the up-to-date knowledge about periarteritis nodosa. We don't talk about periarteritis nodosa and autoimmune mechanism, but it so happens that in our medical schools, we talk more about rare and incurable conditions than about how to fight flies and mosquitoes. In fact, our medical students don't even attend classes that have anything to do with preventive medicine. Why? Because we as their esteemed teachers are more interested in rare diseases than we are in environmental sanitation, in malnutrition, in diarrhoeal dehydration, in how to go about changing the minds of people and the implementation of vaccination programmes. We even separate preventive and curative medicine, as if this can be done especially in small communities.

I will tell you what I think first and then go on with the presentation of a scheme that we have proposed for the training of people at different levels. I would be delighted to hear your responses, and the more aggressive they are, the happier I will be because your criticisms will guarantee us that we will be making fewer mistakes.

In my opinion, there is no real difference between nursing and medicine as there is little practical distinction possible between prevention and cure. It is all health. I think we must make a study in our communities of what the needs are, of what our resources are, and then train people for their particular tasks. I think that at all levels, whether this is the frontline auxiliary or a top planner in the country, there must be some common denominators of knowledge for that particular level, whether this is grade school or high school, a bachelor's or doctorate programme. Health workers must understand one another.

This is my first assumption. And at all of these levels, and especially the higher you get, the greater the emphasis must be placed on the educational aspects of learning and problem solving in contrast to the vocational aspects of training. Comprehension, ability to solve problems and social consciousness are essential ingredients of leadership. The lower you get, the more you reach people who have to know the vocational aspects and must be able to carry out these tasks and do them well.

Many experiments, you know, have been conducted that prove this point. My own professor of surgery, the late Dr Alfred Blalock, the founder of modern cardiac surgery, was a great man and an outstanding teacher. But it just so happened that his technician was a most skilled cardiac operator They say that he was technically better than Dr Blalock himself. So that even a task as difficult as cardiac surgery could be assigned to people with little education. If being a great professor of surgery were a vocational matter, if it were only a skill, and not a matter of problem solving, Dr Blalock would never have been able to win the hearts and minds of the students and influence their future lives as much as he did.

We will not get into further discussion of the Western models of health because we have already talked about that topic. Also this is not meant to be an attack of merciless criticism of what goes on in Western countries. In fact, we know from our colleagues in Western countries that they are also trying desperately to find better solutions and they share some of the same problems.

Let us recapitulate. My thesis is that everything we do in the area of health and education must be based on functional analysis. Without this we are in the dark. We cannot separate prevention from cure at any level, that we must have some system that will assure the progressive care of individuals so that even those located in remote areas of our countries would have access to the services of our profession. This is human right. What has medicine done so far for these people? Medicine and medical schools have assumed that they have to train the highest quality of physician, a person who is supposed to know everything about the universe as well as the human body, everything about all the rare diseases, as well as common diseases. The society as well as medical educators has assumed that a physician must be a human being who is willing to make great sacrifices and give his life to people. The unforgivable result is that when the physician graduates from medical school, he knows very little about any of these things. Worst of all, he is not an educated man if we judge education by the ability to solve problems and assume that the same problems exist in nursing education. A system of progressive care will assure that whatever we put into our curriculum in various schools will have to take into consideration some relationship with what these people are expected to do in the future.

We must not assume that only nurses are supposed to be dedicated individuals, because Florence Nightingale was such an individual. We must not assume that every physician is going to be next to God, because William Osler was one of these people. We are all human beings. Let us do away with our weaknesses and strengthen some of our positive points. Again I think that one ought first to start with an analysis of the needs.

What are these needs? I can only tell you what appears to us at the Imperial Organization for Social Services as the needs of this country, and these must obviously differ somewhat in different regions of the world. We feel that every area with a population of something like 500 or so must have a health house. Now if a village with 50 people is 300 kilometres away from the next station, that village still needs a health house of some sort. But we are talking about averages. We think that health centres must be created for 10 000 to 20 000 people and that provincial hospitals with at least eighty to 100 beds must serve populations of about 200 000 The health centres that I referred to must have some beds available for the care of emergencies and for those patients that cannot be moved. We think that larger regional hospitals are needed to serve populations of about 1 000 000. And then we need national referral centres for very specialized works. Perhaps I am being presumptuous, but it is my feeling that more emphasis throughout the world has been placed on the

creation of these national referral centres, these ivory towers, these university hospitals, than those others that I have enumerated.

We think that frontline auxiliaries are the most important people to bring about better health to our nations. We think that high school education in many countries has been turning out a number of useless individuals who know little about anything. A person who is a high school graduate cannot serve in a restaurant because he has not been taught how to do that. He cannot cook, he doesn't know anything about how to fix wires, he cannot drive an automobile, and so forth and so on. He is preapred with a lot of book knowledge, useless book knowledge, with the complete disregard for the application of this knowledge. He is only prepared to go and participate in the entrance examination of universities. It is again a status symbol to obtain a university degree. But it doesn't matter what he is going to be able to do with that university degree.

We think that this is time completely lost, and we think that if health is taught as an important component of high school education, a combination of prevention and cure, that we are going to have a large number of high school graduates who in their own right can be used in the various health facilities, and they will have skills that will surprise all of us.

We feel that when one finishes high school and wants to enter a university education, we ought to forget about the separation of nursing and medicine. Attack me, if you think I am wrong, but this is our feeling. We feel that all of us must go through two stages. The first stage leading to a B.Sc. degree would turn out medical assistants on the one hand and the graduate nurse on the other. The terminology does get in our way, but I think we all understand one another. We think that the first year of this education should be common to all. The second phase of the programme which leads to master's and doctorate degrees will be discussed later.

The above programme is already being implemented. It is going to be a different kind of experience, completely different from traditional medical education. We are not starting with anatomy, histology, physiology, neuro-anatomy and the cutaneous nerves, assuming that some day if the student is to become a surgeon, he may need this knowledge. It so happens that he is going to forget all of that anyway. Experiments have been conducted to give the anatomy examination to professors of surgery and they have flunked these examinations. This means that the knowledge of anatomy taught in the first years of medical schools has been useless knowledge of anatomy, or only those things that the professors had thought important. If these facts were important, obviously the professors of surgery who are dealing with human anatomy every day should have known them.

What are we then teaching the medical students in our school? We are teaching them during the first year above all to be good sanitarians, and persons who understand the deprived rural and the urban communities, and know how these problems can be prevented. We are also training our students in the area of communication. They learn how to communicate with other human beings, how to influence them and how to utilize their resources.

So, during the first year while the student is in constant touch with people in rural and urban communities, we place emphasis on some knowledge of human biology, bacteriology, pathology and pharmacology; the factors that would put human life at jeopardy. Through the combination of theory and practice, we allow them to see human beings in health and disease and we make them appreciate the importance of prevention. We teach them biochemistry, but not so much about the details of oxidative phosphorylation, but the gross biochemical and metabolic functions, especially those related to human nutrition that all of us as nurses and physicians are expected to know, i.e. what is chemical energy, the energy currency that we talk about everyday as ATP. It doesn't take a genius to understand these if you are good enough as teachers to translate such knowledge into simple words that everybody could understand. Perhaps I am being presumptuous in assuming that this knowledge is necessary for a

nurse. It is necessary for a physician, and it is necessary for a medical assistant. I suppose if a nurse likes to gain her true status as a member of the medical team, she would also have to understand it. Our students learn about crops, because this knowledge has a direct relationship to nutrition. They learn about animal husbandry because this is one of the important elements of nutrition, and how to live with animals safely is essential for the villages.

Sometimes a cow is more important than a human being, because if the cow dies, even the beloved child will also die as the cow may be the only source of income for the family. Therefore, they learn certain elementary things about veterinary medicine. They also acquire some information about dental medicine and oral hygiene. Rural people will never have their teeth pulled unless we teach our auxiliaries to do this job. Within the foreseeable future, there will simply not be a sufficient number of dentists to do this job.

We teach our students about anatomy, physiology and pathology in one integrated course. They understand all of these better if they appreciate what could go wrong if normal function cannot be carried out. The pathological process can be caused by a micro-organism, a cancerous growth, radiation injury, thrombosis accident, trauma, etc., but whatever the situation, we try to see that practices are combined.

It is our assumption that this kind of training can be a common denominator for nursing education, as well as medical education It is also our assumption that this training will produce better future thinkers, even of nurses, than the classical training of spending so much time on purely technical matters that are constantly modified.

Being hidden away in the central supply room of a large medical centre, putting things in trays and learning to autoclave - these have little, if any, educational value as far as I am concerned. If one has never learned these and is assigned with such a task, he or she will learn it. This is not education. This is training, something that will inevitably have to be relearned as the techniques change.

We also think it is important for a nurse, as well as anybody who is involved in health care, to be able to listen to a human being's heart, and say that it is normal or abnormal, and to make certain diagnoses, at least guesses, because we think that kind of a nurse will be able to co-operate better with the doctor and that the doctor will accept more easily the co-operation of his nurse or head nurse as a true partner.

When we reach this stage of basic training, then we come to the more specialized skills, not forgetting the fact that education and vocation at all levels must be integrated. We are also going to make our nurses more interested in social sciences, not only by lectures and seminars, but by actually exposing them to the patients' homes in rural and urban communities, while they learn the art of nursing, and we think they will be better potential leaders of their profession at the B.Sc. level. This will be the equivalent of a B.Sc. in medicine, or the degree that we hope to give to the medical assistants. I have already talked to you about the lower level of nurses who will be trained in high schools, so we won't go back to that unless there are questions.

What will happen to these trainees at the B.Sc. level? If the person is interested to pursue the chosen career, there will be the opportunity to go on to further degrees and specialization. If not, the flexibility is greater than what is now possible.

For example, in the case of nurse practitioners in the U.S. where one has to go back and teach them physical diagnosis with little knowledge of the basic pathologic process. We think that they should be free to move from one profession to another if they wish to. In most instances they will probably not, because under such circumstances the status symbol isn't a main aim and objective. We think they are wise enough at the end of the first year to know what they want to do and compete for entering into that profession.

After the B.Sc. programme comes a Master's degree. This can be in nursing with the emphasis placed on teaching them the ability for problem solving at higher levels. Or the continuation of education can be in the basic medical sciences. And then comes the Doctor's degree. It can again be in nursing, medicine, dentistry, or whatever else they would like to study that is related to health.

At all of these levels, we think that the trainees should be getting together as frequently as possible. This process, we think, has been one of our major problems. We really haven't been getting together, have we? Getting together is sometimes very traumatic. It brings up arguments, bitter discussions, opinions, and prejudices; but that is good. Unless we know what is in our hearts and minds, how can we begin to solve the problems? After all, mostly peace has come after war, and if we get our various health workers together, they can work as members of the same team, without any superiority to one another, and without saying that either profession is more important than the other. Presently, the nurses believe that the doctors do not understand nurses, and the doctors say such things as "the nurses are not good; they are not interested in bedside nursing; they are only interested in degrees; they are only filling our charts", and so forth and so on. I hear these comments every day. If we work together, we would be able to solve the problems together, and delegate the responsibilities to auxiliaries with less education, and they can carry out the same tasks as we are now performing even better.

We think everybody who is in the area of health who is sufficiently ambitious and intelligent must have a chance to advance himself or herself. The assumption that the training of a medical assistant should be the end of the road is wrong. I personally have an utter distaste for this attitude. Why should you hold back a person who is intelligent and ambitious enough to go on further in life? Since the opportunities for higher education become progressively limited, the higher one gets in the echelon, the more one is confronted with tion and a general selection. However, this competition must be open to everybody.

I think I have already taken too much of your time, and thank you for the opportunity that you have so very generously given me to talk things over with you. In closing, it is my frank opinion that nurses have made far greater contributions to the health of human beings in recent and past history than physicians. If you ask me what are the things that I have learned and value most, I must tell you that I have learned a great dèal of these from nurses. I think I would have learned more from them if they had understood my language better, and in fact, if I had been in a position to understand their language better.

I don't believe one group of people is superior to the other. Superiority, or better defined still, security and job satisfaction, is a state of mind and depends to a certain extent upon public opinion and the value of services that a person renders. It obviously relates to the knowledge and educational experiences that one has gone through. I do not really feel that the nursing profession is different from the medical profession, and this is one of my pleas. Let us not go into parallels. Let us say that we are all health workers, that you as nurses should be better problem solvers and health planners than I as a paediatrician, and I should know more about pathophysiologic processes related to the welfare of children. Under such circumstances, for solving my problems, I'll come to you. You will act as persons who know less about heart sounds, but know something about them, who know less about pathogenesis of rheumatic fever, but know something about it, and who know infinitely more than I do about human nature, human suffering, and how to visit homes and how to make sure that the prophylactic drugs are going to be given and how to assure that the proposed medical care is carried out. When this happens, then we need and respect one another to a much greater extent.

ANNEX V

AGENDA

I Opening Ceremony

II Election of Chairman, Vice-Chairman and Rapporteur

III Adoption of Agenda

IV Introduction of Workshop Format for the Seminar

V Topics for Presentations and Content of Working Groups

A. Need for Planning of Nursing Services in Context of Total Health Services

B. Methods of Data Collection

C. Use of Studies for Planning Nursing Policy

VI Plans for the Follow-up of Seminar Achievement by the Participants

VII Evaluation of Workshop and Recommendations

VIII Closing Ceremony

ANNEX VI

LIST OF BASIC DOCUMENTS

1.	Provisional Agenda	EM/THRD.REG.NUR.SEM/1
2.	Provisional Programme	EM/THRD.REG.NUR.SEM/2
3.	List of Participants	EM/THRD.REG.NUR.SEM/3
4.	Need for Planning Nursing Services in the Context of Total Health Care by Miss H.M. Simpson	EM/THRD.REG.NUR.SEM/4
5.	Data Collection by Miss H.M. Simpson	EM/THRD.REG.NUR.SEM/5
6.	The Use of Studies for Planning Nursing Policy, by Miss H.M. Simpson	EM/THRD.REG.NUR.SEM/6
7.	Nursing in the Region by Miss T. Agah	EM/THRD.REG.NUR.SEM/7
8.	New Approaches to Nursing Care by Miss E. Leedam	EM/THRD.REG.NUR.SEM/8
9.	Workshop Procedure, by Miss E. Leedam	EM/THRD.REG.NUR.SEM/9
10.	How to get the most out of the workshop, by Miss E. Leedam	EM/THRD.REG.NUR.SEM/10
11.	Evaluation as a Basis for Forward Planning by Dr J. Cobin	EM/THRD.REG.NUR.SEM/11

ANNEX VII

THEME: EVALUATION AS A BASIS FOR FORWARD PLANNING

PROGRAMME

Saturday, 16 November 1974

8.30 - 9.30	Registration
9.30 - 10.00	Opening of the Seminar H.E. Professor A. Pouyan Minister of Health, Iran Address of Dr A.H. Taba, Director WHO Eastern Mediterranean Region
10.00 - 10.30	Reception
10.30 - 11.00	Election of Officers Adoption of Agenda Introductory remarks by Chairman
11.00 - 11.30	Presentation: "New Approaches to Nursing Care" Miss E. Leedam, Regional Adviser on Nursing Development
11.30 - 12.00	Presentation: "Nursing in the Region" Miss Talieh Agah, Acting Regional Adviser on Nursing Development
12.00 - 12.15	Break
12.15 - 12.30	Seminar arrangements Mrs A. Hosseini, Chairman of Preparatory Committee
12.30 - 13.00	Programme and procedure Miss E. Leedam Dr J. Cobin, WHO consultant
13.00 - 14.00	Allocation of participants to groups Group orientation of their activities

Sunday, 17 November 1974

Topic A: Need for Planning

8.30 - 9.00	Plenary Session (in amphitheatre) Review of previous day's activities Dr J. Cobin Programme for the day Mrs A. Hosseini
9.00 - 10.00	Presentation: "Need for Planning in Context of Total Health Services" Dr M. Ziai, Medical Director, Reza Pahlavi Medical Centre, Teheran, Iran

Sunday, 17 November 1974 (cont'd)

10.00 - 11.00	"Need for Planning Nursing Services in Context of Total Health Care" Miss H.M. Simpson, WHO consultant
11 00 - 14 00	Group work (in individual rooms)

Monday, 18 November 1974

Topic Systematic Approach to Problems

8.30 - 9.00	- Plenary Session Review of previous day's activities Dr J. Cobin Programme for the day Mrs A. Hosseini
9 00 - 10 00	Presentation "Evaluation as Basis for Forward Planning Systematic Approach to Problems" Dr J Cobin
10.00 - 10.30	- Break
10.30 - 13.30	- Group work (in individual rooms)
13.30 - 14.00	- Plenary Session (in amphitheatre) Summary of the day's activities Dr J. Cobin

Tuesday, 19 November 1974

Topic B: Methods of Data Collection

8.30 - 9.00	- Plenary Session (in amphitheatre) Review of previous day's activities Dr J. Cobin Programme for the day Mrs A. Hosseini
9.00 - 10.00	Presentation· "Methods of Data Collection and Processing" Miss H.M. Simpson
10.00 - 10.30	- Break
10.30 - 14.00	- Group work (in individual rooms)

Wednesday, 20 November 1974

Topic C: Planning for Change

8.30 - 9.00	- Plenary Session (in amphitheatre) Review of previous day's activities Dr J. Cobin Programme for the day Mrs A. Hosseini
9.00 - 9.30	Presentation: "Use of Studies in Planning Nursing Policy and Changes" - Miss H.M. Simpson
9.30 - 10.00	Group work (in individual rooms)
10.00 - 10.30	- Break
10.30 - 12.00	- Group work (in individual rooms)
12.00 - 14.00	- Reports from groups (in new groups in individual rooms)

Thursday, 21 November 1974

9.00 - 10.00	Closing Session Report and Recommendations The Rapporteur: Mrs Kaniz Mowla

Thursday, 21 November 1974 (cont'd)

Comments on the Seminar:

The WHO consultants: Miss H.M. Simpson
Dr J. Cobin

For the moderators: Dr Enaam Abou Youssef

For the participants: Mr Ahmed Younis
Miss J.F. Khoury

Closing remarks: His Excellency Dr A. Amiri
Under-Secretary for Technical Affairs
Ministry of Health, Iran

Dr Alexander Robertson, Public Health Administrator, representing the Director, World Health Organization, Eastern Mediterranean Region.

Social Programme of the Seminar

Saturday, 16 November 1974

3.30 p.m. — 1. Ashraf School of Nursing
2. Shahyad Aryamehr

Sunday, 17 November 1974

3.30 p.m. — 1. Golestan Palace
2. Crown Jewels

8.00 p.m. — Rudaky Opera House

Monday, 18 November 1974 — Lunch by: Iranian Nurses Association

6.30 p.m. — Reception by:
Mr R. Booth, Resident Representative of the United Nations Development Programme and Mrs Booth at the UN Building

8.30 p.m. — Dinner by:
H.E. Professor A. Pouyan, Minister of Health, Iran

Tuesday, 19 November 1974

6.30 - 8.30 p.m. — Reception by:
Dr & Mrs A.H. Taba, at the Reception Room of the United Nations Building

Wednesday, 20 November 1974

3.30 p.m. — Queen's University Hospital for Reconstructive Surgery

Lunch by:
Department of Nursing & Midwifery, Ministry of Health

Thursday, 21 November 1974 — Shopping

MOST OF THE ABOVE ACTIVITIES ARE GRACIOUSLY ARRANGED BY THE NATIONAL PREPARATORY COMMITTEE FOR THE SEMINAR

ANNEX VIII

LIST OF PARTICIPANTS

AFGHANISTAN	Mrs Akhtar Sharif General Director of Nursing Division Ministry of Public Health Kabul
	Miss Nadera Samadi Director Nursing School Jalal Abad
	Mrs K. Seemin Deputy Director Nursing Department Wazir Akbar Khan Hospital Kabul
CYPRUS	Miss J. Shellish Senior Matron Nicosia General Hospital Nicosia
	Mrs Loulla Chacalli Senior Tutor School of Nursing Nicosia
DEMOCRATIC YEMEN	Mr Abdul Hamid Abdul Majeed Matron Al Joumhouria Hospital Aden
EGYPT	Dr E. Abou Youssef (Moderator) Director Higher Institute of Nursing Alexandria University Alexandria
	Mrs Aida Kabeel Chief Nurse Ministry of Health Cairo
	Mrs Effat Kamel (Moderator) Deputy Chief Nurse Ministry of Public Health Cairo
	Mrs Soheir Ahmed Shams Director of Nursing Directorate of Health Affairs, Giza Cairo

EGYPT (Cont'd)	Mrs Nadia Yacout Nursing Supervisor Heart and Chest Institute Embaba <u>Cairo</u>
	Dr Isaad Dowara High Institute of Nursing Cairo University <u>Cairo</u>
ETHIOPIA	Sister Tenagne Derebe Head Nursing Education Section Ministry of Public Health <u>Addis Ababa</u>
	Sister Mehret Quana Chief Public Health Nursing Section Ministry of Public Health <u>Addis Ababa</u>
IRAN	Mrs F. Salsali General-Director Nursing and Midwifery Department Ministry of Health <u>Teheran</u>
	Mrs Sh. Herovabadi (Moderator) Assistant Director-General Nursing and Midwifery Department Ministry of Health <u>Teheran</u>
	Miss Azar Riahi (Moderator) Technical Inspector Ministry of Health <u>Teheran</u>
	Mrs Iran Bararsani Director of Nursing General Health Department <u>Meshed</u>
	Mrs Parmis Ershad Director of Nursing General Health Department <u>Guilan Province</u>
	Miss Shahla Esfandiari Director School of Nursing Isfahan University <u>Isfahan</u>

IRAN (Cont'd)

Mrs M. Fazel
Chairman
Department of Nursing Education
Pahlavi University
Shiraz

Mrs Hajar Abdolan
National University of Iran
Teheran

Miss Alice Daniel Zadeh
Nurse Educator
University of Azarabadegan
Tabriz

Miss Fatemeh Faraji Vakili
Director of Nursing and
Behyari School
University of Jondishapour
Ahwaz

Mrs Mahboobeh Khazai
Director of Nursing and Midwifery School
Ferdowsi University
Meshed

IRAQ

Miss Widad Aboul Kadir Al Zahawi
College of Nursing
University of Baghdad
Baghdad

Miss Widad Hussain Abass Alkargulli
College of Nursing
Baghdad University
Baghdad

JORDAN

Mrs Hanneh Dababneh
Director Nursing School
Ministry of Health
Amman

KUWAIT

Miss J.F. Khoury
Principal Matron
Nursing Division
Ministry of Health
Kuwait

Mrs Afifa Hovagamian
Director of Nursing and
Nursing Services in Clinics
Kuwait

Mrs Laila Ali Ahmad Ali
Director
Nursing of School Health
Kuwait

WHO EMRO

LEBANON	Mrs W. Shaya Associate Professor School of Nursing American University of Beirut Beirut
	Mrs Marie Claude Ghosn Assaf Senior Teacher Red Cross School of Nursing Beirut
	Miss Laure Azouri Instructor in Nursing School of Public Health American University of Beirut Beirut
	Miss Jocelyne Zogheb Nurse Educator French University Beirut
LIBYA	Miss Hawa Al Rimali Head of the Nursing Section Ministry of Health Tripoli
	Dr Samira I. Salama Head Nursing and Auxiliary Health Services Ministry of Health Tripoli
	Mrs Zanuba Shaaban Nursing Education Health Manpower Development Section Ministry of Health Tripoli
OMAN	Miss Asiah Ali Said Kharusi Nursing Supervisor Ministry of Health Muscat
PAKISTAN	Mrs Kaniz Mowla Nursing Adviser Ministry of Health and Social Welfare Islamabad
	Mrs Raiza Zahoor Nursing Superintendent Mayo Hospital Lahore

QATAR	Mr Ahmad Younis Senior Nursing Educator Chief Male Nurses Training Centre Doha
	Mr Abdul Razak Kubeisi Nursing School Doha
SOMALIA	Mr Jibril Amin Omar Director Health Personnel Training Institute Mogadishu
SUDAN	Mrs Awatif Ahmed Osman Director Khartoum Nursing College Khartoum
	Mrs Batoul Saad Mursal Senior Instructor Khartoum Nursing College Khartoum
SYRIA	Miss Fatma Wardeh Lecturer Nursing School Damascus
	Mrs Aisha Nasab Saluta Lecturer Nursing School Damascus
UAE	Dr Juma Bilal Assistant Director Curative Department Ministry of Health Dubai
YEMEN	Mr Ahmed Said Nurse Swedish Association Taiz
OBSERVERS FROM HOST COUNTRY	Miss S. Simozar Director School of Nursing Pahlavi University Shiraz

OBSERVERS FROM HOST COUNTRY (Cont'd)

Miss R. Rowhani
Assistant Director
Nemazee Nursing School
Pahlavi University
Shiraz

Miss Molood Arabnejad
Principal Tutor
National Iranian Oil Co.
Teheran

Mrs Ghamar Mir-Kamali
Director of Nursing
Central Ostan
Teheran

Miss Nasrin Vaghar
Director of Nursing
Firouzgar Hospital
Teheran

Mrs Anis Falahati
Director of Nursing
Khosestan Province

Mrs Kobra Dadkhah
Director of Nursing
Kermanshahan Province

Mrs Mastaneh Nemati
Director of Nursing
Isfahan Province

Mrs Zia Rafat
Adviser in Nursing
Municipality of Teheran
Teheran

Miss S. Sayahi
Acting Director
High Institute of Nursing
Reza Shah Kabir
Teheran

Mrs Z. Ghavinchian
Assistant Director
High Institute of Nursing
Reza Shah Kabir
Teheran

Miss Mohabati
Instructor of Nursing
High Institute of Nursing
Reza Shah Kabir
Teheran

OBSERVERS FROM HOST COUNTRY (Cont'd)	Miss Ghassemzadeh Instructor of Nursing High Institute of Nursing Reza Shah Kabir Teheran
	Miss A. Hosseini Consultant in Midwifery General Department for Nursing and Midwifery Affairs Ministry of Health Teheran
	Miss Odabayi Armed Forces Teheran
	Miss Ena Burke Director of Behyari Nursing School Christian Hospital Isfahan

REPRESENTATIVES OF OTHER UNITED NATIONS BODIES

UNITED NATIONS	Mr R. Booth Resident Representative United Nations Development Programme Teheran IRAN
UNICEF	Mr Rachid A. Koleilat Deputy Regional Director UNICEF Beirut LEBANON
	Mr Mehran Meshkati UNICEF Teheran IRAN
UNRWA	Miss Gerda Karnstrom Chief Nursing Division UNRWA Headquarters Beirut LEBANON

REPRESENTATIVES OF OTHER ORGANIZATIONS

ICN	Miss Maria P. Tito de Moraes Nurse Adviser International Council of Nurses Geneva SWITZERLAND

WHO SECRETARIAT

Dr A.H. Taba	Director	WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt
Dr A. Robertson	Public Health Administrator	WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt
Miss L. Turnbull	Chief Nursing Officer HMD	WHO/HQ
Miss E. Leedam	Regional Adviser on Nursing Development	WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt
Miss Talieh Agah	Acting Regional Adviser on Nursing Development	WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt
Dr Joan Cobin	WHO Consultant	Chairman, Department of Nursing, California State University, USA
Miss H.M. Simpson	WHO Consultant	Former Principal Nursing Officer Department of Health and Social Security, Ministry of Health, London, UK
Miss C. Cartoudis	Conference Officer	WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt
Mrs B. Shaarawy	Secretary	WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt

RESOURCE STAFF

Miss E Heber
WHO Nurse Educator
Nursing Advisory Services Project
Kabul
AFGHANISTAN

Miss A.T. Garcia
WHO Public Health Nurse
Institute of Health Manpower Development
Aden
DEMOCRATIC YEMEN

Miss M. Rouzic
WHO Nurse Educator
Nursing Education Project
Amman
JORDAN

Miss S. Nasser
WHO Nurse Educator
Nursing Education Project
Benghazi
LIBYA

Miss K.A. Ali
WHO Nurse Educator
Local Health Services Project
Hodeida
YEMEN

ANNEX IX

NEW APPROACHES TO NURSING CARE

By

Elizabeth Leedam*

"Evaluation as a Basis for Forward Planning" and "New Approaches to Nursing Care " - these two subjects are very closely connected. The former implies a need to measure what we have achieved before we plan what we will do next. The latter gives ideas on what direction future or forward planning can take.

We are fortunate to be in Iran for our work, because here are examples of good nurses, good nursing and good health care. I am sure they have their critics, but I know they are always seeking ways of giving better nursing care, of testing new ideas, of trying new developments. You will see and hear about many of these during this Seminar.

Nurses in Iran have gained well-merited recognition and respect. Their salaries and working conditions compare favourably with other professions in this country. They hold positions of responsibility, and co-operate with their medical colleagues on an equal basis. But, I am sure they have their problems.

Nurses in some other countries are not so fortunate, and nursing in other places is not as good as in Iran. However, one should not compare one service with another without taking into account all the factors which exert an influence on nursing. Factors such as the economy of the country, how much health care can it afford; the policies of the country, how much priority is given to health and nursing by the Government; the educational level of the country, not only from the point of view of the recruits to nursing, but from the point of the expectations of the general public; the climate of the country, how this affects the health of the population. It would be impossible to list all in the short time available, impossible and unnecessary. Nursing should only be compared with that in other countries to discover ways which will help it to develop to its full potential.

Discussions about nurses and nursing can get very involved and emotionally charged, probably because there is no one definition of WHAT IS NURSING. There are many definitions, and we each like to think that our own particular version is the best one. Instead of adding my ideas on this very controversial subject, I would prefer to try and see how nursing is evolving.

Nursing began by caring for those who were ill or injured. This soon became associated with helping doctors in their efforts to cure patients. So much so that at one period nursing was seen solely as a physician assistive role, and all nursing functions were considered as being performed on and for people for whom doctors were responsible.

The recognition that one could prevent illness, and avoid the need for medical care, and the concept of promoting health brought a totally different role to nursing. So did the growing realization of the multiple causes of disease, some of them not directly connected with the body's functioning, and the many factors concerned in rehabilitation. "Physical, mental and social well being of all peoples" is the declared aim of WHO, "not merely the absence of disease and infirmity". Nursing to-day should be concerned with the whole spectrum of health care, and not just with curative care.

What is expected of nurses to-day in the complex pattern of health care? That we meet the demands of sophisticated medical care in the Intensive Care Units, in the Operating Rooms, in the hospital wards. That we keep up with the latest advances of knowledge in pharmacology, in genetic research, in endocrinology, in many other fields. That we meet the needs of the

* WHO Regional Adviser on Nursing Development, EMR

mother and baby throughout the entire maternity cycle, in the home and in the hospital. That we consider the family in the community as the focus for our care. That we teach the family about cleanliness, nutrition, family care and family planning. That we examine schoolchildren to detect early deviations from normal. That we carry out immunizations in clinics and homes. That we do not forget the workers in industry. This list is not comprehensive. In all these activities we are expected to behave with "tender loving care".

That people matter to us is axiomatic. We would not have become nurses if we did not care about people. The sad part is that the education and preparation of nurses has concentrated so much on the scientific aspects that the humanitarian ones are often forgotten.

To prepare one nurse to carry out all the duties required would be time consuming, and should not be necessary. Many Ministries of Health, however, to-day want nurses who can function either in the hospital or in the community, and the present, often narrow, hospital-based preparation of nurses does not always equip them to function well in the community. The wonder is that they perform as well as they do. The challenge nursing is to find ways of educating and utilizing different categories of workers to give the coverage for the needs of health care of today.

In an attempt to close some of the gaps in health care many workers have been hastily recruited from rural or peripheral communities, narrowly trained and employed to carry out a varied range of functions. Their job titles and rewards have also varied considerably, and are often unrelated to their training or assigned tasks They have been expected to carry out tasks for which they were not prepared, and this practice has created conflicts and abuses. Although nurses were not involved in the planning or training programmes for these workers, they were frequently assigned for nursing duties, and the nursing personnel were unprepared to direct or supervise them. The communities served were often disappointed and critical of the continued gaps in the health care they received.

A well-organized nursing system, responsible for the education and practice of nursing personnel could cope with these problems, could be accountable for the services provided and should participate in the planning, preparation and utilization of all staff whether for community health or for nursing care in the hospital.

What do we mean by a nursing system - all the factors involved in the preparation and utilization of all personnel giving nursing care? Each country must decide what functions it will include in its nursing care, and this should include the wide range of needs in the community as well as in the hospital. Nurses, and others, who have had their horizons limited by the four walls of the hospital must be ready and willing to open their minds and their ranks to include into the nursing system all levels of all practitioners. Considering nursing as a system will help to create a better balance in nursing. It should help to bridge the gap which so often exists between the education of nurses, who are sometimes prepared for functions they never perform, and the needs of the service. It will help to develop the nursing potential in a country to the full.

What is different in thinking about nursing as a system? I would contend that it lies in the totality of the concept. That nursing is considered as a whole, made up of many parts. Definitions of the word "system" include such phrases as complex whole; organized body of things, material and immaterial, co-ordinated, connected; series of parts which work together. We already talk of the health system, the educational system, the political system, and the term nursing system is not new. It is the interdependence of one part with another which is sometimes overlooked.

The personnel in a nursing system must include every category of worker giving nursing care, from the primary health care worker in the community and the nurse's aide in the hospital to the most senior nurse administrator and nurse teacher.

Education of all personnel should be in their own country. To develop a cadre of suitable senior administrators, teachers or specialists may involve preparation elsewhere in the first instance. Fortunately, some institutions now recognize the need for special adaptation for students from other countries, but the aim should be to train every level of practitioner in his/her own country.

I am not going to discuss nursing education further at this moment. It is a subject which has received a great deal of attention in the past, and with the new ideas and technologies in education which are available today, it is possible for nursing education to make major contributions previously not thought possible

We should not think of education of nurses separately from their utilization. The opportunity to put into practice what has been taught is as important as the teaching. But even the best prepared nurse is unable to function without the proper support It must be remembered that supplies, equipment and facilities are important for the proper performance of nursing duties. No nurse can work without the tools for the task.

This support should also include legal control for the safeguard of the general public from the activities of unqualified personnel, as well as the recognition and reward for the practitioners who have been trained.

A nursing system is only complete when all three sections, personnel, their preparation and utilization are complete. It is efficient and effective to the extent that it meets the identified needs; it is economical of manpower and other resources, (i e. it makes the best use of them); it forms an "open system" with a recognized way of adapting to change, evolving to a better standard, and becoming self perpetuating.

The challenges facing us in nursing today are many. These include the hope that the nursing care given in each country is the best for that country, to meet its own specific needs and within its own resources Nursing must successfully integrate with a wide variety of other disciplines, all giving health care. It must be prepared to meet new demands occasioned by the changing ideas and ideals of health care, and in particular to be aware of the needs of the vast numbers of the population who do not at the moment have access to any form of health care. It must find ways of educating and using many more health workers.

How can we begin to meet these challenges? By deciding how well we are doing at the moment, and where we could do better? By being ready to adopt new approaches to health care? By thinking of nursing as a system, rather than a series of separate parts, we can decide how well we are contributing to the whole? We can begin to plan for the maximum utilization of the services of every member of the health team to develop the nursing potential of our countries to the maximum. We cannot do all this in one step. This Seminar is designed to help nurses make a beginning; to evaluate as a basis for forward planning.

ANNEX X

NURSING IN THE REGION

By

Talieh Agah*

The World Health Organization during the past twenty-six years, has been strenuously involved in efforts to elevate the standard of health and eliminate disease - in essence to promote the health and happiness of the whole man, throughout the world.

The WHO Regional Office, Alexandria, Egypt, has had the responsibility and challenge of assisting countries in our Eastern Mediterranean Region to meet their health needs. These efforts have been multi-disciplinary, with the challenges shared by many, for, health is a complex matter, and many fields and disciplines are involved in this complexity. Our own profession, nursing, is one of these.

The aim of all the members of the health team is, as we have indicated, to maximize for individual citizens of their countries the achievement and enjoyment of a healthy life. This aim cannot be achieved unless there is total involvement of all these disciplines.

Nursing, as a profession, cannot move or improve alone, it must inter-relate with other disciplines within and outside the health team. These joint efforts provide opportunities for nursing and other health workers to get together, exchange ideas, compare experiences, and analyze problems and difficulties, to be able to find solutions, with emphasis on proper educational preparations for developing services to meet the total health needs of the society.

Though WHO is able and willing to guide and give support to all health care activities, it will not impose ideas. Its contribution is to provide a resource of technical and professional specialists who will assist in individual tasks, but the desire and responsibility for improvement, rest squarely on the shoulders of member countries themselves.

On many occasions, WHO has provided opportunities for nurses and other health workers to get together.

The nurses of our Region had their first WHO-promoted Regional Seminar in Lahore, Pakistan, in 1960, the second in Teheran in 1966 and a Group Meeting in Nicosia (Cyprus) in 1970. Possibly some of you also attended those Seminars. They were convened at a time when noteworthy expansion and improvement of health services, throughout the Region, were taking place. Their participants were well aware that a consistent effort on the part of the professional nurse would be demanded if she were to make a significant contribution. The opportunity which the Seminar gave for study and discussion of the present status of nursing was fully utilized and incentives given for its improvement

Recommendations and resolutions stemming from the work of these Seminars in which you can look back over this period of fourteen years to see what we as nurses have accomplished, but what a long way we have yet to go, included the following:

1. Establishment or Strengthening of Nursing Divisions within Ministries of Health or a Central Nursing Division on National Level

An active Nursing Division in the Ministry of Health is a necessity for effective administration. It should generally provide leadership and assist in planning and up-grading the nursing educational programmes, nursing services and community health in general. This Nursing Division should also form a core of resource personnel to be consulted on all matters related to nursing.

* WHO Acting Regional Adviser on Nursing Development, EMR

The majority of the countries of the Region have developed a national Nursing Division in the Ministry of Health. However, further development and strengthening of these divisions are essential for advancement of nursing programmes.

2. Registration and Legislation concerning all Nurses

Although some preliminary action has been taken in some of the countries of this Region regarding Registration and Legislation, these matters require further studies and action on national level, and, of course, assistance and support from concerned Governments.

3. Forming National Nurses Associations and aiming towards Membership in the International Council of Nurses

The majority of the countries of this Region are members of ICN. A few others should raise the level of general education as well as the standard of their nursing programmes to be eligible for membership.

4. Establishment of a Regional Programme by WHO for Post-Basic Courses and also practical Programmes for Refresher Courses for Nurses with long-term Service

With technical contributions and opportunities provided by WHO, and mainly the desire and willingness to improve, many changes have taken place regarding nursing education in all the countries of this Region.

For example, in this country, Iran, twenty-five years ago, there was not one school of nursing on a higher educational level, now there are more than twenty training many nurses a year. Egypt is trying a new programme, educating nurses in Technical High Schools. Six thousand will qualify next year. Colleges of nursing have been established in Egypt, Iran, Iraq, Jordan and Sudan.

There is a post-basic nursing degree programme in Pahlavi University, Shiraz. Other basic and post-basic schools in universities are providing opportunities for potential nurse leaders to advance their education to a Masters' and Doctorate level. Hundreds of practical and auxiliary nursing and midwifery schools have been established throughout this Region. Many fellowships in various fields of specialty, for professional advancement, have been granted to nurses. But the problem of graduate nurses not returning to their own countries or migrating to others, needs careful study and consideration. The loss of these human resources, or "brain drain", should be of great concern to the nursing leaders and their respective national authorities.

Though great achievements have been made, they are still a far cry from all that will be necessary to meet the present and future nursing needs of the Region. So then, the future of nursing is in the hands of nursing leaders such as yourself gathered here to-day. With greater effort and enthusiasm on your part, inspiring motivation and support from your governments, and with technical guidance from WHO much more could be accomplished.

5. Assistance with the work of a Committee to be formed under the Auspices of WHO for Development of Nursing on an International and Inter-Country Basis

The Regional Expert Advisory Panel of Nurses was formed. "The aim of this Panel would be to enable practising nurses to make a more meaningful contribution to the highest quality of health care, by assisting the Regional Director in identifying and suggesting ways of meeting the nursing needs of the countries". Selected members of this Panel met in the WHO Regional Office early this year. They planned for this Regional Nursing Seminar and volunteered to function as moderators in the small group meetings and further discussed and

recommended possible future activities of the Regional Expert Advisory Panel of Nurses.

8. A Regional Workshop may be convened on how to conduct nursing studies through using simple research methodology such as problem-solving techniques, for the improvement of health services through better nursing education and nursing service.

9. Conducting of studies and evaluation of national nursing needs, nursing resources and the utilization of nursing personnel, for the purpose of finding ways to provide for the optimum utilization of professional and auxiliary nursing personnel and the re-allocation of non-nursing activities to other trained personnel, this would involve both study of national needs and resources by a national body as well as work-sampling studies to show the utilization of nursing personnel in one nursing service department.

In accordance with these recommendations, we have now planned this Seminar to give you an opportunity to tackle some of your problems, find solutions by simple procedures and methodologies in eventually meeting the needs of your respective countries.

As evidence of the enthusiasm he shows and importance he ascribes to the development of nursing in our Region, we are honoured in having our Regional Director, Dr A.H. Taba, with us for part of this Seminar.

Practically involved in the advancement of nursing in this and all other Regions is the Chief Nurse from WHO Headquarters, Miss Turnbull.

Dr Robertson, as Head of the Division of Health Manpower Development, EMRO is vitally concerned with the development of cadres of trained staff in the whole gamut of health careers.

We are looking forward also to profound thought-provoking contributions from our consultants, Miss Simpson and Dr Cobin. We hope all these will make this a Seminar to remember.

Please remember that we in WHO are here to assist you in any way we can.

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ANNEX XI

NEED FOR PLANNING NURSING SERVICES IN THE CONTEXT OF TOTAL HEALTH CARE

By

H. Marjorie Simpson*
WHO Consultant

1. Health and Planning for Health Care

Health is not an end in itself, it is a means to a diversity of other ends. Possession of health permits the exploitation of life's opportunities to the full. A health service is an enabling service aimed towards helping people to do what they wish to do with maximum enjoyment and minimum damage to themselves or others, be it to reach the moon, procreate, hold down a job or dance.

A health service cannot be planned in isolation from the economic and social life of the community it is designed to serve. Agriculture, animal husbandry, education, communications, employment, housing, environmental hygiene and personal health services all have claims on the nation's resources and have to be balanced one with another. "Health planners, therefore, should be concerned not only with traditional health services, but also with the numerous other factors that promote social and economic development and, at the same time, health in its broadest sense".[1]

Additionally a health service has to be planned in the context of a dynamic society. Scientific knowledge is growing at an ever accelerating pace. The technical application of this knowledge lags behind but continuously makes available progressively more sophisticated equipment. Populations increase, often accompanied by a narrowing base of family support. Changes are occurring in the position of women; higher levels of education and of standards of living result in lower thresholds of tolerance of illness. Health services must be planned for flexibility with built-in monitors of changing conditions and change agents to keep the service in harmony with the changing society.

"Any complete health service will make provision for operations within five broad categories - namely:

(a) The health maintenance or health attainment stage, in which the principles of healthy living (physical and mental) and the fundamentals of good hygiene and good nutrition are taught and practised.

(b) The increased risk stage, in which specific preventive measures are taken to protect those who are exposed to any sort of increased health risk.

(c) The early detection stage, in which, by detecting illness in a person who presents first symptoms of a disease, it is possible to give treatment at an early stage, thus preventing needless suffering and cost and perhaps even untimely death.

(d) The clinical stage, which at present requires the greatest concentration of professional nursing skills and care, devoted to patients whose health problems are acute and whose diseases were neither prevented nor detected at an early stage.

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* Former Principal Nursing Officer
Department of Health and Social Security
London

(e) The rehabilitation stage in which disability is prevented or, if this is not possible, the patient is helped to use his entire remaining potential If there is no hope of rehabilitation and death is inevitable, this fifth stage provides the opportunity to prevent unnecessary deterioration and, finally, to assist the patient in those activities that contribute to a peaceful death.

The relative emphasis on the different aspects of the health service will vary according to national needs and resources".[2]

The concept of national needs and resources sounds deceptively simple. Attention has already been drawn to the varied calls on national resources. Need is a nebulous concept. There is a small core of scientifically established health needs, for example for an uncontaminated water supply or for vitamin C. These scientifically established needs are not necessarily those to which the public gives priority nor even do they always command universal recognition from professional health workers. The services for which a nation provides resources may not coincide either with scientifically established need or with demand from consumers or their professional advisers. It is never going to be possible to provide the best services for everyone all the time. Demand is insatiable, resources limited. Planning involves choices about which needs and whose needs are to be met It is necessary to set limited objectives and to examine a variety of ways of reaching them.

The complexity of scientific knowledge demands specialization. Limited resources necessitate optimum use of those available. Increasingly health care delivery systems are coming to be regarded as team activities.

A health team has been defined as "a non-hierarchical association of people with different professional backgrounds but with a common objective, which in any given setting is to provide patients and families with the most comprehensive health care practicable".[3]

Nursing is an essential element in any health care system and nurses must prepare themselves to take a full professional role within the health care planning team. "Systematic planning for nursing must take place within the framework of national health planning which in turn must be a constituent part of national development planning" [4]

2. Fact Finding for the Planning Process

A health service has day by day to meet immediate demands. Decisions are made in the light of the practitioner's professional knowledge based on previous education and experience. Colleagues and experts can be consulted or working groups set up to thrash out more complicated questions. Regional, national or international committees may advise on broader issues. These professional activities may be paralleled by a formal administrative structure planning the service at unit, local, regional and national level. This administrative structure may or may not be linked to Government. A health service is dependent on the judgement of its professional personnel who should be involved at all levels of planning. This throws a responsibility on these personnel to keep their professional knowledge up to date and to seek continuously to improve it through an effective information system and by carrying out research and using its results.

"Underlying all effective methods towards the solution of problems - including the methods of research - is the need for facts, systematically gathered and presented in an orderly way. Fact-finding must provide a basis for any effective approach to problem-solving".[5]

One method of obtaining facts is through a reliable information system. Such a system is essential for effective health care planning. Information is required at the point where health service is delivered, at local levels and usually at regional and central levels depending on whether a national health service or another type of service is in operation.

There is no universal pattern that would fit the requirements of every country.

The nursing information sub-system should be an integral part of the overall health services information system. The usefulness of the information system does not depend on the type of organization but essentially on whether or not those persons responsible for nursing have been able to state clearly their information needs and to have these included in the information collected. This will be possible if senior nursing staff are involved from the beginning in the design and development of the information system. This also implies that senior nursing staff must be trained in modern managerial techniques and that nurses at all levels should learn to document the nursing process.

There are five sources of information on which a nursing health information system could be based: routine statistics, data banks or data registers, ad hoc studies or surveys, literature on relevant research, expert opinion.

People in administrative positions are busy and the interpretation and use of data collected from these sources presents difficulties. Undoubtedly nurse administrators should develop their competence in this respect but they might also wish to consider establishing nursing intelligence units closely associated with those responsible for the management of nursing services on the one hand and on the other with health service intelligence units.

Information systems form a basis for decision making in health care planning, for monitoring change and for research.[6]

Research will also produce facts but it does more than this. It advances the frontiers of knowledge and acts as an agent for change both by indicating directions for change and by experimental introduction of change.

Arnstein in her introductory talk to just such a gathering as this, the International Conference on the Planning of Nursing Studies, defined research in two ways. "Research is the planned systematic attempt to answer a question", and "The purpose of research is to discover answers to meaningful questions through the application of scientific procedure". She adds, "there have been great discussions and sometimes a good deal of emotional energy expended on the difference between a study and research. If one accepts either of the above definitions it seems to me the words are interchangeable".[7] I am in full agreement with her. People say illogically "it's not meant to be scientific, I just want to know ..." Scientific method has been developed so that there is a reasonable chance that at the end of a study we shall 'know' or 'not know' or 'know partially'. The thing to remember about facts is that it is essential to establish the degree of accuracy they represent and then to be scrupulously honest with oneself and other people in using them. This is what scientific method makes possible.

No one should plunge lightly into research or undertake trivial work. The researcher incurs definite ethical obligations. First and most important are those to the people and/or institutions studied. No harm must come to them, their right to refuse to participate must be respected; they are entitled to 'feedback' when the research is completed. Second, the research worker has obligations to his sponsors. He must warn them if the study they want done is not feasible or not possible within the resources available. He can never promise a successful outcome. Sponsors are entitled to be kept informed of progress and to an honest final report produced on time and including caveats where necessary if material is unreliable. Third, the researcher has obligations to the scientific discipline within which he works. He should seek to advance the frontiers of knowledge, to develop new tools and to check existing theories. He has an obligation to acknowledge help whether from his team or other sources; to ensure his team observes the ethical code of the science and to report on the scientific aspects of his project.

Not all problems are amenable to research. Research is a long-term business Each project adds only a drop to the pool of knowledge. Many projects will fail to produce the hoped for results. In the physical sciences this is well accepted. In the social sciences which are less highly developed, there is all too often an expectation that each project will produce usable results and that major break-throughs will be common This is unrealistic. Research should be going on all the time in the background, feeding the pool of knowledge. What is essential is that practitioners in the health service should establish channels so that they can tap the pool with ease.

Research will produce more reliable facts and new knowledge on which to base professional judgement. It will not make policy decisions or ethical judgements though it may provide pointers to the consequences.

The day to day work of planning and providing a health service and the nursing component within it will rely on professional judgement informed ideally by a reliable information system and an on-going research programme. All methods of consultation with consumers, between health service personnel and within the wider context of national policy will be employed to keep the service in harmony with the society it serves.

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ANNEX XII

DATA COLLECTION

By

H. Marjorie Simpson*
WHO Consultant

1. Preliminary work

In research one does not hurry into the field. It is necessary to be familiar with the current state of knowledge in the science and in the field to be studied. So far as professional health workers are concerned they should, as part of their normal professional expertise, be cognisant of the current state of knowledge in their own specialty and a minority of them will be skilled in the research methods of a relevant science. It is still as well to check up and a search of the literature and discussion with others known to be working in the field should be regarded as an essential preliminary to any study. It is followed by:

(a) the identification of the specific problem for investigation, question to be answered or hypothesis to be tested,

(b) the selection of the scientific discipline or disciplines which have a contribution to make in the investigation.

It goes without saying that one does not undertake research in a scientific discipline with which one is not familiar. There are many sciences with a contribution to make to the study of nursing problems: biological, sociological, psychological, managerial, mathematical to name but a few. Research teams can be uni-disciplinary, inter-disciplinary or multi-disciplinary. The research programmes can be joint or concurrent or consecutive.

Studies may be descriptive, experimental or field trials. Every science has to describe and classify the phenomena with which it deals. The science of nursing is an embryonic state. At present most nursing studies are descriptive in nature and properly so. Accurate descriptions and classifications are useful not only as the essential foundation for a science but also to provide more reliable information on which professional judgements can be made. A description cannot provide a prescription. A description of what staff are doing does not tell us what they ought to be going. A description of patients' opinions about their care does not tell us how to increase their satisfaction. A measure of patient anxiety does not tell us the level which is therapeutic. Descriptive studies quantify and help to classify phenomena. Once nursing activities are quantified and classified it may be possible to make a professional judgement identifying a, b and c as nursing duties and x, y and z as non-nursing duties. The study has not shown this but it has facilitated a professional judgement. The description may identify factors which appear to be influencing a situation, e.g. a choice of food at meal times has been shown to be associated with greater satisfaction with hospital feeding than more money spent on food. This may not be a directly causal relationship but the association is worth following up. The data collecting and processing instruments developed for a descriptive study may subsequently be converted for use to provide information regularly for management purposes.

Descriptive studies may lead to experimental work to test hypotheses derived from the descriptive study. An experiment which aims to see what changes occur if an innovation is introduced has problems related to the establishment of causal relationships, control of other variables and introduction of control groups, which themselves may produce ethical problems. There are procedures for dealing with these problems. If, however, one wants to say that one situation is in some sense 'better' than another then the criteria for 'better' must be made explicit. The second situation may be cheaper, quicker, preferred by

* Former Principal Nursing Officer
Department of Health and Social Security
London

patients or staff or meet a specification based on professional judgement. Measures which show more effective nursing care in terms of improved patient recovery rates or welfare are still not available in any form which can be readily used Thus assessment of the current nursing situation or evaluation of the care given or introduction of change designed to improve a situation present difficult measurement problems This lack of criteria for assessment of nursing care is one of the major blocks in determining nursing policy in administration, education or practice.

It may be necessary to give innovations field trials as well as to test them in experimental situations. Field trials encounter much the same difficulties as the more limited experiments because of the lack of criteria for assessment.

Direct relationships between nursing care and patient recovery have not so far been demonstrated statistically. Patient satisfaction and staff satisfaction studies have produced insufficiently sensitive or consistent measures for evaluation of quality of care. They could be worth further exploration. Studies which attempt to measure the differency between intention and achievement give some information on specific activities. For example, the difference between what a doctor or sister ordered and what the patients received can be used as a measure of success. The same technique can be used citing any other source of authority. Attempts can be made to achieve a consensus of opinion instead of using the authority of the individual. It is not yet possible to answer questions as to whether a particular form of nurse education or administrative organization or of nursing practice increases the patient's chance of recovery or speeds it. At present measures such as those mentioned above can be used Nurses are beginning to examine the effects of nursing practice in relation to specific activities or types of patient. They will gradually build up fundamental knowledge. Aydelotte summarizes the characteristics appropriate for criteria for evolution of nursing care as follows:

- They should be stated in terms of results to be achieved with the patient, not in terms of actions of the nurse
- They describe the desirable conditions to be observed if care is as it should be.
- They provide the best information available to assess the present status of the patient as well as the potential for future welfare.
- They are the criteria that can be demonstrated to be the most crucial to the welfare of the particular group of patients.
- They are realistic, but they are rigorous enough to encourage continued study of the nursing process for improved methods.[1]

The literature search should have led to a specific and very precise statement of the problem to be studied, to a decision about the scientific approach and the type of project appropriate to advance the current state of knowledge. It now remains to set up the study.

2. Methods of data collection

(a) Population and sample

A population may be defined as an entire group of people (or things) belonging to the category to be studied, e.g. all student nurses in hospital, the inhabitants of a town, readers of 'Nursing Research', associations in membership with I.C.N.; members of the meetings of a local health authority.

For small scale studies it may be possible to include everyone in a population. It can however be both expensive and time-consuming to do so with large populations particularly if observation or interview data collecting methods are used. It is then customary to employ sampling techniques.

A sample is a group taken from the total population. Random sampling ensures that each member or item in the population has a known chance of being chosen. Simple random samples can be obtained by drawing names from a hat or by allocating a number to each person or item and using a table of random numbers. Each person or item has an equal chance of being drawn.

Systematic random samples. Names can be drawn from a sampling frame, e.g. a list of members of an organization, a list of hospitals in a country. The necessary sample is then obtained by taking every n-th name on the list starting from a random number not greater than the sampling interval. Care must be taken that there is not a relationship between the properties of the population, the ordering system and the sampling system as a systematic error or bias could be introduced into the sample.

Stratified random samples can be used where the distribution of characteristics it is desired to study is uneven. The population is divided into subgroups not necessarily using the same sampling interval in each subgroup, e.g. in hospital there are students, staff nurses, sisters, etc. In the stratified sample all Chief Nursing Officers may be taken but only 1:7 of staff nurses.

Two stage or multi-stage random samples. It will be appreciated that to interview or observe a random sample spread over a wide geographical area, e.g. all the women in a country, could be prohibitively expensive in time and money. It is possible to draw a random sample of geographical areas and then to sample the relevant population in the areas drawn in the first sample.

It is best to avoid using samples selected by the researcher or anyone else on a basis other than random sampling, e.g. judgement sampling or quota sampling. It is not safe to generalize from these samples to the population from which they were drawn and significance tests for the reliability of results cannot be applied whereas with random sampling the conclusion drawn from study of the sample can be applied to the population from which it was drawn and the likelihood the results were due to chance can be statistically calculated.

Sample size. Sample size depends on the degree of accuracy required in the findings, the variations expected in the population to be studied and the size of the total population.

(b) Methods of collecting data

Fundamentally there are four methods of collecting data from observation, interviewing, written material and documents.

Observation. "Observation can fairly be called the classic method of scientific enquiry. The accumulated knowledge of biologists, physicists, astronomers and other natural scientists is built upon centuries of systematic observation, much of it of the phenomena in their natural surroundings rather than in the laboratory".[2] In the social sciences observation presents difficulties in the greater risks of influencing subjects and in problems of physically being present to observe phenomena occurring particularly at infrequent intervals. Observation is invaluable in studying small communities, institutions or groups of subjects.

Observation can be participant where the observer joins the group he wishes to study, living and/or working amongst them. He may or may not declare himself. If he does certain things may be concealed from him; if he does not, resentment may be expressed when he reports his findings. Observation may be strictly non-participant with the observer recording his observations without involvement in the group. There are various intermediate possibilities.

If the activities to be observed do not take place in a geographical space which can readily be observed, observations may be made on an activity or time sampling basis or the subject to be studied may be shadowed.

Observation may cause people to alter what they do. Most observers do not use information collected during at least the first 24 hours to give people time to settle down and forget they are being watched.

Probably the greatest hazard against which the observer has to guard is unconscious interpretation of what he sees. Observers can be trained to record exactly what they see, tears running down a child's cheeks not the child crying, a nurse talking with a patient, not a nurse reassuring a patient. Alternatively they may need to interpret. For example it is possible to record no teaching of student nurses because activities undertaken jointly by trained staff and students have been recorded only as service to the patient. It is important that all observers within each project use the same definitions and rules and know whether or not they are to interpret.

Observers are liable to other errors. Familiarity with the subject under observation may lead to failure to note the obvious whilst deviations from normal are recorded thus providing a false picture of the whole. An observer may be influenced by his preconceptions.

Observation may be assisted by video tapes, photographs, microscopes, stethoscopes, monitoring equipment or any of a multitude of aids to the senses.

Interviewing. Research interviewing differs from therapeutic interviewing, selection interviewing, counselling, etc The interviewer in research is seeking information, making no judgements and making every effort to avoid influencing the responses of his subject.

Interviews may be structured with the interviewer adhering completely to the interview schedule, recording answers to precoded questions by ringing the appropriate code on the form. Some questions may be open-ended allowing the respondent to elaborate his reply or express his views. In free interviewing respondents express their views, or describe their activities untrammelled by questions, though it is usual for the researcher to predetermine certain aspects of the matter on which the respondent can be asked to comment. Free interviews are most useful when exploring a completely new field and may be used as a preliminary to drawing up a more structured schedule for subsequent use. A variety of intermediate types of interview between the completely free and the completely structured are used.

Interviewers need to be trained in their approach to people, in the use of their schedules, in the use of 'prompts' and 'probes'. Prompts aid recall and ensure comprehensiveness of an answer. Probes such as "anything else?", "why was that?" are neutrally worded aids to securing complete answers. Some factual information may need to be checked; "so that makes five of you in the house, yourself, your husband, the two children and your lodger?". With factual matters the interviewer may be allowed to repeat or explain or ask for clarification. It is probably safer to allow no deviation from the printed word with opinion questions. With knowledge questions there is always a danger of 'educating' the respondent.

Cards can be shown to the respondent and he can be asked to ring the appropriate answer from the list on the card. Tape recorders may be used to facilitate recording of free or semi-structured interviews.

"The choice between formal and informal methods depends on the character of the survey problem and the use to be made of the results. The formal approach achieves greater uniformity and this is a weighty factor when comparability between interviews is important and when the interest is in the characteristics of the aggregate more than in those of the individual Its use becomes questionable when complex phenomena are under study".[3] Informal techniques require more skill and greater awareness of the dangers of introducing personal bias.

Written responses. Written responses may be elicited in a wide range of forms. First there is the questionnaire which can be completed by subjects on-the-spot or mailed to them. As in interviews the questions may be structured and precoded or open-ended. Alternatively

respondents may be asked to write essays or keep diaries. They may be asked to complete the equivalent of an observation schedule but recording their own activities at stated intervals. The returns asked for may be in numerical form, e.g. household budgets or clinic attendances. A whole range of tests used by psychologists come into this category: intelligence tests, attitude surveys, thematic apperception tests for example.

Great care is required in drawing up any questionnaire or self-recording document to ensure that it is readily comprehensible, unambiguous and easy to complete. The response rate from mailed documents is normally lower than from interview or observation based studies. This despite prepaid and addressed envelopes for reply, reminders and careful explanations. Interviewer bias is eliminated. It remains an open question whether people are more likely to act as they say they will or as they record in writing. Where information may not be readily recalled, the opportunity to check before answering is an advantage and the same applies when considered views are wanted. Postal surveys are unsuitable where spontaneous responses are needed. Some people may answer embarrassing or personal questions more readily when they are not seeing the enquirer face to face.

Whether observation or interview or written responses are chosen for a study, a pilot run is essential to test the data collecting instrument, to note response rate and check timing. In all three forms of study respondents' right to decline to take part must be respected. Respondents are entitled to know what organization is responsible for the survey and to have a written note of the purpose of the study. At no time does the researcher promise benefit to the respondent but a feedback of findings can be promised and should be ensured.

Documentary research. This may be a research method in its own right or its use may be supplementary to other methods. Material such as census material, central or regional reports of medical officers of health, previously published studies form a useful background to data collected for a specific project. They provide checks on the generality of findings and help to judge the significance of survey results.

More important much information can be gathered from existing documents which, appropriately handled, can provide insight into trends and even causes of events. Typically historical research is of this nature. Primary data is obtained from contemporary documents, letters, articles in journals, evidence to commissions of enquiry, minutes of meetings, account books, treatment records. These show the situation as it appeared contemporaneously. Secondary data is not so valuable being obtained from writings and recordings of a date subsequent to the events.

3. Preparing data for use

For completeness a reminder of the steps necessary to make raw data yield information is appended.

Raw data before it can be used has to be organized.

Editing for completeness, accuracy and uniformity, (e.g. of interviewer's interpretation of questions) should be in progress whilst the data is being collected.

When data collection is completed any information which was not precoded must be coded. Unstructured information presents problems. It is customary to draw a 10 per cent random sample of the completed responses, classify the answers and develop codes and instruction sheets for coders. In preparing codes either for precoding or coding subsequent to data collection it is wise to use standard codes if they exist, e.g. the WHO classification of diseases.

Coding completed, processing the data can start. For small-scale surveys hand counting is practicable. Pin or Cope-Chat cards are a useful aid. The information is punched on numbered spaces round the edges of the card, a knitting needle inserted into the stock of

cards will allow the punched cards to fall out for counting Usually, however, the coded information is punched onto cards or tape for machine or computer counting

The data is made to yield information by producing frequency distributions, by calculating measures of central tendency and of spread. Cross tabulations and the calculation of correlation co-efficients indicate relationships between variables Tests of significance indicate the likelihood that correlations are due to chance

Reports on research projects are presented in narrative form illustrated by tables, charts, graphs, photographs, illustrative quotations. The findings arising directly out of the data collected are subjected to scrutiny in the light of the theories of the science used and in the light of the results of previous studies in the same field. The researcher will try by these means to understand and interpret his findings and build them into the general body of knowledge. It is at this stage that the health service practitioners will be in a position to assess the applicability of the results to the health service.

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ANNEX XIII

THE USE OF STUDIES FOR PLANNING NURSING POLICY

By

H. Marjorie Simpson*
WHO Consultant

"To drown in treacle is just as unpleasant as to drown in mud. People today are in danger of drowning in information, but because they have been taught that information is useful they are more willing to drown than they need be. If they could handle information they would not have to drown at all".[1]

Nurses need to be involved at all levels of policy-making in the health services. Their contribution will be made in accordance with their professional opinion based on their professional education and experience. Salaried nursing officers need to be employed at central, regional and local levels to work with the health service planning authorities. No one can, however, be an expert in all branches of nursing. It is worth discussing how best 'expert' nursing advice can be made readily available at the level at which it is needed, in the place where it is needed, at the time when it is needed. A panel of 'experts' whose services could be called upon for short-term advisory or demonstration work is one possibility. Advisory committees through government or professional associations is an alternative. Centres of excellence could be developed where people could go to learn about particular aspects of nursing. Resource centres could be associated with them for the collection and dissemination of written information and for the organization of short teaching programmes. People of exceptional talent are always going to be in short supply. The problem is to make their talents as widely and as effectively available as possible.

A reliable information system is an essential background for planning a nursing service. Nurses need to work out what information they need to have collected at each level in order to be able to give soundly based advice. Nursing records at the point of delivery of the service have had less attention than they deserve. Yet they are basic to the systematic provision of care. Decisions have to be taken as to what information should be extracted from these records for transmission for planning purposes to the more distant local, regional and national planning levels. Planning for personnel is dependent on adequate information about the characteristics of staff being available in suitable form at each planning level. What personal history information, what national registers are needed? Information on the volume of work and staff numbers is crucial to health care planning. Nurse planners have to determine their needs and make them known. Their needs may have to be modified in the light of what is practical and routine returns required from a service should be reviewed regularly to make sure that nothing is being asked for that is not being used and that the burden of preparing records is not pressing too heavily on practitioners.

Research should be in progress all the time in the background feeding its findings as they become available to the health service planners and practitioners. Decisions will be taken according to the best knowledge available at the time. What is important is that administrators develop skills in assessing the validity of the information they handle. When decisions have to be taken on incomplete information, they have to keep those decisions under review so that as more precise knowledge becomes available changes in practice can be introduced.

Nurses and research

It is not profitable to have amateur research carried out Planning should therefore include plans to prepare a nucleus of nurse researchers. It will always be a minority of the nursing profession, or indeed of any profession, who undertake research, but the

* Former Principal Nursing Officer
Department of Health and Social Security, London

work of that minority is most important for sound development of the service. This means provision for at least some of the profession to graduate and then, for those interested in research, to proceed to post-graduate work, abroad if necessary in the first instance. Experience with skilled teams is required before the researcher is ready to design projects and lead teams.

Nurses skilled in research are especially needed to carry out research into nursing practice. This is the area in which least help can be obtained from researchers from other disciplines Nurses themselves must identify the problems needing investigation and develop methodologies for use. Often they will choose to do multi-disciplinary studies but nurse leadership is required.

Problems in nursing education and nursing service have much in common with educational and organizational problems related to other groups. More help is therefore available from scientists from a wide range of disciplines. It is not unusual to see research into nursing start in one or other of these areas The interest of researchers from other disciplines in nursing problems is valuable, both because they contribute effectively to understanding of the problems they investigate and because working with them is excellent experience for would-be nurse researchers. These non-nurse researchers are often most generous with their time and skills and may be willing to guide nurse colleagues in carrying out studies which without help would be beyond their powers.

Many nurses take part in research as part of their normal work. For them some introduction to the techniques of research improves their performance and makes the rather dull work of data collection more interesting. Formal instruction is difficult to arrange, though introductory courses on statistical methods and survey methods may be available through the country's normal education system or it may be possible to organize courses specially for nurses.

The majority of nurses will not be involved in research but any planning of a nursing programme should include plans to make sure that every nurse can read and use research findings. Ideally this skill should be obtained during basic nursing education. If it is not, research appreciation courses can be helpful in introducing nurses to research concepts and methods. Unless this skill is developed, research will be misunderstood and findings misused.

In the early stages of development of a nursing research programme, nursing research discussion groups enable nurse researchers to meet each other, give mutual aid and encouragement and keep each other informed of work in progress. At a later stage nurses will probably wish to join scientific groups for the discussion of theories and methods.

A nursing research interest group is likely to consist of the users of research and the meetings are likely to be devoted to discussion of findings and their use. It is helpful if nurses versed in research method are prepared to be members of these groups as their guidance is needed in assessment of research reports.

If research is to contribute to the planning of nursing services, funds have to be available. Research is a costly activity. It is wasteful to allow teams to disperse at the end of a project and long-term support for research units is helpful. One of the great difficulties that research in nursing has run into is that much of the work has been done in single projects and there has been too little build-up of sequential studies, each growing out of the findings of its predecessor.

People often ask for an index or bibliography of nursing research. In global terms this is not a practical proposition. Nurses each in their own speciality need to know not only the nursing research in that speciality, but also to be aware of the work which has been done by and for other disciplines. Nurses should be so prepared that they keep, for themselves from their own reading, index cards relating to their work. Research units, reference centres or

centres of excellence where they exist can be expected to have information in greater depth.

Bibliographies are useful but many busy practitioners are daunted if they receive a list of some thirty or so references. They want to know the current state of knowledge. Sometimes it is worthwhile to commission a review of the literature and an assessment of the present position. This is skilled work. Journals such as 'Nursing Research', which provide abstracts of projects, facilitate the dissemination and use of findings.

Nurse Planners then who want to use studies for the planning of nursing policy have first to give some thought to planning for such studies to be available. This may mean planning for the preparation of a small group of nurse researchers and cultivation of friends in other disciplines who will take a continuing interest in particular aspects of nursing, investigating them themselves, and helping nurses to do so too. It will mean planning for funds on a long-term basis and developing activities to facilitate the dissemination and use of findings.

Subjects for investigation

As already pointed out, most of the early studies in nursing have to be descriptive in nature leading to classification and quantification of the phenomena studied and the identification of factors which appear to be associated with each other. Experimental work is handicapped by the absence of clear criteria for assessment of findings.

Small-scale work is undoubtedly useful if well executed. It usually relates to a question seen as a problem by the people being studied. It can be carried through reasonably quickly and the results can be fedback for use immediately. It is not safe to generalize the findings beyond the population studied. Many promising starts in nursing research have come to grief because projects were too massive for the resources available. From the planner's point of view, large scale studies from which it is possible to generalize to the total nursing population are the projects of choice. If they are commissioned, skilled research workers must be employed accustomed to handling large-scale work and they must be given massive resources.

Nursing manpower for example is a complex subject. Recruitment, selection, training and attrition of personnel determine the work force available. Career patterns, deployment of staff, division of labour, centralization of services, automation, equipment, buildings and transport all affect the use of the work force available. Over against this must be set the wide range of services to be provided depending on such factors as the population served, the nature of the diseases prevailing, the terrain and the existing state of medical and nursing knowledge. It is clear that there is going to be no quick answer to the question 'how many nurses are needed?'.

Yet studies can contribute to our understanding of the various factors affecting the situation. It is worthwhile to know what staff are doing as a basis for deciding what they should be doing. It is useful in planning recruitment to know the characteristics of the population from which the recruits must be drawn. It may be helpful to know what public opinion is of nursing as a career or to get opinions from potential recruits. Career patterns can be studied retrospectively to see how careers have developed in the existing work force or prospectively by enquiring about peoples' aspirations and expectations. In this way information can be built up about the various aspects of the central question. In the end, however, it will be a policy decision how many nurses to employ or to seek to employ.

Fundamentally, however, what nurses should be studying is nursing. The development of a reliable nursing record system is an important tool of research as well as of practice. In the health maintenance or health attainment stage how effective are the teaching methods used? Are the hygiene and nutrition being taught up to date and influenced by recent research?

In the increased risk stage, what proportion of the people at risk are innoculated or vaccinated? Does the occupational health nurse use her records to detect hazards of the work or accident-prone individuals? How does the public health nurse use her records to detect vulnerable groups?

In the early detection stage much of the responsibility will fall on the midwife, the public health nurse and the home nurse. Have they developed and tested systems of surveillance? How do they help people to accept the need for treatment of symptoms which are not disabling?

In the clinical stage the whole range of nursing activities needs examination for effectiveness. Nursing equipment has been subjected to far too little research. Communication skills are not well developed.

The rehabilitation stage involves studies of ways to work with individuals and families to help them to cope with residual disabilities. There are services which may have to be provided by the community if handicapped individuals are to remain at home. The problems of the handicapped need detailed study and means of alleviating them have to be tested experimentally. Institutional care of the handicapped presents particular problems in personal relationships. Immense research effort is needed before nurses know how to "assist patients in those activities that contribute to a peaceful death".

The use of studies in the assessment of nursing care and nursing service requires great care and logical thinking

It is possible to establish norms by study of existing practice. These, however, are norms based on averages which even if weighted to take account of factors proven to affect the situation still say nothing about omissions or superfluous activities. There is value in knowing norms of patient satisfaction for different aspects of care or norms for nursing hours available per patient per day.

These norms can be supplemented by professional judgement as in dependency studies where the nurse in charge of a ward may be asked to make explicit the care she judges each patient needs. Time values can be assigned on the basis of observation to the various categories of care to arrive at a measure of workload. Or professional judgement may be used to determine which tasks should be carried out by each grade of staff.

What we do know is that professional judgement varies widely. So the search goes on for indicators of effectiveness of care in terms of benefit to patients. Studies fall into four main groups: attempts to arrive at expert opinion or a consensus of opinion, case studies, task studies and consumer satisfaction studies.

It is not comfortable to work in a state of uncertainty questioning traditional ways and trying out new methods. In a research-minded profession the mind is always questioning, the senses are alert for sequences in events which may suggest causal relationship; records are not only kept, they are used. The profession is aware of aspects of nursing practice which need investigation and is prepared to act on proven conclusions. Brotherston pointed out that "for most of us it is probably much easier to work round the clock in the routine of patient care than it is to sit in front of a writing pad, for a couple of hours, to work out alternative methods of dealing with our problems and procedures. A tendency to roll quietly down the well-worn track of routine exists in all professions".[2] The growth of research-mindedness in the profession and the development of research facilities to study nursing problems means not an easier way of life, but a more exciting one with the goal of achieving a better service and of being able to recognize it when we achieve it.

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ANNEX XIV

* EVALUATION AS A BASIS FOR FORWARD PLANNING

By

Joan Cobin, R.N., Ph.D.

The topic for today's workshop session is Evaluation. As on previous days this will be a brief presentation of some information on the topic. The application of this information to the work you are doing in your small groups will be the most important task of the day.

Evaluation is the process of determining whether what one set out to do was actually accomplished and how well. The purpose of making this determination is to decide if one should continue doing as one is doing or if a change is indicated. The continuous evaluation of nursing practice is essential so that we as professionals will know if we are meeting the nursing needs of our own society. A brief review of systems theory will help to more clearly demonstrate the relationship between societal needs and the evaluation process.

A system is any process that has inter-relating parts which influence one another. The solar system is an example. The planets all exert influence upon one another as they revolve in their prescribed orbit around the sun. A change in the orbit of any one of the planets would effect the pattern of all the others. A system then is a set of parts that interrelate for a purpose. It is never linear, there is no beginning and no end. Envision society as a large circle with a number of overlapping smaller circles contained within it. The large circle (society) can be thought of as a super system with a variety of subsystems represented by the smaller circles. The subsystems only exist to meet specific needs of the society. The purpose for each system, it can be assumed, is derived from the super system. For example there would be no need for a health care delivery system if there were no health care concerns in the society. The systems contained within a given society can be identified as education, government, industry, religion or health, to name a few.

We, as a health care profession, exist only to serve society. This is a point that must be made crystal clear. The health care professions do not exist to serve the persons in the profession but rather to meet societal health care needs. If we do not identify and cope with these needs we will cease to exist or be incorporated into another subsystem. Taking a closer look at the smaller circle within the super system that is identified as the nursing system we note several essential elements. These elements are input, output, and feedback. The input is the resources of the super system, people, fiscal and environmental as well as the ideas and beliefs of the persons in the society. The output is the product of the system. In education, it is the graduate. With nursing it is patient care delivery and health maintenance in the acute and ambulatory care settings. Feedback is the remaining element. It is the message the super system gives back to the system that indicates whether or not the product is appropriate to the need. If, upon examination, the product of your nursing system is not useful to the consumer then the system must be modified. Recall that evaluation is defined as the process of systematically determining whether we have, in truth, accomplished what we set out to do and how well. The feedback mechanisms in systems theory provide us with a conceptualization of evaluation.

Evaluation as a process provides essential feedback to the system when the following steps are sequentially adhered to.

1. Determine the objectives of the system. What is the goal? What is to be accomplished?

2. Develop criteria. How well must the practitioner perform? How many do we need? What will be the outcome of having that many practitioners performing that well?

* A summary of a taped presentation given with the use of overhead projector transparencies

3. Select or construct measuring devices. What are the real indicators of the desired behaviours? How do we know one when we see one? What is the best method of measurement?

4. Apply measurement devices to product.

5. Analyze and interpret data collected from measurement against criteria.

6. Modify system as evaluation indicates.

A diagrammatic schema of this process is attached to allow you to visualize the sequence of events.

Evaluation is a value judgement based on predetermined criteria regarding the outcome of any measurement. It is a value judgement because the criteria are developed by persons. The persons are professionals who having looked at societal needs, as well as the resources available, made a determination of an acceptable performance level. You are all struggling with designing a nursing study. I hope that by now you are beginning to realize you must plan your evaluation strategies as you plan your studies. Each of you has a totally different set of societal expectations to work from. You must make your own value judgement as to what is acceptable when your data are collected. Your analysis can only be meaningful within the society or culture studied.

I want to say a few words with respect to measurement versus evaluation. Measurement is the process of using a test, scale, or instrument to obtain a relatively objective and quantified indication of a person's standing on a characteristic represented by the measurement device employed.

- Measurement data may be ordered and ranked along a scale from high to low
- The range of scores affords a basis for measuring achievement relative to the past performance of the individual learner or the performance of all or group of learners measured previously by that device.

Evaluation is a judgement or interpretation of the data obtained from the tools of measurement relative to the previously declared specific learning objectives.

A measurement instrument is designed so that when administered to an individual a numerical score can be obtained. Should you give a 100 item test to a group of persons each person would achieve a score. You can say this person got so many right or so many wrong answers. The scores can be ordered to give us a range of scores. The evaluation occurs when you say all persons who achieved a score of more than 60 are successful. The number sixty was presumably determined from a set of criteria. If it turns out that no persons achieved above sixty the evaluator would begin examining the system. Was the lack of success due to the characteristics of the learners? The quality of instruction? or is the measuring instrument ineffectual? With modification the system is then tried again. It is a never ending process.

The subject of measurement is the topic for tomorrow so we will not pursue it further here; however, I hope that you are able to separate evaluation from measurement.

In summary, evaluation must be an integral part of planning. Evaluation can only be meaningful when an outcome is measured against pre-determined objectives and criteria. You began this Seminar by identifying problem areas of nursing that need to be studied. Today we will begin the design of the evaluation process along with your study plan as you learn to write specific objectives. Tomorrow our subject will be data collecting and your group will mo into selecting measuring instruments. We are working at a rapid rate. Our goal is not to have you design a perfect study but rather to have the experience of working through the process in a structured environment that consists of other learners and facilitators of learning. I wish you well in your endeavours.

ANNEX XV

EVALUATION OF THE SEMINAR

The most essential element of the workshop format is the group process. The preparatory work resulted in good achievement, moving the participants from a gathering of individuals to six cohesive working groups. The group process itself - becoming acquainted, developing common or shared goals, identifying the type of leadership, becoming cohesive and then separation - was present and each group was given feedback and guidance each day as the process developed.

The Seminar was evaluated by collecting data on the way the participants changed as the Seminar progressed

The most desired behaviour was the development in each participant of an attitude that the systematic or scientific approach to studying nursing issues was useful.

The second behaviour desired was that the participants would work together within a workshop format.

Methods of Measurement used for Evaluation

The planning group determined that measures of these two behaviours would include:

1. Daily reaction. Papers written by each participant.

2. Daily recoding of each participant's involvement by the moderators on a checklist of possible behaviour of individuals in a group setting. The checklist included a rating scale of 1-5 for most behaviours. Each item on the checklist was discussed by the moderator group to achieve, as much as possible, a common definition for all items (appended at and on evaluation).

Analysis of Data

The planning group decided to analyze data for evidence that there was a trend for all participants to acquire the two behaviours identified above by looking at change in (i) individual behaviour, (ii) group behaviour and (iii) total participant behaviour.

The daily reaction papers were read each day for evidence of the two behaviours being measured, attitude regarding systematic methodology and the workshop format. A summary of the data from reading the papers of all participants was reported to the plenary session each morning.

A thorough review of a random selection of every Reaction Paper written by fifteen participants (about 25 per cent) showed that in general the desired behaviours were attained. A general trend of early enthusiasm but confusion levelled to satisfaction and enjoyment of working in a group, with feelings of concern for each others' work and ideas, and genuine support of workshop content and methodology.

The planning group concluded that the data obtained from Daily Reaction Papers supported the belief that the Seminar goal had been attained.

Moderator checklist data were reviewed for the three categories of behaviour that were indicated as characteristics of group work. The data were analyzed to identify positive changes in group behaviour.

The moderators as a group reported that the use of the daily checklist, which required specific observation of each participant, assisted them to become more effective group facilitators.

The checklist as an instrument for measuring change in the three categories has not been tested as being valid. Therefore, though a vast quantity of data was available, it was determined to use the sums of each category for each group only to indicate trends.

Changes in each group for each category occurred as indicated in Table I. The numerical score indicated for each group for each category on the first and the last day of the Seminar represents the sum of each of the scales in that category.

The analysis of data as indicated in Table I was interpreted to mean that the positive trend, (e.g. increased total score for every group in every category) indicates the two desired behaviours for the participants most likely achieved.

The final recommendations were unequivocably interpreted as being a positive measure of the behaviours regarding attitude towards the systematic approach to studying nursing problems and the willingness to accept and be involved in the workshop format.

One other measure of success for the attainment of the goals of the Seminar will be a follow-up enquiry to all participants within six months of the Seminar. The results of that enquiry will not be included in this report as it will delay distribution. An addendum will, however, be forthcoming when the material has been collected and analyzed.

TABLE I

Possible Score

Group		Score (sum of scales in each category)	First day	Last day	Change
I	NV	20	131	154	23
	V	25	131	139	8
	P	15	89	95	6
II	NV		120	165	45
	V		80	134	54
	P		54	102	48
III	NV		111	143	32
	V		100	104	4
	P		76	98	22
IV	NV		123	152	29
	V		142	152	10
	P		95	116	21
V	NV		113	120	7
	V		88	114	26
	P		82	86	4
VI	NV		121	144	23
	V		130	166	36
	P		86	97	11

NV = Non-verbal V = Verbal P =Productivity

DAILY RATING SCALE FOR MODERATORS TO EVALUATE PARTICIPANT LEARNING

Participant name: ____________________

Moderator name: ____________________

Non-verbal behaviour

1. Promptness: yes _____ No _____
2. Seating position in ___ ___ ___ ___ ___ out (5 4 3 2 1)
3. Posture interest ___ ___ ___ ___ ___ **apathy** (5 4 3 2 1)
4. Facial expression excitement ___ ___ ___ ___ ___ apathy (5 4 3 2 1)

Verbal

1. Quantity (frequency) . high ___ ___ ___ ___ ___ low (5 4 3 2 1)
2. Quality
   to the point: high ___ ___ ___ ___ ___ low (5 4 3 2 1)
   own agenda: high ___ ___ ___ ___ ___ low (5 4 3 2 1)
3. Innovative: high ___ ___ ___ ___ ___ low (5 4 3 2 1)
4. Facilitative. high ___ ___ ___ ___ ___ low (5 4 3 2 1)

Productivity

1. Seeks clarifications: often ___ ___ ___ ___ ___ seldom (5 4 3 2 1)
2. Time needed to settle into task: quick ___ ___ ___ ___ ___ slow (5 4 3 2 1)
3. Product completed in time allotted: Yes _____ No _____

Measurement criteria. Positive high score = enthusiasm and/or movement towards Seminar goal.

ANNEX XVI

SELECTED SUMMARIES OF GROUP WORK

I EDUCATIONAL PROBLEMS

1. Need for planning

Problems in Nursing identified through "brain storming"

Recruiting students
Shortage qualified teachers
Recruitment interested teachers
Lack clinical facilities for students
Shortage of beds
Shortage clinical instructors
Choosing right person for right position
Language problems in educational media supplied (films, film strips, etc., books)
Clinical supervision
Lack qualified role model in clinical area
Poor example in clinical area
Lack local training institutions
Evaluation nursing curricula
Curricula setting according to needs of country (urban - rural - total health needs)
Varying curricula in different schools same country
Job description, task analysis as basis for educational programmes
Licensing examinations for nurses and midwives - high failure
Student wastage
Student utilization for nursing care (beyond educational ability)

2. Systematic approach to problems

The problems could be grouped into those involving students, those concerning teachers, curricula and teaching materials and clinical facilities.

The sub-groups chose student recruitment, shortage of teachers and licensing examinations as their main topics.

The problem of shortage of teachers was stated in the form "Evaluation of the effect of student: teacher, ratio on student performance".

The outcome "student performance" had to be defined. It was decided that this aspect had too many variables, and the problem was finally stated as "Evaluation of the effect of teacher. student rates on the students' understanding of the principles involved in performing nursing care activities".

3. Methods of data collection

The ratio of teaching staff to students varied in the different schools.

(a) A survey would be made of student teacher ratios.

(b) In each hospital a random sample of student and recent graduates would be taken.

(c) They would be given a verbal interview on the nursing principles involved in the procedure they were performing (by a qualified nurse teacher not involved in any of the programmes)

(d) The performance of the activity would be evaluated (students and graduates would not know that they were being watched or would be interviewed).

Predetermined criteria for performance and knowledge would be set.

The results would be tabulated and would indicate whether there were any significant differences in performance and/or understanding of principles due to:

(a) number of qualified teachers

(b) total number of teachers

(c) number of clinical instructors.

4. Planning for change

These results would be useful in providing a realistic basis for planning the numbers of teachers required in the various categories. The existing distribution might need changing.

II MANPOWER PLANNING

1. Need for planning

Problems in nursing identified through "brain storming":

Shortage of recruitments
Reluctance to enter nursing
Shortage in rural areas
Shortage on night duty
Loss of married women
Male nurse utilization
Unqualified staff
Village workers
Auxiliary staff
Difficulties in posting
Wastage of students
Wastage of trained staff
Working conditions
Salaries
Poor image of nurse
Wrong image of nurse

2. Systematic approach to problems

These ideas divided into three main areas.

(a) Recruitment - students and staff

(b) Drop-outs - education and service

(c) Allocation by area and time

A sub-group chose as their subject "The opinion of nurses about their profession". This was clarified into why nurses chose and remained in nursing. Search of literature showed that studies of this nature usually gave idealistic and often unrealistic reasons for becoming nurses, and that conditions of work were the strongest influence on whether nurses remained in the profession and where they worked. Thus a clear understanding of the variations in nursing working conditions in one country should be done.

3. Methods of data collection

Graduate nurses, both diploma and degree nurses, were to be studied.

They worked in private and government organizations, in rural and urban areas in curative and preventive fields.

They would be divided into three categories.

(a) New graduates 0 - 3 years experience

(b) Graduates 4 - 10 years experience

(c) Graduates over 10 years experience.

Data to be collected would be on.

(a) Type of job opportunities

(b) Working conditions

(c) Interpersonal relationship

(d) Relationship with the community

(e) Chances of promotion

(f) Opportunities for professional advancement

(g) Fringe benefits.

Working conditions would involve.

(i) Salary

(ii) Hours of work

(iii) Holidays and leave

(iv) Transport

(v) Physical facilities of all work

(vi) Social and physical environment

Factors affecting salary.

(a) Education - basic and post-basic

(b) Years of service

(c) Position

(d) Yearly increments

(e) Leave with or without pay

(f) Bonus

(g) Overtime

(h) Shift work

(i) Deductions from salary - Tax, pension, health insurance

Questionnaires of the single answer type were to be used. These would be pre-tested before circulating to nurses. They would be sent out through:

Hospital Administrations

Health Centres

Private Agencies

Ministry of Health

Coding, tabulation and analysis would need more thought and work than was available during the workshop and would also require the advice of a statistician. There would also be a need to establish comparative criteria for progression with similar requirements and responsibilities.

4. Planning for change

It was anticipated that the results would indicate which type of service and which factors attracted and retained nursing personnel in this country. These results could influence recruitment campaigns, types and location of nursing schools to be developed and, hopefully, future policies regarding employment of nurses.

This group felt that good nursing care can only be given by nurses who are satisfied in their profession. This involves more than salary, important as that is. Job satisfaction is equally, if not more important, and working conditions which are congenial play a major part

III NURSE UTILIZATION

1. Need for planning

Problems in nursing identified through "brain storming":

Better use of nursing services and time
Improvement in patient care
Job satisfaction
Job description
Communication patient/nurse - nurse/administration
Recruitment
Identifying needs for rural areas
Identifying needs for urban areas
Areas for integration of services
Avoid duplication of care
Avoid omissions of needed care
Realization of equipment for procedures
Responsibility for supervision
Public's attitude to nurses
Too junior nurse giving complex care
Highly qualified nurses giving elementary care
Use of nurses for non-nursing duties
Use of nurses for duties not related to health care
Retirement
Working hours
Basic training - Curriculum planning

2. Systematic approach to problems

The group decided that it was necessary to establish present performances of nurses before planning for future. Sub-groups chose:

(a) Public Health Nursing

(b) Hospital Nursing

(c) Multi-purpose nurse

The group decided to use as meaning of Nurse Utilization the following:

"To be able to use the nurse to the best advantage in the given time by having good organization, administration and facilities, having proper communication between nursing staff, medical and paramedical staff".

The public health nursing group then established the criteria for ideal activities which should be rendered by the public health nurse under the following headings:

(a) Pre-natal care

(b) Post-natal care

(c) Child care in well-baby clinic

(d) Health education in class

(e) Home visits

(f) Preventive clinics (immunization)

(g) Family planning

(h) Reporting and recording of activities

3. Methods of data collection

The next need was to construct or select measurement tools and methods of study. These were

(a) Interviewing nurses

(b) Interviewing patients

(c) Questionnaire to nurses

(d) Questionnaire to clients

(e) Studying reports

(f) Listing actual work done by nurses

(g) Observation of public health nurse

(h) Study community services given by health centre

The data were to be tabulated or coded to show:

(a) Time on home visits

(b) Time spent in various clinic activities

(c) Time spent on professional duties in various activities

(d) Time spent on non-professional duties

(e) Time spent on recording, reporting

(f) Time spent on administration

(g) Time spent on patient-centred activities

(h) Time spent on unit-centred activities

The group realized that there was need to define criteria for ideal activities and to determine which were professional and which non-professional duties, which of the recording was a nursing responsibility and which could be done by non-nursing personnel, etc.

4. Planning for change

Once the duties, time and activities had been studied the group felt that meaningful job descriptions could be drawn up, allocation of correct number and level of staff decided. This would give greater job satisfaction and the improved work would contribute to better health care.