

The ICN Leadership For Change™ Programme – 20 years of growing influence

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Aim: The aim of this article was to present experiences from the field in the context of the International Council of Nurses' Leadership for Change™ programme, which celebrates 20 years of excellence in 2016 for developing the leadership and management capacity of nurses worldwide.

Background: The programme was launched in 1996 in order to boost nurse participation in the healthcare policy-making process, globally, and to foster within the nursing profession the requisite skills for nurses to lobby for and assume a greater responsibility in the leadership and management of health care services.

Introduction: Over the course of two decades, the programme has been implemented in cooperation between ICN, national nurses associations, the World Health Organization, Ministries of Health and a variety of donor organizations such as the W.K. Kellogg Foundation and development agencies such as USAID and AUSAID. The programme has been implemented in more than 60 nations throughout Africa, Asia, Europe, the Middle East, Latin America and the Pacific Islands, to name a few regions.

Methods: This article offers an overview of the impact that certified ICN LFC nurse trainers and their colleagues have had in the United Arab Emirates, Vietnam and the United States of America and is

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affiliated islands and the North Pacific Islands.

Results: Twenty years of growth and empowerment are now the ongoing legacy of the ICN LFC Program, which has graduated and deployed nurse trainers around the world and achieved significant advances in the professional development of nurse leaders on an international scale.

Implications for nursing and health policy: Nurse leaders can improve the health and well-being of their nations in collaboration with consumers and other key stakeholders. Nurse leaders are critical in improving health systems, their work places and broader societal challenges through sound nursing practice, education, research and evidence-based health and social policy change.

Keywords: Developing Countries, Health Policy, Health Systems Reform, International Collaboration/Cooperation, International Issues, Nursing, Nursing Capacity Building, Nursing Leadership, Policy, Social Policy, Staff Development, Workforce Issues, World Health Organization

The International Council of Nurses (ICN) has been responding for many years to needs identified by member associations to change and improve the way nurses are prepared for management and leadership. Between 1985 and 1990, the ICN focused on the needs of nurse managers and developed an ICN Position statement, publications and Congress presentations.

During the years of 1990–1995, further resource materials were developed in the context of strengthening nurse leaders' and managers' knowledge and skills during a period of rapid change with health reform occurring in many parts of the world. The relevance of health sector reform to nursing was significant then and continues to be today in many nations.

The ICN Leadership for Change (LFC) programme™ was launched in 1996 as a project to strengthen leadership skills among nurses and broaden the positive impact of nursing on health systems and the wider societies they are responsible for. This was to be achieved by imparting new skills and knowledge to enable participants to manage and implement appropriate and proactive leadership strategies. Sally Shaw, then former Director of Nursing with the New Zealand Department of Health took on the challenge as coordinator of the ICN LFC project. She developed the initial resource modules and launched what has today become a 20-year endeavour to bring the experience and skills of nurses to effectively drive evidenced-based policy-making worldwide.

Thanks to generous funding from the W.K. Kellogg Foundation; Phase 1 LFC was initiated and implemented for selected countries in the Caribbean, Latin America, the South Pacific, and East, Central and Southern Africa. Examples of these countries included the following in the Caribbean: Bahamas, Barbados, Jamaica, St. Lucia, and Trinidad and Tobago. Nations in Latin American included: Argentina, Brazil, Chile, Colombia and Mexico. The South Pacific group (1997–1999) included the following countries: Cook Islands, Fiji, Kiribati, Samoa and

Tonga. In East, Central and Southern Africa between the years of 1998 and 2001, LFC was implemented in the following 14 countries: Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. LFC was then initiated in Singapore in 1999. The Singapore programme was the only country-level programme during the 1996–2000 period – all other programmes were regional.

From 1998 to 2000, a Phase 2 of the Caribbean and Latin America programme was initiated. This extended the LFC project to an additional 16 countries in the Caribbean and Latin America. The expanded 16 countries in the Caribbean and Latin America included: the British Virgin Islands, Grenada, Guyana, Bolivia, Costa Rica, Dominican Republic, Ecuador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Salvador and Venezuela.

Phase 1 was put into motion with four strategic goals for nurses and the nursing profession at its core:

- Participate in policy development and decisions during health reform and beyond;
- Be effective leaders and managers in nursing and health services;
- Help prepare future nurse managers and leaders for positions of influence in changing health services; and
- Influence changes in nursing curricula, so future nurses are prepared appropriately.

These goals have structured and animated the evolution of all programmes within the increasingly broad LFC initiative.

LFC Phase 2 ushered in three additional core goals:

- Provide for the continued development of current participants to help ensure sustainability;
- Provide a programme that takes account of the needs of participating countries and their stages of overall development and economic change;
- Provide a regional focus for networking, and for nursing and professional association leadership development, not just country-level activities and projects.

Following half a decade of LFC progress, an evaluation of the Leadership for Change programme focusing on the impact and sustainability of outcomes was carried out under the direction of James Buchan, PhD, DPM and funded by the W.K. Kellogg Foundation (ICN 2002). Results noted that the programme was in high demand, but that obtaining funding was often problematic. Another difficulty was reaching enough people in a country to help ensure maximum impact and ongoing sustainability. In some instances, ownership of the programme and product by local stakeholders was not seen as a priority.

Lessons learned from this evaluation were integrated into future planning. ICN addressed the three key issues – cost, local ownership and support, and critical mass – by introducing the ICN LFC Training of Trainers (TOT) initiative in 2002. Dr. Stephanie Ferguson was brought onboard as a consultant to help Sally Shaw design the TOT initiative and materials.

The purpose of the ICN LFC TOT initiative was to improve the implementation of the Leadership for Change programme by placing the responsibility for leadership training directly in the hands of the stakeholder organizations. ICN retained ownership of the LFC copyright and intellectual property under licensing agreements with NNAs and health sector organizations.

The TOT initiative allowed the Leadership For Change™ programme to reach more people and have a greater impact at organizational and country levels. The interaction of familiar peers and colleagues in the LFC training process boosted confidence and solidarity among both trainers and trainees. This positive outcome in turn stimulated greater “buy-in” in countries from key stakeholders, enhancing the likelihood of sustainable outcomes.

The TOT approach led to selected trainees in turn becoming trainers, thus providing a further opportunity for their own continued development, as well as seeding the organization with an occupational commitment to fostering leadership within their own ranks, and a broader impetus by nurses to bring about changes in educational curricula based on their experience with LFC. Similar to the Phase 1 and 2 programme graduates, ICN LFC TOT graduates qualify for International Continuing Nursing Education Credits (ICNECs).

Finally, by allowing countries to develop the capacity to run their own programmes using a tested methodology, as well as by implementing networks for distance-based education, TOT reduced the cost of LFC implementation.

Between 2001 and 2013, the ICN LFC programme expanded significantly in accordance with growing global demand from nursing associations. LFC was rolled out in the

Western Pacific Region of the World Health Organization (WHO WPRO) in Mongolia, Vietnam, Papua New Guinea and China. Other national nurses associations in the WHO WPRO began such as Hong Kong with representatives from Macau. In the Eastern Mediterranean Region of the World Health Organization (WHO EMRO), ICN LFC programmes were implemented in United Arab Emirates, Yemen, Saudi Arabia, Jordan, Bahrain, Syria, Qatar and Iraq. In South East Asia Region of the World Health Organization (WHO SEARO), programmes were successfully implemented in Bangladesh and Nepal. In addition, partnerships with National Nursing Associations (NNAs) and national Ministries of Health have led to LFC being implemented in South Africa, Thailand and Portugal.

From project to programme

In 2003, the ICN LFC evolved from a project to a programme and Sally Shaw handed over the responsibilities of project coordinator for the ICN LFC she pioneered and made globally successful to Dr. Stephanie Ferguson, Programme Director. During the Ferguson years, the ICN LFC programme was trademarked and copyrighted worldwide and the ICN LFC programme and the ICN LFC TOT programs were extended to new regions of the world in partnership with the World Health Organization Regional Nurse Advisors and Allied Health Advisors. This included the Western Pacific Region with LFC programs implemented in Vietnam, Mongolia and China and the Eastern Mediterranean Region with the implementation of the ICN LFC programme in the United Arab Emirates (UAE), Saudi Arabia, Yemen, Jordan and Bahrain. ICN efforts intensified in the Pan American Health Organization (PAHO) and Africa region with the expansion of LFC in the original LFC project countries sponsored by W.K.Kellogg through the TOT initiative. The LFC programme was further strengthened by developing the mechanisms in the ICN LFC and TOT programs with licensing agreements and continuing education credits through ICN's International Continuing Nursing Education Credits (ICNECs).

Sally Shaw remained active as the ICN LFC faculty leader through WHO sponsored programmes in Nepal and Bangladesh. During her time working in Nepal and Bangladesh, Sally wrote a book, “Nursing Leadership”, highlighting the successes of the ICN LFC project from 1996 to 2000, sponsored by ICN and published by Blackwell Publishing in 2007 (Shaw 2007). Her book proved to be an apt afterword to a successful career dedicated to achieving greater involvement for nurses in global health policy decision-making, and a greater recognition of the invaluable contribution of nurses and nursing to healthy and prosperous lives, communities and societies.

Expanding the LFC vision

In 2006, ICN undertook an expansion of the original Vision of the ICN LFC programme. The original LFC project vision read:

Nursing in the 21st Century will have selected nurses at a country and organizational level equipped with the knowledge, strategies and strength to lead and manage in health services and in nursing through change and into a healthier future for all populations.

The expanded 2006 vision statement was intended to reflect a need for stronger focus on nursing involvement in health policy. New challenges to health care and populations globally required that nurses have policy influence and political skills to make sustainable change in health systems, nursing services and the communities and societies they care for. Thus the revised 2006 vision statement reads as follows:

The 21st century nurses will have the knowledge, strategies and ability to lead and manage in changing nursing and health services, and to influence health policy towards healthier futures for all populations.

This expanded vision boldly called on nurses and nursing to assert their leading role in health care and health policy.

By 2007, over 60 nations were implementing the ICN LFC programme. The ICN LFC programme had proven itself to be globally adaptable to the needs of health systems while retaining its basic methodology. Societies saw a marked increase in nurse leaders' influence and in their ability to build sustainable partnerships and develop new models of nursing care to improve the quality of patient care. This was particularly evident in maternal and child health, primary and community health, and elder care.

In 2012, Dr. Ferguson did a survey to determine the way forward with the ICN LFC programme, particularly in the context of revised resource materials needed and platforms and venues for delivery in the 21st century (Ferguson 2012). Results found that there is a need for scaling up nursing leadership and management capacity at the national, regional and global levels and in all health sectors and settings including regulation and academia.

LFC continues to be needed with the changing demographics of society, increase in non-communicable and infectious diseases worldwide, increased public expectations of nation's citizens, restrictions in economic resources and continued health reform or health system redesign. Nurses are an important part of the solution to many problems that governments face today. Many health systems have been reformed but not designed to secure quality and safeguard health care. Some global health systems are not promoting access to flexible and local services. These worldwide trends in health

system change and need for re-design will increase the opportunity for innovative and cost-effective nurse-led solutions in a variety of health sectors and academia.

Dr. Ferguson also learned that there is a need for a faster mode of delivery for the ICN LFC programme using a hybrid/blended methodology. ICN had historically done all of the LFC programs using paper-based resources, PowerPoints and on-site delivery with four workshops ranging from 5 to 8 days depending on country programme plans. The programme usually lasts from 18 to 24 months. ICN also had an ICN Leadership for Change Network but it was not using social networking technology to easily communicate best practices and lessons learned between ICN conferences and congresses. ICN capitalized on the knowledge gained from the survey and created the new web portal and social media platforms necessary for LFC participants and outcomes of the team projects to be shared by using technology. The new website can be found at leadership.icn.ch.

ICN's national ICN LFC coordinators and participants asked for less workshops and more innovative methods for transmitting knowledge using technology. They also asked for new topics such as information and skills development in health information technology and new topics about organizing frameworks and systems thinking, as well as more information on policy development and evidence-based practice. ICN redesigned the LFC programme as two workshops, with a 3-day Monitoring and Evaluation meeting and a 3-day TOT, if countries are interested.

As a result of the online survey conducted by Dr. Ferguson, the Vision of LFC was revised in 2013 with an updated mission and strategic goals as outlined below:

Vision (Revised in 2013)

The 21st century nurses will have the knowledge, strategies and ability to lead and manage in complex and dynamic nursing and health service arenas so as to influence the development of the profession and the advancement of health and social policies towards healthier futures for all populations.

Mission

To assist in preparing nurses for management and leadership during health sector change and reform, and enhance their contribution to health services.

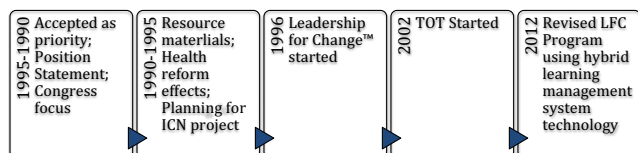
Key strategic goals (Revised in 2013)

Supports nurses to:

- Engage in the development of health and social policy;
- Be effective and dynamic leaders and managers;

- Align the contribution of the profession in socioeconomic, professional and regulatory developments;
- Maintain and advance their own competence and to identify, develop and support future generations of leaders.

Key milestones in the ICN focus on nursing management and leadership



Implications for nursing and health policy

As ICN moves forward now, 20 years later, ICN LFC graduates are now working around the globe improving life in their varied environments. As Ferguson (2008) noted, in Nepal, Bangladesh, Myanmar and Nicaragua, LFC graduates reduced maternal mortality and hospital infections. In Barbados, Guyana, Kenya, Zimbabwe, Mauritius, St. Lucia, Trinidad and Tobago, and Yemen, they implemented new quality improvement programmes in the hospitals they work in. LFC graduates established training programmes in HIV and AIDS, TB and malaria in Kenya, Uganda, Papa New Guinea and Tanzania, and created new human resources development strategies in Barbados, Botswana, China, Guyana, Suriname, Jordan, Kenya, Tanzania, Malawi, Mauritius, Saudi Arabia, Seychelles and the United Arab Emirates.

Nurse leaders have developed a model to improve home-based care and build partnerships between nurses and communities in Lesotho, and tools to strengthen the leadership skills of senior nurses working in public health settings in Malawi. In Mozambique, LFC-trained nurses established a national nursing council, and in Tanzania, LFC-trained nurses finalized the national nursing guidelines, of which the maternal and child health guidelines were adopted as a model by the WHO in the Africa regional office in their work with nations throughout the continent to decrease maternal and infant mortality.

ICN knows anecdotally that ICN LFC™ graduates are less likely to emigrate. This suggests that the programme is an effective strategy and incentive to encourage nurses to stay in their home country and in the workforce. This is tremendously important for health systems throughout the developing world striving to improve nurse retention. This is

particularly important now as the World Health Organization focuses on determining a new Global Strategy for Human Resources for Health 2030 (http://www.who.int/workforcealliance/media/news/2014/consultation_globstrat_hrh/en/) and a future strategic direction for nursing and midwifery 2016–2020 (http://www.who.int/hrh/news/2015/midwifery_nurse_agenda/en/).

In celebration of the 20 years of excellence the ICN LFC programme has achieved, three countries will be highlighted to show some level of impact since their implementation of the programme and the TOT initiative. These countries are the United Arab Emirates, Vietnam and the USA/North Pacific islands.

LFC roll out and outcomes in the United Arab Emirates

Established in 1971, the United Arab Emirates (UAE) is a federation of seven emirates, Abu Dhabi (the capital), Ajman, Dubai, Fujairah, Ras a-Khaimah, Sharjah and Umm al-Quwain. The UAE occupies an area of 83,600 km², or roughly the size of Portugal, and, according to a 2013 census, has a total population of 9.2 million, of which 1.4 million are Emirati citizens and 7.8 million are expatriates. The UAE shares land borders with Saudi Arabia and Oman and sea borders with Iran and Qatar. The country has contrasting landscapes of desert, dunes, oases and mountains. All seven emirates share an Islamic and Arabic heritage. Health expenditures represent 3.2% of the UAE’s GDP.

Healthcare system

The country has developed a comprehensive healthcare system within a short period of time. There are 70 hospitals, 15 of which are federal institutions, and more than 150 primary healthcare centres and clinics. Eleven university health centres, 10 centres for mothers and children, and 110 special units for mothers and children in hospitals and primary healthcare centres round out the healthcare infrastructure. In addition, Dubai is home to two healthcare-free zones, Dubai Healthcare City and Dubai Biotechnology and Research Park (United Arab Emirates 2013). The workforce in most of these institutions is comprised of a core of UAE nationals and well-trained professionals from many parts of the world with diverse international experience.

Despite a quality healthcare infrastructure, the UAE is confronting major public health challenges brought about by poor diet, lack of exercise and tobacco use. The country has high rates of lifestyle-related chronic diseases such as obesity, diabetes and cardiovascular diseases. The Diabetes 2012 Atlas

Update places the UAE eleventh globally for the disease and fifth regionally, with almost 19% of Emirati nationals already diabetic (United Arab Emirates 2013).

To face these challenges, the UAE is undergoing structural changes. The government's new strategy is to simplify the multiple levels of governance in the country including the tangled bureaucracy of a healthcare system currently managed by both federal and local authorities.

Nursing in the UAE

There are approximately 30 000 nurses working in the UAE of which 75% work in governmental hospitals. The estimated nurse to population ratio in the UAE is 316 nurses per 100 000, a superior ratio compared to the average of EMRO at 180 nurses per 100 000, but significantly below the ratios achieved in countries such as Canada where the ratio is 929 nurses per 100 000, and the UK, with 880 nurses per 100 000 (World Health Organization 2015a,b,c).

UAE nationals are underrepresented in the nursing workforce. Although the number of nursing schools and educational programmes has consistently increased, few UAE nationals choose nursing as a career. Some studies have identified number of social and cultural factors that contribute to this situation (El-Haddad 2006). However, important initiatives have been put in place to strengthen the nursing profession, the very first of which was the establishment of the department of nursing by the Ministry of Health in 1993 (Al Rifai & Van der Merwe 2002). A decade later the Emirates Nursing Association was established in 2003, a positive in the recognition of nursing as an invaluable profession, followed by the establishment of the UAE Nursing and Midwifery Council in 2009 to promote and advance nursing and midwifery services and to protect and promote the health and safety of the public (UAE NMC, 2010).

Recent government policy has reinforced the importance of nursing, officially recognizing the profession as a national priority in 2013, and launching a national initiative to promote nursing as an attractive profession. The goal is to encourage young Emiratis to enrol in nursing all the while maintaining the current multinational workforce. This initiative includes reviewing nursing salary scales, upgrading and expanding nursing education programmes and utilizing mass media campaigns for public awareness and image building.

One aspect of developing future Emirati nurses is enhancing their leadership skills in order for nursing to contribute fully to the fast-paced development of health services in the UAE. The LFC programme presented an excellent opportunity to implement an action-learning programme that aims to develop nurses as effective leaders.

The ICN LFC programme launches in the UAE

In 2002, a partnership between ICN, EMRO-WHO and the Federal Department of Nursing of the UAE Ministry of Health was put in place to launch the ICN LFC programme in the UAE, the first LFC programme to be implemented in the EMRO region. During the first phase, 29 nurses and allied health professionals graduated from the LFC programme of which eight were selected and trained as certified ICN LFC trainers. The programme continued to run in 2007–2008, 2008–2010 and 2011–2012. The fifth phase of the programme was launched in 2015. Since the start of the ICN LFC programme in the UAE, a total of 99 nurses have graduated, 21 have become ICN LFC-certified trainers. The fifth phase aims to graduate 35 nurses, with four trainers to be certified. This will bring a total of 134 graduates and 25 certified trainers (Department of Nursing, MOH, UAE 2008, 2010, 2012).

LFC projects

A total of 23 projects have been developed over the course of the four phases of the LFC programme in the UAE. These projects addressed nursing and healthcare issues identified by participating nurses as a result of their scanning and analysis of health priorities of UAE communities and the overall healthcare system. These projects aimed to address specific issues, including community health awareness and education, nursing workforce issues, improvement of nursing clinical practice, quality issues and patient satisfaction and empowerment.

The impact of selected projects from phase 4

A number of projects were carried out in order to better analyse and understand the impact of the LFC programme on nursing practice in the UAE. Below is a brief review of one of those projects.

Project 1 – ‘The efficiency of communication between nurses and other healthcare professionals in Al Qassimi hospital – UAE’

The team identified a strong rationale for the project in view of the review of incident reports which revealed that ineffective communication was a root cause for more than 65% of all sentinel events reported. The team aimed to achieve this by adopting a structured communication technique that is designed to convey information in a brief manner that is accurate and time-saving. They reviewed the present professional communication pattern in the hospital and identified its strengths and weaknesses.

A self-administered questionnaire consisting of 10 questions covering the following areas was developed: magnitude of the

problem; consequence of ineffective communication on patient care and safety; reporting of incidences related to problems with communication; reasons for ineffective communication; and managing ineffective communication. The questionnaire was distributed to the 430 nurses working at Al Qassimi Hospital in order to assess the communication pattern used by these nurses.

The team selected the SBA tool (S: situation, B: background, A: assessment) as a key enabler of patient safety that promotes and improves communication among healthcare providers. Thirty-five staff nurses were randomly selected from male surgical unit who participated in an awareness session about the SBAR tool. The tool was then introduced and used in the same unit and the effectiveness of the tool in improving the quality of patient care and safety was evaluated.

The results revealed that reporting of incidences related to problems with communication improved from 37.5% to 53% and proper management of problem with communication improved from 21% to 28%. This project improved healthcare providers' communication, enhanced patient safety, saved staff time and was included in the hospital strategic plan to be used by other healthcare professionals.

The results of this project were presented at the ICN conference held in Melbourne in 2013.

LFC's impact on nursing and health care in the UAE

In addition to the specific impact of each project, the implementation of LFC in UAE has contributed to the government efforts to foster national leaders from within the nursing profession in particular and the healthcare community in general. Many of the graduates have utilized the acquired competencies to strengthen their roles as leaders. Others have built the necessary self-confidence to assume new roles and to introduce changes in their clinical practice.

The programme has also contributed to building a positive image of the profession in the community. For example, local newspapers have published press releases and interviews after each LFC workshop and following every graduation ceremony with positive captions on the programme and on nurses' role as leaders in the healthcare system (Gulf news 2002 & 2008) and (Khaleej Times 2003, 2004, 2005 & 2007).

Ten years of the leadership for change programme in Vietnam

Vietnam has a population of 94 348 835 spread over a territory 1650-km long, covering 331 201 km² from the subtropical Southern coast to the mountains of the North. It

borders Cambodia, China and Laos in one of the most economically dynamic regions of the world. Health expenditures account for 6% of Vietnam's GDP.

Background of the ICN LFC in Vietnam

The ICN LFC programme was launched in Vietnam in 2004 following negotiations by the leaders of the Vietnam Nurses Association (VNA) with ICN. Once agreement was reached on the details of the programme, Mrs. Nguyen Bich Luu, nursing officer with the Ministry of Health was appointed to the position of national coordinator for LFC by the Minister of Health.

Five phases of the ICN LFC programme were carried out in Vietnam between 2004 and 2014. The first four phases of the LFC programme were implemented as three-way collaboration between the Vietnamese Ministry of Health, WHO WPRO and the International Council of Nurses. The fifth phase of the programme was rolled out with a reduced role for ICN and an increased role by the Vietnam Nurses Association, in line with ICN's goal to foster indigenous training capabilities in non-member nations.

The Vietnamese Ministry of Health was responsible for coordinating the selection of trainers and programme participants in selected medical and nursing schools, facilitating all on-site logistics, ensuring trainers had sufficient time off from other duties to enable them to implement the programme effectively, and providing a national coordinator for all ongoing technical components of the programme including support and supervision for the trainers.

WHO WPRO and WHO Vietnam supported and funded the proposal; in coordination with the Vietnamese Ministry of Health and ICN. ICN provided programme content in the form of its tested methodology and credentialing framework, supplied the resource materials for trainers and participants (trainer manual and resource modules), trained the trainers and assisted them and the national coordinators in adapting the ICN programme to meet the specific requirements of Vietnam, supervised programme implementation through liaison and communication with the national coordinators and arranged an annual visit by an ICN consultant specialized in nursing and health policy. In addition, the ICN LFC director carried out site visits every 15–18 months in order to monitor compliance with LFC methodology and standards.

Objectives

The objectives of the LFC programme implemented in Vietnam reflect the global goals of the LFC programme. These include strengthening competencies of nurse teachers and managers in Vietnam in order that they be able to influence

policy and health system improvements, develop quality, cost-effective models of delivering services, be effective contributors to the broader healthcare team, contribute to on-going leadership/management development programmes for others, and influence changes in curricula and other training programmes.

Methodology

The principles of the basic methodology are action-learning based on workshops, team projects, mentoring, on-site learning activities and individual development planning.

Key results

A total of 302 nurses graduated from the five ICN LFC programmes implemented between 2004 and 2014, of which 28 were accredited as trainers. The graduates were drawn from 19 provincial health departments, 34 medical and nursing schools, 141 hospitals covering 43 of Vietnam's 63 provinces and municipalities.

Team projects

As in all LFC programmes, projects represent an important part of the training process and a means by which the impact of the programmes can be measured and clearly highlighted. The most impactful team projects carried out in the context of the LFC Vietnam programme centred on nursing management and infection control. The Vietnam LFC participants applied the skills and training they acquired as a result of their participation in the LFC programme by developing and implementing a 3-month training programme on nursing management for nurse managers, developing and implementing an infection control training programme for healthcare workers, developing and implementing a hospital quality management training programme, developing and implementing guidelines on infection control and a training programme on injection safety, developing and implementing training programmes on prevention standards, developing and implementing a national master plan for 2015–2020 on nursing and midwifery services, developing and implementing the national master plan for 2012–2015 on infection control, and developing and implementing the Vietnam nursing common competencies standards.

ICN LFC impact in Vietnam

The ICN LFC programme has had a significant and positive impact on the nursing profession in Vietnam, in particular by palpably enhancing leadership skills and capacity for nursing in Vietnam. The nursing profession has undergone a marked increase in recognition at the level of the general population,

and adherence to the principles of the ICN LFC methodology has resulted in the promotion of a stronger confident image for nursing in the eyes of their colleagues in health care, in particular medical doctors. Two-thirds of the participants in the ICN LFC Vietnam programme have been promoted to higher positions within their profession and the health sector.

ICN LFC roll out and outcomes in US-affiliated South Pacific Islands

Introduction and background

The US-Affiliated Pacific Islands (USAPI) are composed of six jurisdictions that include three US territories, American Samoa, the Commonwealth of the Northern Marianas and Guam, and three freely associated state (FAS) countries, the Federated States of Micronesia (Chuuk, Kosra, Pohnpei and Yap), the Republic of the Marshall Islands and the Republic of Palau. USAPI spending on health expenditures varies between 6.7% of GDP (lowest) in American Samoa to 13.8% of GDP (highest) in the Republic of the Marshall Islands.

The six USAPI's cover area within the Pacific Ocean that is larger than the continental United States, are inhabited by a population of over 500 000 people who speak some 20 languages (Wasem 2015). Within the region, there are approximately 1100 nurses, but the distribution of nurse to population ratio varies widely from 180 to 560 per 100 000. Within the USAPI, there are six schools of nursing, which include one bachelor's degree programme and five associate's degree programmes that are based in local community colleges. There are no graduate level nursing programmes in the region. In some of the jurisdictions, many of the physicians are expatriates whose tenure in the region is short, while the locally educated nurses serve as the long-term healthcare workforce. Across the USAPI, nursing is the backbone of the healthcare system. In many instances, along with providing clinical care, nurses serve as administrators in key departments or programme directors for specially funded programmes from the US government or international agencies. For this reason, cultivation of leadership skills among the nurses in the region is a key priority for moving the agenda of health forward in the region.

ICN LFC programme

Seventeen chief nurses, supervisors and mid-level healthcare managers from across the six USAPI participated in the ICN leadership for change programme (ICN). The key aim of the project was to build leadership capacity among mid/senior level nursing and administrative managers from the region. Funding support for the programme came from a variety of sources

Table 1 USAPI ICN LFC projects.

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- Decubitus ulcer reduction X2
 - OPD waiting time reduction
 - Organizational leadership capacity X2
 - Midwifery career ladder
 - Organizational leadership capacity
 - Access to IUD technology
 - Expansion of HIV/STI services
 - Development of a strategic plan
 - Strategic plan for management and leadership
 - Cervical cancer screening follow-up
 - Standardized point referral across MOH
 - Move administration of daily insulin from ED to the community (home) setting
-

including the Pacific Island Health Officers Association, US Centers for Disease Control and Prevention, Pacific Island Primary Care Association, University of Hawaii at Manoa Nursing and local jurisdictions. The programme was hosted at the University of Hawaii at Manoa in Honolulu, Hawaii, and consisted of three 5-day sessions that spanned over 1 year. A total of 12 change projects were undertaken by the participants.

Table 1 summarizes the projects that were undertaken by this group.

The ICN LFC programmes are usually implemented on a country by country basis, with participants drawn from a single national healthcare system, sharing similar challenges, ready to work on a common project. The LFC USAPI programme posed a new challenge in that participants came from different jurisdictions that do not share common health systems, have very different types and levels of resources and face differing challenges. In order to adapt to this unique programme environment, LFC USAPI was designed to allow participants to select a change project that was relevant to their home jurisdiction. Five faculties from the University of Hawaii at Manoa Nursing Department also participated in the programme and served as advisors for the participants. In addition, each participant identified a mentor from their home jurisdiction.

Outcomes

Eleven of the 12 projects (91%) initiated were completed to the level of the initial implementation phase, meaning, the project was implemented to affect change, and initial, short-term outcomes were measured. The following example illustrates a successful project outcome.

The Ebeye diabetes insulin management project

The Ebeye team (from the Republic of Marshall Islands) consisted of the Ebeye hospital director of nursing, the quality

improvement officer and the health administrator. They identified a problem related to the management of diabetes mellitus among a population of 10 000 residents of the island atoll of Ebeye. At the time of the project, 82 residents of Ebeye required twice daily injections of insulin. These individuals were required to travel to the Ebeye hospital emergency department (ED) twice daily for their insulin injections, resulting in 164 encounters each day for insulin administration. The aim of the Ebeye team project was to shift daily insulin administration from the ED to the home setting.

The Ebeye team examined the current policy and procedures and conducted a root cause analysis of why people were dependent on the ED for insulin administration. The team, the supply chain (the Ebeye Hospital did not have 82 vials of insulin to issue to citizens each month), healthcare worker practices (this had become routine practice and was not questioned) and community education (the community thought this practice was acceptable) as the root causes of this phenomenon. The Ebeye team worked to reorganize the supply chain for insulin and syringes, drafted policy and procedures for dispensing insulin and syringes, worked with the diabetes clinic staff to educate the diabetic community members, and educated staff and patients on improved practices. The project was fully implemented over the course of 9 months of work and by the last session of the LFC programme, 62 of the 82 diabetics on Ebeye were on home administration of insulin.

Next steps included moving the remaining diabetic citizens into home administration of insulin and conducting long-term follow-up to examine the impact of the programme in terms of health outcomes and cost savings.

Impact and sustainability

The ICN LFC programs are typically administered over the course of about 1 year so that the timeframe for measuring long-term impact and sustainability exceeds the formal programme timeline. However, the team from Ebeye affirmed commitment to continue on with the project. On an ongoing basis, the percentage of Ebeye resident diabetic patients who managed daily insulin injections was tracked and the cost savings related to decreases in ED utilization were recorded. The importance of tracking long-term outcomes is essential in order to justify the expenses (in terms of direct costs and personnel time) incurred from such programmes as LFC. Even if long-term outcomes are not as successful as intended, important lessons learned can be useful for ongoing system monitoring and change at the local level.

Factors that facilitated successful projects

There were several factors that facilitated short-term success of the LFC programme for the USAPI. Half of the participants were financially supported by their home jurisdiction health sector. Therefore, the local jurisdiction had a vested interest in success at the home level. All participants identified a local mentor and those who chose mentors who had significant influence in the participants organization were more successful compared to those who chose mentors who had less power within or were external to the organization. We found that the power and influence of the mentor were important factors in the success of the LFC participant.

Finally, for some of the small, resource-strapped USAPI jurisdictions, working in a crisis mode is the norm, and it is quite easy to lose track of one project as competing problems frequently emerge. To mitigate this common issue, each participant was also assigned an LFC faculty advisor from the University of Hawaii at Manoa Department of Nursing. The role of the faculty advisor was to stay in contact with the participant for the purpose of coaching where necessary, assisting with setting timelines and providing content expertise as needed. Therefore, each participant had a local mentor and an external advisor. This dual support system served to enhance progress towards completion of the projects in the LFC programme.

Lessons learned

Several important lessons were learned from USA/North Pacific ICN LFC programme collaboration. The partners found that financial contribution from the sponsoring jurisdiction can serve as a catalyst for sustained focus on the chosen project. ICN and other partners also learned that advice from University-based faculty is useful for providing a ready source of external expertise, technical assistance and project support, which all will enhance project success. Finally, all partners learned that empowering nurses by providing them with leadership skills can serve as a catalyst for important change in any healthcare system. Substantial resources are not always required to make significant changes in the USAPI jurisdictions. Instead, teamwork, collaboration and cooperation, coupled with empowerment can result in large changes even within the context of limited resources.

Next steps

The next steps include assessment of long-term outcomes as noted above, and expansion of the LFC programme within the local jurisdictions in the North Pacific Islands. All participants completed the trainer portion of the programme, and as such are now equipped to serve as ICN LFC-certified train-

ers in their own local jurisdiction. ICN expects to see many more LFC programs across the USAPI, and along with these programmes expanded empowerment of nursing to serve as leaders and catalysts for healthcare quality improvement and change in the region.

Celebrating a legacy of leaders

The ICN LFC programme has been embraced by nurses and other health professionals and partners across the globe over the course of a two decade evolution that is entirely the result of these very nurses, in their roles as participants, graduates, trainers and, most importantly, leaders. The ICN LFC programme is an implicit statement of intent on behalf of all nurses: nurses are leaders in their work places, in their communities and in their societies and possess the confidence and the skills to lead effectively worldwide.

The ICN LFC programme sprung from an understanding within the global nursing profession that nurses are uniquely positioned to deliver health care, health knowledge and the ability for populations to live in health and prosperity, in every corner of the globe, without exception. ICN celebrates the past 20 years and looks forward to the future as the organization continues to develop the world's most outstanding nursing leaders.

Author contributions

The following authors contributed to the article as follows:

Study conception/design: SF

Data collection/analysis: SF, FA, MM, LN, KQ, AT, JC, TP, MS, MN, MS, GJ

Drafting of manuscript: SF, FA, MM, LN, KQ, AT, JC, TP, MS, MN, MS, GJ

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Supervision: SF

Administrative/technical/material support: SF, KQ

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