

# Report of the Forum for Government Chief Nurses and Midwives

**17-18 May 2006**

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Department of Health and Human Resources

**R**eport of the Forum  
for Government **C**hief Nurses  
and Midwives

**17-18 May 2006**



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- Dr Deva-Marie Beck (Rapporteur), Mrs Mwansa Nkowane and Dr Jean Yan – for their work on the report; and
- Ms Sara Cottler and Mrs Marguerite Pfyffer – for their administrative support.

## Acronyms

ART	anti-retroviral treatment
CARICOM	Caribbean Community
CNO	chief nursing officer
CNR	Council of National Representatives
DOTS	directly observed therapy, short-course
ECS	electronic collaboration systems
EFN	European Federation of Nurses Associations
EIP	Evidence and Information for Policy Cluster (WHO)
EPR	Epidemic and Pandemic Alert and Response (WHO)
FHN	family health nurse
FNIF	Florence Nightingale International Foundation
GAGNM	Global Advisory Group on Nursing and Midwifery
GCNMO	government chief nursing and midwifery office/officer
GHWA	Global Health Workforce Alliance
HDS	Health Policy, Development and Services (WHO)
HIV	human immunodeficiency virus
HRH	health and human resources
HWI	Healthy Workplace Initiative
IBP	implementing best practices
ICM	International Confederation of Midwives
ICN	International Council of Nurses
ICNM	International Centre for Nurse Migration
IECPCP	interprofessional educational and collaborative patient-centred practice
ILO	International Labour Organization (Office)
IMAI	Integrated Management of Adolescent and Adult Illnesses (WHO)
IMCI	Integrated Management of Childhood Illnesses (WHO)
IMPAC	Integrated Management of Pregnancy and Childbirth (WHO)
KRA	key result area
MDG	millennium development goal
MDR-TB	multi drug-resistant tuberculosis
MIP	meeting of interested parties
MNCH	Maternal, Newborn and Child Health (WHO)
MPS	Making Pregnancy Safer (WHO)
NGO	non-governmental organization
NM	nurse and/or midwife



This report aims to be a comprehensive guide to urgent action rather than a detailed account of the proceedings. It focuses on the individual and collective influence that nurses and midwives can exercise – not only in advancing national, regional and global priorities, but also in promoting the specific proposals made in the areas discussed. Part 3 summarizes the technical sessions, Part 4 the nursing reports and Part 5 comprises the Forum statement – a summary of the agreed actions required.

## 2. Opening session . . . . .

**Dr Tim Evans, Assistant Director-General, Evidence and Information for Policy Cluster (EIP), WHO:**

This is a very significant time for nursing and midwifery on the world stage. The visibility and actions of global nursing and midwifery networks need to be increased, with a global positioning of nurses and midwives. Strategies employed must achieve a stronger nursing/midwifery signal that can provide ongoing key inputs into the stream of WHO policies and recommendations on recruiting, maintaining and sustaining a viable and vital health workforce worldwide. This will make a significant contribution to the health of humanity. The 2006 World Health Report – Working Together for Health – emphasizes that “people are a vital ingredient in the strengthening of health systems”.

**His Excellency Love Mtesa, Ambassador of Zambia to the United Nations (presented on behalf of Dr Sylvia Masebo, Minister of Health, Zambia):**

Zambia was chosen as a showcase country for World Health Day 2006 and the Zambian people and their leaders enthusiastically embraced the theme – with public demonstrations, parades of appreciation and, at all levels of the government, in-depth discussions, planning and commitment. Nursing and midwifery is considered to play a catalytic role in the accomplishment of many of the Millennium Development Goals (MDGs)<sup>1</sup> – in the establishment of an integrated health-care system and, particularly, in reducing maternal and infant mortality and strengthening maternal and child health. The need for nurses and midwives cannot be over-emphasized – they are the backbone of health-care delivery in Zambia. Leadership and recruitment within their ranks is essential to the health of all Zambians. (See Annex 2 for the full text of Dr Masebo’s keynote address.)

**Dr Jean Yan, WHO Chief Scientist, Nursing and Midwifery Office (NMO), WHO:**

Dr Yan welcomed the participants and outlined the goals, objectives and agenda of the Forum. In acknowledging the progress of the 65 countries that have committed to maintaining a national office for chief nurses and midwives, she noted that 122 countries still need to make this commitment. Dr Yan highlighted the value-added contributions of nurses and midwives to the health-care sector worldwide and stressed the need to strengthen existing global networks and create new networks for the 14 million nurses and midwives worldwide. Further use should be made not only of these networks but also of leading-edge Internet platforms. Mechanisms need to be developed to make the contributions of GCNMOs more visible, both within their governments and to the public at large. The GCNMOs were welcome to officially participate in the 59th World Health Assembly (WHA) – an opportunity to highlight nursing and midwifery contributions to the global health arena. In conclusion, Dr Yan stressed that, if WHA resolutions are ever to be carried out, it is imperative that nurses and midwives be included in strategic discussions, planning and implementation at all levels. “It’s not just talk anymore,” she said, “it’s action!”

<sup>1</sup> A complete list of the UN Millennium Development Goals may be obtained at <http://www.un.org/millenniumgoals/>

### 3. Plenary sessions . . . . .

#### Technical session 1: Strengthening health systems and patient safety

**Chairperson: Dr Liz Wagner, Regional Nurse/Midwife Adviser, WHO Regional Office for Europe (EURO)**

Dr Wagner described the a study on the implementation and evaluation of the family health nurse (FHN) concept currently in progress in Europe – the WHO Multi-National Study of the Family Health Nurse Concept. Participating countries include Armenia, Estonia, Finland, Germany, Kyrgyzstan, Lithuania, Portugal, Republic of Moldova, Scotland, Slovenia, Spain and Tajikistan. Working groups have been established to harmonize FHN across Europe, establish links with government chief nurse officers and draw up a tight, strategic action plan with a three-year timeframe. Highlights of the action plan include building sub-groups to study certain issues further, including education (competencies and roles), indicators and outcomes, translation of relevant literature, and exchange programmes to share knowledge learnt in the different countries on the benefits of the FHN.

**Mrs Pauline Philip, Public Health Administration Specialist, Patient Safety Programme, Health Policy, Development and Services, Evidence and Information for Policy Cluster (HDS/EIP), WHO:**

The World Alliance for Patient Safety was launched in 2005 to improve health-care safety through policies and regulations governing the health-care system. It aims to raise standards and expectations for improvements in safety, promote appropriate leadership and research on patient safety. The importance of nurses taking a lead in patient safety is seen to be critical – simple measures can save lives. Evidence shows that over 1.4 million people worldwide are suffering from infections acquired in hospital; 5–10% of the patients admitted to hospitals in developed countries acquire one infection or more; the risk of health-care associated infections is 2–20 times higher in developing countries than in developed countries. The Global Alliance for Patient Safety acknowledges the importance of nursing and midwifery in all areas of the Patient Safety Programme:

- blood safety,
- injection practices and immunization,
- water, basic sanitation and waste management,
- safety of clinical procedures, and
- hand hygiene.

**Professor Barbara Parfitt, Secretary General, WHO Collaborating Centres for Nursing and Midwifery Development, Global Network Secretariat:**

Professor Parfitt described the development of Scotland’s participation in the Multi-National Study of the Family Health Nurse Concept. In Scotland the project aims to develop and evaluate the education programme at Stirling University, incorporating a 40-week basis of competency development. In Phase 1 (2001–2003) the role of 31 FHNs was tested in remote and rural areas. In Phase 2 (2003–2006) the role of 15 FHNs is being tested in urban areas, with follow-up in remote and rural areas.

Evaluation of Phase 1 was completed at Robert Gordon University and the recommendations were to:

- revise FHN competencies;
- employ facilitators to support FHNs and teams through change;

- conduct further research in urban areas; and
- follow up FHNs in remote and rural areas.

Evaluation of Phase 2, currently being completed at Glasgow Caledonian University, focuses on the key question: What value does the FHN approach bring to care? The evaluation is looking at the study's implications for end-users of the service, as well as the FHN practitioners themselves and their colleagues. It is also reviewing the interviews and questionnaires used in the study. The report of the Scottish Executive Health Department (SEHD) is due to be completed in summer of 2006.

Overall outcomes indicate that the study will provide a comprehensive contribution to a significant review of community nursing throughout the European Region. Benefits are already being observed – detailed data compiled from pilot countries is contributing to a greater understanding of community needs and improving teamwork; nurses are working in a more family-focused way and are demonstrating the need to sustain and nurture change.

### Chief nurse officer's response

**Dr Elena Stempovscasia, Government Chief Nurse, Ministry of Health and Social Protection, Republic of Moldova:**

The goals and objectives of nursing reform in Moldova's health-care system are to assure the provision of high quality services that are equitable and accessible to the whole population by a) changing the current system into a client-oriented service, and b) treating nursing as an important component in primary health care (PHC) reforms. To accomplish this, Moldova is basing its approach on the WHO Health-for-All Strategy, the Munchen Declaration and the FHN concept, using elaborated quality standards for socio-medical home care and palliative care services.

The Republic of Moldova does not have a well-defined policy for human resources for health (HRH) and needs to establish one on the basis of empirical data that will allow for selection of the best specialists. The development of an HRH policy will need to incorporate improved conditions of service with a focus on adequate salaries, motivation and recognition of health workers. A system to assure the availability of essential drugs for prophylaxis and treatment of diseases is also required.

HRH planning is important in maintaining staff in the field. It should be based on careful consideration of existing staff resources, the needs for effective systems of staff integration, an accurate estimate of resource-change possibilities and consideration of changes and losses. Take external factors into consideration, it should also focus on staff performance and provide programmes for staff development. The staff necessary to achieve these goals must be provided and measures, such as knowledge evaluation and testing, must be taken to assure that staff resources are adequate, able and available to accomplish specific functions.

Administration of HRH should include the economic, social and political aspects. The quality and quantity of human resources are important in maintaining performance and professionalism.

Giving people the power to act efficiently is an important investment.

<sup>2</sup> Subsequent to the Forum, this report – The WHO Europe Family Health Nursing Pilot in Scotland – has been released and is available at <http://www.scotland.gov.uk/Publications/2006/10/31141146/2>

### Technical session 2: HIV/AIDS/TB

**Chairperson: Mrs Margaret Phiri, Regional Nurse/Midwife Advisor, WHO Regional Office for Africa (AFRO)**

#### HIV/AIDS

**Dr Sandy Gove, WHO Technical Coordinator, Integrated Management of Adolescent and Adult Illness (IMAI), Partnerships, External Relations and Communications (PEC), HIV/AIDS, WHO:**

WHO is developing a package of integrated prevention, treatment and care services based on the public health approach to the scale-up of universal access for the treatment of HIV/AIDS.

WHO's vision for the health sector includes:

- integrated services that link testing, prevention, treatment and chronic care and support;
- equitable access to services for all in need, including vulnerable communities; and
- active partnership of communities in the design and delivery of their health services.

**Critical components** in expanding the capacity of testing and counseling include:

- voluntary testing and counseling,
- provider-initiated testing and counseling for diagnostic functions,
- routine testing,
- infant diagnosis, and
- family counseling.

**Prevention** can be maximized through:

- prevention of mother-to child transmission,
- prevention of sexual transmission,
- prevention of transmission through injecting drug use,
- prevention within the health-care setting, and
- the establishment of new technologies for HIV prevention.

**Accelerating treatment scale-ups** involves:

- making anti-retroviral treatment (ART) available to children and adults,
- the prevention and management of opportunistic infections,
- the provision of care – including nutrition, palliative and end-of-life care; and
- linking HIV/AIDS and TB services.

**Scaling-up** will also be complemented by the collection of strategic information such as:

- surveillance of HIV/AIDS and sexually transmitted infections (STIs),
- the identification of treatment outcomes and monitoring of HIV drug-resistance,
- monitoring of the health sector's response to universal access, and
- research into operational effectiveness.

**Strengthening the health systems in support of HIV/AIDS** includes placing emphasis on:

- leadership and stewardship,
- national strategic planning and management,
- procurement and supply management, strengthening of laboratory services,
- development and management of human resources, and
- the establishment of strategies for sustainable financing in this area.

Dr Gove noted the challenges to the scale-up of HIV services such as the findings of the “3 by 5” Report<sup>3</sup>, the alignment of partnerships, sustainable financing, affordable commodities, the crisis of HRH availability, and equitable access to education and treatment.

The challenges in scaling up treatment include:

- inadequate financing,
- the human-resources crisis,
- the need for affordable commodities,
- the stigma and discrimination associated with HIV/AIDS,
- accountability,
- death from HIV.

HIV is the largest cause of staff attrition – with 15% HIV prevalence, up to 33 % of health workers have been lost to HIV in 10 years. HIV/AIDS treatment, prevention and care services are now being developed for health workers.

There is, furthermore, a need for HRH training and planning, together with measures to empower HRH towards universal access. Dr Gove emphasized the need for strategies to help health systems retain health workers.

A comprehensive training package, Integrated Management of Adolescent and Adult Illness (IMAI)<sup>4</sup>, provides a flexible set of tools to support rapid scale-up of integrated HIV prevention, care and treatment. IMAI is an integrated primary care approach that addresses common acute and chronic conditions and rebuilds basic health services from the “inside out”.

<sup>3</sup> For more information on the WHO/HIV “3 x 5” initiative see <http://www.who.int/3by5/en/>

<sup>4</sup> See <http://www.aids2006.org>

## Tuberculosis

**Dr Paul Nunn, Coordinator, TB/HIV Drug Resistance, WHO:**

There is an “unholy alliance” between HIV/AIDS and TB – 250 000 deaths were recently identified as due to TB/HIV. Multi drug-resistant TB (MDR-TB) is present in 102 of 109 countries studied. In 2004 there were 1.7 million deaths due to TB, 98% in the developing world; 80% of the 8.9 million new cases of TB were in 22 high-burden countries.

The global TB control targets are to:

- 1) achieve 50% reduction in TB prevalence and deaths by 2015 and reach the related MDG – Goal 6;
- 2) combat HIV/AIDS, malaria and other diseases, in keeping with MDG, Target 8;
- 3) halt and begin to reverse the incidence of TB by 2015.

A treatment strategy for detection and cure of TB – directly observed therapy, short-course (DOTS) – ensures equitable access to the highest quality care (diagnosis and treatment) for all TB patients. Since the DOTS strategy was introduced, over 20 million people treated have shown a high rate of cure.

The Stop TB strategy is geared to the achievement of MDG 6. The Global TB Plan for 2006–2015 – the new vision for TB treatment and cure – includes the International Standards for Tuberculosis Care and The Patients’ Charter for Tuberculosis Care<sup>5</sup> (covering the patients’ responsibilities), TB control approaching the 2005 targets, and a new TB strategy to adapt to new conditions. However, the lack of human resources is recognized to be a major constraint to the achievement of these goals as nurses are essential to the successful implementation of the plan.

## Chief nurse officer’s response

**Mrs Dorica Sakala Mwewa, Chief Policy Analyst, Nursing Services, Ministry of Health, Zambia:**

The 2002–2007 HIV/AIDS Project for Nurses and Midwives in Zambia was developed by the Zambian Nurses Association to “care for the carers”. The Project aims to: a) reduce the prevalence and incidence of HIV infection among nurses and midwives, and b) contribute to the improved health and working abilities for those infected or affected.

Targeting all the nurses and midwives in Zambia, in both the public and private sectors, the project’s areas of active intervention include the development of knowledge to equip nurses and midwives with an up-to-date understanding of HIV/AIDS that will enable them to develop and implement effective procedures for clinical work. It also identifies connections between HIV and the workplace, supports and promotes voluntary counselling and testing (VCT) with the provision of active care and support, and endeavours to nurture some of the income-generating activities.

A cumulative total of 1950 nurses have been trained to date. HIV and workplace guidelines, developed and approved by the Zambian Ministry of Health and the International Labour Organization (ILO), have been used in ongoing workshops in the provinces and provincial coordination meetings. A total of 1435 questionnaires on VCT have been circulated to nurses and, in an exercise to provide information specifically to raise nurses’ awareness, project-related material has been sent to over 170 VCT centres throughout the provinces. Furthermore, 86 HIV/AIDS care and support groups for Zambian nurses and midwives have been funded to date and the Zambian Government has also provided free ART to all eligible Zambians.

<sup>5</sup> See <http://www.who.int/tb/publications/2006/istc/en/>

**Technical session 3: Making pregnancy safer and reproductive health research**

**Chairperson: Dr Prakin Suchaxaya, Regional Nurse/Midwife Advisor,  
WHO Regional Office for South-East Asia (SEARO)**

**Partnership for maternal, newborn and child health**

**Mrs Ten Hoop-Bender, Executive Officer, Partnership for Maternal, Newborn and Child Health (MNCH), WHO:**

Each year more than half a million women die during pregnancy and childbirth and more than 10 million children die before their fifth birthday, almost 40% of these in the first month of life. At least two-thirds of these deaths could be prevented. These statistics were critical markers in the creation of a new global health partnership launched in September 2005 – the WHO Partnership for Maternal, Newborn and Child Health (MNCH) – between partner countries, international organizations, non-governmental organizations (NGOs), professional organizations, academic and research institutions and bilateral donors.

The partnership aims to draw special attention to the health of mothers and children and supports global efforts to achieve MDGs 4 and 5. Its global thrust will give greater visibility to maternal, newborn and child health, while achieving better coordination under country leadership, increased commitment to PHC, reduced competition and duplication, and more efficient use of resources – with shared and agreed goals. It is designed to be country-led yet globally inclusive, comprehensive, flexible, collaborative and results-oriented.

**Making pregnancy safer**

**Dr Monirul Islam, Director, Making Pregnancy Safer (MPS), WHO:**

Every year 4 million babies die in the first 4 weeks of life – 10 000 die every day. 99% of newborn deaths are in developing countries and almost all these deaths are due to preventable conditions. Yet, most information and investment focus on high-tech solutions to the 1% of deaths that occur in rich countries. Infections are the biggest overall cause of newborn deaths and remain the most feasible to prevent and treat.

Reducing child mortality by two-thirds by 2015 – MDG 4 – will only be achieved if neonatal deaths can be reduced. Millions of babies could be saved annually if we could assess the situation, mobilize political will and finances, make effective interventions known and available, scale up and improve maternal and newborn care, monitor coverage, and measure and report impact. Nurses and midwives can make major contributions to reaching these targets in the following areas:

- pre-pregnancy care,
- support and education for the prevention of pregnancies that are unwanted or too early,
- health promotion – with a specific focus on nutrition,
- antenatal care and implementation of essential interventions,
- screening for syphilis and HIV, prevention of mother-to-child transmission (PMTCT) and meetings of interested parties (MIPs),
- iron supplementation, and
- deworming.

Nurses and midwives continue to play a critical role during delivery and the postpartum period – in infant feeding, training in Kangaroo mother care<sup>6</sup>, immunization, family planning and, if complications arise, identification, management and referral.

<sup>6</sup> For a practical guide on Kangaroo mother care (a method of care of preterm infants which involves infants being carried, usually by the mother, with skin-to-skin contact), see <http://www.who.int/reproductive-health/publications/kmc/>

Training materials<sup>7</sup> developed on midwifery, caring for newborns and HIV in pregnancy include Integrated Management of Pregnancy and Childbirth (IMPAC), Managing Complications in Pregnancy and Childbirth and an essential newborn care course, Managing Newborn Problems. Other useful publications now available focus on issues such as neonatal and perinatal mortality, low birth-weight, the critical role of the skilled attendant, strategic approaches to making pregnancy safer and, coming soon, a toolkit for strengthening midwifery.

Challenges related to making pregnancy safer include:

- implementing evidence-led care,
- addressing the global shortage of human resources,
- the over-medicalization of the natural process of childbirth and infancy, and
- the still-marginalized status of women and children in some parts of the world.

Nurse midwives play a key role in reducing newborn mortality and achieving related MDGs. Almost 40% of under-5 year old deaths are neonatal. Countries with the highest numbers of neonatal deaths are also those that have high maternal death rates. Up to 50% of neonatal deaths are within the newborn's first 24 hours of life. Birth and careful first-week attendance are key elements. Most babies die during this critical stage, yet this is when care coverage is lowest for vulnerable mothers and babies.

The first step in dealing with high neonatal and infant mortality is to address the incidence of high neonatal mortality rate (NMR), tetanus and infections. Honduras, Indonesia, Nicaragua, Peru and Sri Lanka halved their neonatal mortality rates during the 1990s. Intervention packages that reduce newborn deaths focus on:

- clinical care;
- skilled obstetric and immediate newborn care (hygiene, warmth, breastfeeding) and resuscitation;
- emergency obstetric care to manage complications such as obstructed labour and haemorrhage;
- antibiotics for preterm rupture of membranes and corticosteroids for preterm labour;
- emergency newborn care for illnesses, especially sepsis management and care of very low-birth-weight babies (including Kangaroo mother care).

Other critical elements include outreach services, the use of folic acid and a focused four-visit antenatal package that includes:

- tetanus immunization,
- detection and management of syphilis and other infections,
- early identification of pre-eclampsia,
- malaria intermittent presumptive therapy (for health systems with higher coverage and capacity),
- detection and treatment of bacteraemia,
- postnatal care and education to support healthy practices,
- early detection and referral of complications,
- family-community counseling and preparation for newborn care and breastfeeding,
- emergency preparedness, and
- clean delivery by a traditional birth attendant (if no skilled attendant is available).

<sup>7</sup> See <http://www.who.int/reproductive-health>

Dr Islam warned that nurses must assume roles as leaders to address and implement MDGs 4 and 5 – without the critical role of nurses, these goals will never be met.

In conclusion, he posed two challenging questions to participants: What role are nurse midwives going to play? When are nurses going to have a voice to demand change?

### Child and adolescent health

#### **Dr Elizabeth Mason, Department of Child and Adolescent Health, WHO**

(Dr Venkatraman Chandra-Mouli made the presentation on behalf of Dr Mason):

The immediate goals in this area are a) to reduce the 1990 infant and child mortality rate by two-thirds by 2015, and b) to promote the physical and mental health of adolescents so as to reduce HIV prevalence among young people aged 15–24 by 25% by 2010.

There are several challenges to reaching these goals:

- the physician and nurse density per 10 000 population varies enormously;
- the distribution of physicians and nurses is unequal – physicians tend to cluster in urban areas;
- under-five mortality rates tend to be highest in rural areas;
- many countries rely on nurses for under-five care;
- the performance of physicians in clinical tasks is assumed to be better than that of nurses and, in some countries, existing regulations do not allow nurses to perform the case-management activities necessary for the tasks they are expected to perform.

Evaluation of the integrated management of childhood illnesses (IMCI) in Brazil showed that nurses and physicians performed similarly in the assessment of the child but nurses performed better in the correct classification. Furthermore, nurses were more likely to prescribe antibiotics correctly to the child in need and also performed better in advising caretakers. The assumption that physicians perform their clinical tasks better than nurses is therefore false. In view of nurse/physician densities and the distribution of nurses relative to under-five mortality, nurses can and should play an important role in under-five care. Based on evidence, government chief nursing officers can help improve the access of under-fives to quality care by challenging common nurse/physician assumptions and by improving regulations.

Adolescents are no longer children but they are not yet adults. There are one billion adolescents in the world today. Many different players need to contribute to their health and development. It may be useful to think of these players in concentric circles of contact and influence.

- At the centre of care is the adolescent himself or herself.
- The first circle comprises those in immediate contact with the adolescent – parents, siblings and various other family members.
- The second circle includes those who are in regular contact such as the adolescent's own friends, family friends, teachers, sports coaches, religious leaders and health workers.
- The third circle includes musicians, film stars and sports figures who have a tremendous influence from afar.
- Finally, in the fourth circle, politicians, journalists and bureaucrats (within the government and private sectors) who, through their words and deeds, affect the adolescent's life in small and big ways.

Health-service providers are critical in helping well adolescents to stay well and ill adolescents to get back to

good health. They can act as change agents by helping influential people in the community understand and respond to the adolescents' needs. Adolescent health-service providers need to have clinical competencies as well as interpersonal communications competencies. They also need to have personal attributes – beliefs, positive attitudes and values – that are critical to being “adolescent friendly”. These attributes enable them to deal with their adolescent clients/patients in an empathetic and non-judgmental manner. Adolescents around the world point to two key characteristics of adolescent-friendly health workers.

- They are respectful.
- They are non-judgmental.

Nurses and midwives have a particularly important role to play. They are in a unique position – by virtue of their education, numbers, and diversity of practice arenas – to contribute to the health of adolescents. Drawing upon the expertise of nurses and midwives from around the world, WHO's Department of Child and Adolescent Health and Development and the Department of Human Resources for Health have outlined the core competencies of professional nurses and midwives to be developed through training. Several useful tools for nurses and midwives are available, including an orientation programme on adolescent health for health-care providers, and an adolescent job aid<sup>8</sup>. Strategies to integrate an adolescent health and development component in nursing and midwifery curricula have also been developed.

### Reproductive health and research

#### **Dr Michael Mbizvo, Coordinator, Reproductive Health and Research (RHR), WHO:**

Dr Mbizvo commenced his presentation with the following statistics on developing countries:

- 3 million girls undergo female genital mutilation every year;
- cervical cancer is the most common cause of cancer deaths in women (200 000 per year);
- 120 million couples have an unmet need for safe and effective contraception;
- an estimated 340 million new sexually transmitted infections cases occur annually.

Unsafe sex is the second most important global risk factor to health – HIV/AIDS is a major manifestation of sexual ill-health. Of an estimated 529 000 maternal deaths, 99% occur in developing countries. Poverty dramatically increases a woman's chances of dying prematurely. Failure to address sexual and reproductive health is not only tragic and sad, but a perpetual violation of human rights – the right to life and to health.

The Department's vision and strategy is the attainment – by all peoples – of the highest possible level of sexual and reproductive health. The core components of the reproductive health plan are:

- gender, reproductive rights, sexual health and adolescence;
- promoting family planning;
- maternal and perinatal health;
- preventing unsafe abortion;
- controlling sexually transmitted and reproductive tract infections; and
- technical cooperation between WHO and countries.

The plan also includes a sexual health research component where sexually transmitted and reproductive tract infections are being studied through the global strategy for the prevention and control of sexually transmitted infections (STIs). WHO RHR has prepared a broad spectrum of peer-reviewed publications and evidence-based technical guidelines, materials and tools to support reproductive health care<sup>9</sup>.

<sup>8</sup> See <http://www.who.int/child.int/adolescent-health/publications/publist.htm>

<sup>9</sup> See <http://www.who.int/reproductive-health>

Nurses and midwives can make significant contributions to the improvement of reproductive health care and research, as demonstrated by the following studies.

- In Taiwan a study identified nurses' perceptions of facilitators and barriers to taking a sexual history, *Public Health Nurse*, 2003.
- In Swaziland a study identified adolescent views on decision-making regarding risky sexual behaviour, *International Nursing Review*, 2004.
- In South Africa collaboration between traditional medicine and modern health practices was studied, *International Nursing Review*, 2002.
- In Canada engagement in the process of community development for HIV prevention was studied, *Journal of Advanced Nursing*, 2001.
- In the United States of America sexual health risks and protective resources of homeless adolescents were studied, as well as the need for gender and sexual orientation-specific interventions, *Journal for Specialists in Pediatric Nursing*, 2005.
- In the United Kingdom research focused on the management of embarrassment and sexuality in health care, *Journal of Advanced Nursing*, 1999.

The Global Alliance of Nurses and Midwives Communities of Practice is a collaborative network involving WHO, nursing and midwifery collaborating centres and institutions. It uses the IBP/ECS Knowledge Gateway to:

- link nurses and midwives globally through simple electronic communities of practices;
- provide a platform for discussions with experts and individuals from different countries; and
- offer opportunities for local and international colleagues to share new knowledge, expertise, experience and lessons learnt.

WHO RHR is committed to the achievement of universal access to reproductive health by 2015, as set out at the International Conference on Population and Development. RHR is also integrating this goal into strategies to attain internationally agreed development goals, including those contained in the Millennium Declaration of the United Nations 2005 World Summit (MDGs).

### Chief nurse officer's response

#### **Mr Dileep Kumar, Nursing Adviser, Ministry of Health and Welfare, India:**

India is a nation of more than one billion people; it consists of 35 states and union territories with diverse demographic, geographical, economic and cultural settings. No appreciable decline in the maternal mortality rate (MMR) has been observed since 1990. India has a total of 865 135 Indian nurses currently registered.

India has developed a National Rural Health Mission (NRHM) and a Reproductive and Child Health Programme with the aim of:

- improving availability of quality health care in rural areas;
- forging partnerships between central, state and local government, with a special focus on 18 states that have weak public health indicators (though it covers the entire country);
- developing community ownership of health facilities;
- creating synergy between health and determinants of good health;
- strengthening government commitment to increase public spending;

- undertaking architectural corrections within the health system;
- providing an opportunity to promote equity and social justice.

The key maternal health strategies require skilled attendance at delivery, both in the community and in institutions. Strategies for improving newborn care include the provision of good antenatal care and nutrition and ensuring that skilled personnel attend all (that is, 100%) deliveries. Guidelines and training materials are available.

Other initiatives that have been put in place include a revised post-basic syllabus, a pilot study for a curriculum for the independent midwife/nurse practitioner, and a national consortium for a doctorate in nursing that includes video-conferencing capacity. For all these educational initiatives Minimum Standards for Nursing Practice and a Code of Ethics and Professional Conduct for Nursing in India have been developed.

**Technical session 4: Pandemic preparedness and response**

**Chairperson: Mrs Kathleen Frisch, Regional Nurse/Midwife Advisor  
WHO Regional Office for the Western Pacific (WPRO)**

**Global influenza**

**Dr Keiji Fukuda, Coordinator, Global Influenza Programme (GIP), WHO:**

There are three influenza patterns:

- seasonal (human) – caused by viruses well adapted to people;
- avian – normally infects birds, but can sometimes infect people; and
- pandemic – when an animal influenza virus (i.e. a “novel” virus) adapts to people and spreads worldwide.

The main disease-control strategies for seasonal human influenza include global virus and disease surveillance, annual vaccination campaigns, communications and education, together with related initiatives such as the provision of antiviral drugs, the worldwide recommendation to “stay home if sick” and to maintain good personal hygiene.

The now famous H5N1 is one of many different avian viruses and the cause of major losses among poultry. It can infect many other animal species. It first appeared in Asia in 1996 and has subsequently spread to Africa, Asia, Europe and countries in the Eastern Mediterranean Region. It is the most visible potential human pandemic virus – but not unique.

H5N1 is a pandemic candidate. It is able to infect people and can replicate in humans and cause disease. So far it has not gained the ability to spread easily from one human to another. Pandemic influenza – when an animal-derived influenza virus adapts to people and spreads worldwide – has major implications: the entire global population is susceptible; the pandemic can last for months; and it is more intense than seasonal influenza, with extensive and extended community outbreaks. Social disruption is also possible – with travel being affected, widespread absenteeism in business and schools, and short supplies of some critical resources.

Pandemics have varied widely throughout history and need to be put in perspective. In 1918 the Spanish flu caused 20–40 million deaths, a scale similar to the total number of deaths from World War II. No comparable outbreak had occurred since the “black death” of the Middle Ages. In 1957 the Asian flu caused 1–4 million deaths, notably worse than a very bad influenza season. In 1968 the Hong Kong flu caused 1 million deaths – this is seen, however, as a bad, but regular, influenza season.

Some key questions about pandemics continue to be unanswerable:

- When will the next pandemic appear?
- What specific virus will be the cause?
- How severe will the health consequences be?

What is clear, however, is that we can anticipate social disruption, impact on international travel, local and global economic losses, over-reaction, fear and uncoordinated policies that could actually increase adverse outcomes.

WHO has identified five strategic actions to respond to human pandemic influenza.

- 1) Reduce human exposure to H5N1.
- 2) Strengthen the early-warning system.
- 3) Intensify rapid containment operations.

- 4) Build capacity to cope with a pandemic.
- 5) Promote global scientific research, more rapid vaccine development and expanded production of vaccines.

WHO makes extensive use of social mobilization and communications that focus on the reduction of risk behaviour – an information network developed in collaboration with the United Nations Children’s Fund (UNICEF), the Food and Agriculture Organization (FAO), key NGOs and other partners. WHO has also strengthened early-warning systems and activities for rapid-containment operations. A third updated pandemic protocol has been posted and related national discussions and training were held in July 2006. Capacity-building activities are also being implemented. Furthermore, WHO is offering guidance, missions and training and promoting research and the development of vaccines. An epidemic and pandemic alert and response (EPR) web page is available on the WHO website<sup>10</sup>. The challenge is not “when to expect” but “what to do”. Pandemic preparations are a long-term activity but they can make the difference.

**Chief nurse officer’s response**

**Ms Ang Beng Choo, Chief Nursing Officer and Registrar, Ministry of Health, Singapore:**

Singapore’s recent experience with severe acute respiratory syndrome (SARS) in 2003 provided lessons to build on. Teamwork proved crucial in helping the country overcome the deadly virus in a timely manner. A strong partnership between the people and the government is invaluable in minimizing the impact of a flu pandemic. Several pandemic planning assumptions can be made – for instance:

- there are often two or more waves – either in the same year or in successive flu seasons;
- a second wave may occur 3–9 months after the first and may be more serious (as seen in both 1918 and 1968);
- each wave lasts about 6 weeks.

Singapore’s Pandemic Preparedness Plan now includes an integrated approach that involves all relevant government agencies, with coordination across the whole spectrum of government. This plan encompasses:

- surveillance,
- understanding response and impact mitigation, and
- vaccinating the population.

It also includes a colour-coded risk management approach – for example, **green** refers to animal-to-animal disease; **yellow** to inefficient human-to-human transmission; **orange** to efficient, but limited, human-to-human transmission; **red** to widespread infection; and **black** is designated to indicate out-of-control, morbidity and mortality.

Singapore has also developed a plan to vaccinate its population whenever this is indicated. With the support of the United States of America, a Regional Emerging Disease Intervention (REDI) Centre has been developed. This is an important step in building a global network of surveillance. The Centre is working on three technical assistance training courses. It is also testing work procedures and processes that have been worked out in response to crisis situations and is addressing the issue of stockpiling of Tamiflu. Public education campaigns are in progress – in newspapers, pamphlets, handbooks and on a designated flu website. Singapore has also developed a business continuity plan and schools are being prepared to tap channels such as the Internet, postal services, telephone services and free-to-air broadcasting services to communicate with students and engage them in learning about pandemic preparedness.

<sup>10</sup> See <http://www.who.int/csr/en/>

To address the vector source of the avian flu, Singapore has banned the imports of live poultry and birds, poultry meat and eggs from bird flu-affected countries. It has stepped up a) inspection and testing of imported eggs and poultry at points of entry, and b) checks on local poultry farms and slaughterhouses. Singapore's farms are now required to implement biosecurity measures such as bird-proofing poultry houses and disinfecting vehicles. Farm and slaughterhouse employees have been briefed on how to recognize signs of bird flu and are required to report unusual deaths or suspicion of the disease. Farms are also now closed to visitors.

Within an hour of the first bird flu case being detected, the Singapore Agri-Food and Veterinary Authority and related agencies will be mobilized to control the situation. All hospitals and doctors will be advised to be on alert. Suspected cases will be sent to Tan Tock Seng Hospital for assessment and, if necessary, to the Communicable Diseases Centre 2 for isolation. As soon as clinical signs of bird flu appear, all birds with positive test results will be culled nationwide. All farms will be "sealed off" during this culling procedure and all eggs produced will be destroyed. Farm-owners will receive ex-gratia payments for the poultry culled. Furthermore, all measures necessary to eradicate the disease, safeguard public health and maintain public confidence will be taken.

In conclusion Ms Beng Choo cautioned that "we must prepare for the worst, even as we hope for the best."

### Technical session 5: Human resources for health

**Chairperson: Mrs Silvina Malvárez de Carlino, Regional Nurse/Midwife Advisor, WHO Regional Office for the Americas (AMRO)**

#### Human resources for health

**Dr Manuel Dayrit, Director, Human Resources for Health (HRH), WHO:**

"We have to work together to ensure access to a motivated, skilled, and supported health worker by every person in every village everywhere."

– Dr Lee Jong-wook, Director-General, World Health Organization (2006)

Dr Dayrit outlined the key reasons for people leaving the health-care workforce – migration either to another country or from rural to urban areas within the home country, risk of violence or illness and death, change of occupation or activity (for example, unemployment, part-time employment or finding work outside the health sector), or retirement (either early retirement or at the statutory age).

The five critical messages in the 2006 World Health Report are outlined below.

- 1) Educated and well-trained health workers save lives.
- 2) Support and protection of health workers is essential.
- 3) There must be worldwide strategies to enhance the effectiveness of the health workforce through new strategies.
- 4) Imbalances and inequities must be tackled.
- 5) Governments must take the lead.

Dr Dayrit emphasized the promotion of partnerships and cooperation and the alliances of stakeholders within countries, backed by global and regional reinforcement and the building of trust among all stakeholders.

In closing he said, "Health workers save lives – support them, educate them, love them. Do not leave them, or they will leave you. That's not a threat, that's not a promise, it's already a fact of life!"

### Global Health Workforce Alliance

**Professor Francis Omaswa, Executive Director, Global Health Workforce Alliance (GHWA):**

Abundant historical evidence shows us that there are no short cuts in addressing the need for developing HRH:

- HRH shortages, skill mixes, migration and the work environment in health systems must be addressed;
- HRH are critical to outputs and outcomes, health systems and budgets.

There are now great risks in “standing alone”. A few ineffectual, fragmented and isolated measures were taken in the past but not only was there a lack of best-practice norms and standards, but there were insufficient learning opportunities, monitoring and evaluation. The current crisis in HRH does, however, have inherent opportunities:

- powerful levers are now in place for joint action in building health systems and harmonizing global initiatives; and
- working together we can improve performance, promote mutual accountability and engage with existing and new stakeholders.

Techno-political harmonization must involve health systems and the key issue of HIV/AIDS, as well as fiscal space and ceiling. Building information evidence should include public and private sectors.

The focus of the GHWA is to build the capacity of stakeholders. GHWA two-year deliverables include implementation of national strategies, generation of evidence and information on what works, guidance on how best to plan and implement strategies, and a growing community of practice.

### Chief nurse officers’ responses

**a) Mrs Sandra MacDonald-Rencz, Executive Director, Office of Nursing Policy, Health Canada:**

The overall goals of the Pan-Canadian Health Human Resources Strategy, currently being implemented, are to secure and maintain a stable and optimal health workforce in Canada and to support overall health-care renewal. Annual funding (US\$ 20 million) has been allocated to support initiatives on:

- 1) health human resources (HHR) planning;
- 2) interprofessional education for collaborative patient-centred practice (IECPCP); and
- 3) recruitment and retention.

Included in this overall plan is the HHR Databases Development Project where funding is being given to data providers to enhance their ability to collect information. Work is also under way to define and approve minimum data sets for occupational therapists, physiotherapists and pharmacists.

Canada is involved in the IECPCP Initiative which aims to:

- promote and demonstrate the benefits of interprofessional education for collaborative patient-centred practice;
- stimulate networking and sharing of the best approaches to interprofessional education for collaborative patient-centred practice;
- increase the number of health professionals trained in collaborative patient-centred practice, pre- and post-licensure;

- increase the number of educators prepared to teach from an interprofessional, collaborative patient-centred perspective;
- facilitate interprofessional collaboration in both education and practice.

Canada is also addressing recruitment and retention through the office of nursing policy.

The Canadian Healthy Workplace Initiative (HWI) addresses the issues and challenges outlined below.

- Costs of unhealthy workplaces to health professionals, to the health-care system and to patients are widely known; many innovative healthy workplace projects are being identified across Canada.
- There is a need for coordinated effort and improved knowledge exchange and uptake.
- The Pan-Canadian HHR Planning Framework is moving forward the related development of evaluation strategies, collaboration on the Aboriginal HHR Initiative and linkages with patient-wait time and care guarantees, key areas of concern to the Canadian general public.

**b) Mr Mitchell Clarke, Chief Nursing Officer, Ministry of Health, Barbados and Chairman; Regional Nursing Body, CARICOM:**

Based on common HRH indicators, a regional data base for HRH has been developed in Barbados, ensuring one system of data collection and using one software. Features of the system are outlined below.

- 1) In the basic log-in window the user enters his/her user name and password.
- 2) The main switchboard window allows the user to choose which option he/she desires.
- 3) The data entry form window is where the user enters demographic information about the nurses.
- 4) The reports page allows the user to choose what reports are needed.
- 5) The selected specialty page shows the form that allows the user to choose a specific area from which to generate reports. In response to queries about demographic information entered into the system, various printable forms display the information the user requires.
- 6) The database utilities section allows database administrators to control the users of the system, editing and/or restricting user privileges.
- 7) The user administration section allows for user information and privileges to be entered and edited. Records can also be deleted and access halted in case of user termination.
- 8) The change-password section of the system allows for the changing of users’ passwords.

**Technical session 6: Building health leadership capacity/leadership competencies**

**Chairperson: Dr Fariba Al-Darazi, Regional Nurse/Midwife Advisor,  
WHO Regional Office for the Eastern Mediterranean (EMRO)**

**Competencies for GCNMOs**

**Dr Marla Salmon, Director, Lillian Carter Center for International Nursing; The Nell Hodgson Woodruff School of Nursing, Emory University:**

The primary responsibility of GCNMOs is to achieve national public health goals through nursing and midwifery. The public good is seen as the “end”; nursing and midwifery as the “means”.

- For the “end” the chief nursing/midwifery office requires the capacity to plan, set policies, innovate, establish programmes, provide technical assistance and surveillance.
- For the “means” the qualities of the chief nursing/midwife officer include key leadership and assurance in meeting public health commitment.

GCNMO competencies comprise two domains. As outlined above, however, the key notion is that neither stands alone nor can succeed without the other.

- 1) **The first domain is public service.** This requires the capacity to address public-policy development and implementation, understand the political process and be political savvy, convene meetings and network, foster and maintain partnerships, collaborate across disciplines and sectors, build and maintain partnerships, communicate and advocate, and represent and serve as a spokesperson for nursing.
- 2) **The second domain is health leadership<sup>11</sup>.** This requires the ability to be an agent for transformation, the ability to execute plans and the ability to relate to people.
  - **Transformation capacities** needed in this domain require an orientation towards achievement and the community, together with a strategic approach based on analytical thinking and skills in finance, information-seeking and innovative thinking.
  - **Execution capacities** include skills in change leadership, collaboration, communication, the technical management of information, performance measurement, organizational design, process and project management, together with initiative and an organizational awareness.
  - **People capacities** include team leadership, human resources management, talent development, interpersonal understanding, an ability to build relationships, plus attributes such as self-confidence and professionalism.

**Nursing directorate — structure, roles and functions at the ministry of health**

**Dr Judith Shamian, President and Chief Executive Officer, Victoria Order of Nurses, Canada:**

The functions of the chief nursing officer (CNO) are to provide advice to government and access to decision-makers, to participate in agenda setting, to retain authority, to be the visible face of nursing for a nation and a unifying voice for diverse interests and roles. The CNO must build a national evidenced-based policy agenda, adding one block at a time. He or she must disseminate knowledge widely and engage and interact with a broad range of stakeholders, including targeted individuals and groups.

<sup>11</sup> This health leadership model is based on core competencies outlined by the National Center for Healthcare Leadership – see <http://www.nchl.org>

The CNO’s role provides an unparalleled opportunity to develop an appreciation of national and international challenges, while providing insight to others on the value of the role of nursing. It involves partnership. To influence and shape this, we need to establish the art and science, build incrementally and deliberately, and act thoughtfully! We must navigate murky waters – the next 10 years will be about change and flux. The leaders of nursing and CNOs will need to have charisma, courage, connections, a strong sense of self, intellect, stamina and, most of all, they need to be “bilingual” – that is, they must speak and understand “nursing” as well as the language and world of systems, health care, politics and the rules of the game. They need to know both worlds intimately and be able to explain one to the other!

The Officer in the Nursing Directorate in a federated structure – like Canada which is provincial and federal – reports to an assistant deputy minister and a deputy minister, but also works with secretaries general and directors in a matrix relationship.

The chief nurse who functions in an **executive model** is more likely to be found in unitary states where the ministry directly administers the health-care system throughout the country. This role applies to positions in national ministries in which the CNO exercises line authority over nurses and nursing services throughout the jurisdiction in question. For CNOs to exercise their authority effectively in this model, they need to have a reporting relationship within the upper levels of the bureaucracy where policy and macro-management decisions are made and carried out on a day-to-day basis.

There is also a **chief nurse advisory model**. This position does not carry line responsibility for the nursing workforce but, for optimal effectiveness, the reporting relationships of the position must again be at a senior level. Where this applies, an advisory CNO position can exercise influence on ministerial policy comparable to that of the executive model, although with less bearing on day-to-day management.

The **chief nurse dispersal model** (or quasi-model) is one in which there is no CNO – in many instances the pre-existing CNO position has been eliminated and the nurses dispersed among the ministry’s various programmes. Nurses in these positions may exercise some influence on policy and management as part of multidisciplinary teams and, in certain situations, they may be the team or programme leader. Although relatively senior in such instances, they often remain at a distance from central decision-making.

The **chief nurse programme model** manages specific programmes like education, human resources, HIV and others. This role requires a content expert and a manager with the responsibility to influence and manage programme-level functions and cross-functional and sector links. How is this accomplished? Methods include:

- making regional visits;
- arranging conference presentations and workshops;
- teaching classes;
- meeting with nurses at all levels on an ongoing basis;
- attending and creating forums for nursing and non-nursing stakeholders;
- making links with relevant government colleagues;
- participating in ministers’ and deputy ministers’ meetings, both nationally and internationally;
- sending out regular E-mail newsletters;
- publishing articles in professional/academic nursing and health journals;
- bringing the face of nursing into government through visiting scholars and other invited guests; and
- hosting national and international meetings.

## Government chief nursing responses

### a) **Dr Fatima Al-Rifai, Director, Federal Department of Nursing, United Arab Emirates:**

“A competency is an underlying characteristic of an individual, which is causally related to effective or superior performance in a job.”

– Boyatzis, 1982

The Director of the Federal Department of Nursing of the United Arab Emirates sets the strategic direction for the nursing service, secures resources (financial and human resources) and political support, builds leadership capacity, develops nurses of the United Arab Emirates, regulates and sets up standards, leads quality initiatives, coordinates and builds partnerships and networking, and is the national voice for nursing issues.

- The leadership competencies required for this role include:
  - skills in strategic planning,
  - organizational awareness,
  - problem-solving skills and customer focus,
  - a mission orientation,
  - the ability to innovate;
  - an understanding of team behavior, and
  - a tolerance to high stress.
- Leadership also requires her/him to be an “employee champion” who is flexible, has interpersonal skills and respect for others, including the ability to:
  - teach others,
  - continue learning,
  - value diversity, and
  - address conflict resolution.
- She/he needs to have extensive nursing knowledge, and:
  - be an expert in management of resources and information,
  - have a retentive memory,
  - pay attention to details, and
  - have skills related to reasoning, reading and writing.
- She/he also needs to:
  - be a “change consultant” who demonstrates teamwork, reasoning, influence and negotiation, integrity, honesty and creative thinking;
  - build the expertise of nurses;
  - address workforce diversity; and
  - develop the visibility of nursing.

- The challenges and opportunities faced in this position include:
  - the need to sustain programmes and projects;
  - dealing with “too many” projects and overload;
  - the need to secure resources (budgets);
  - the ability to effect change in an organizational environment; and
  - the ability to address high turnover and the related loss of expertise.

Based on her own experience, Dr Al-Rifai’s closing words to her colleagues in the Forum were to “Invest more in capacity-building. Deal with change effectively. Strengthen your own competencies. Deal with stress and manage time”.

### b) **Mr Mark Jones, Chief Advisor, Nursing, Clinical Services Directorate, Ministry of Health, New Zealand:**

A leadership role requires the ability to be **BIG** – **B** for **beginning** or **being**; **I** for **in**; and **G** for **government!**

To do the work of a CNO, keep **BIG** in mind!

- You need **big ears** – to listen to what is being said, to pick up on opportunities and to accept feedback.
- You also need **big feet** – to get out and about into the real world, to resist being trodden on, and to stick in doorways (when the doors are being closed against you and your endeavours).
- You need a **big mouth** – to speak out appropriately, to share your vision and to advocate for the nursing profession and others.
- You also need a **big stomach** – for challenge, for setbacks and for official dinners.
- You must have a **big heart** – to embrace a range of viewpoints, to show compassion, to provide stamina and to have fun.
- And you must also have a **big brain** – to be pragmatic, able to work around barriers rather than against them, have an eye on the vision, use judgment to anticipate hurdles and windows of opportunity, and influence systems to promote our vision!

## 4. Nursing reports — updates on recent activities

### 4.1 Reports by WHO regional advisers on nursing and midwifery

#### *Mrs Silvina Malvárez de Carlino, EMRO Regional Adviser on Nursing and Midwifery*

The report below was based on the Strategic Directions for Strengthening Nursing and Midwifery Services.

#### ■ KRA 1: Health planning, advocacy and political commitment

The problems related to shortage and poor distribution, recruitment and retention, and migration of skilled nurses and midwives (NMs) are common in all six WHO regions. Very few national policies on management and planning of the nursing and midwifery workforce have been established. Furthermore, the registration system of nurses and midwives is either poor or non-existent. All regions indicate that involvement of nurses and midwives in health-policy formulation and planning is limited and there is a lack of strong leadership. Response to KRA1 in the regions is outlined below.

- AFRO is developing a guideline for the implementation of strategic directions for nurses and midwives.
- AMRO is conducting a study on the nursing workforce and supporting implementation of a plan for nurses and midwives.
- SEARO assisted countries in the development of national strategic plans for nurses and midwives, disseminated workforce management guidelines for nurses and midwives and convened a meeting – the Multidisciplinary Advisory Group on Nurses and Midwives and Networking of Nurse/Midwife Education and Institutions.
- EMRO has established nurse/midwife service units to develop a national plan and strategies.
- WPRO established the South Pacific Chief Nursing Officer Alliance, a toolkit for nurses and midwives, and developed software to support workforce planning.

#### ■ KRA 2: Management of health personnel for nursing and midwifery services

Challenges to KRA2 include a shortage of personnel that compromises the quality of service, plus the fact that most nurses and midwives are underpaid, not recognized and have a poor career path.

##### Regional responses

- AFRO and SEARO are addressing the issue of migration of nurses.
- AMRO has analysed working conditions, devised a method to analyse the workload and developed a virtual learning course.
- EURO is working on supporting initiatives to improve skills, working conditions and incentives.
- EMRO is supporting the improvement of the working environment.
- WPRO has conducted a policy analysis and published a document on migration of skilled health personnel in the Pacific Region.

#### ■ KRA 3: Practice and health system improvement

The challenges to KRA3 are that nurses and midwives are not recognized as independent professionals but rather as secondary to doctors. The general observation is that there are too few standards for their practice,

there is no quality assurance for service and no monitoring system has been established for nurse/midwife contributions to the MDGs.

#### Regional responses

- AFRO is advocating for an enhanced nursing and midwifery contribution.
- AMRO is scaling up ANM production and working on the improvement of the mental health programme, planning for an increase of midwives and (trained) skilled birth attendants (SBAs), and supporting the HIV/AIDS 3x5 initiative.
- SEARO is working on policy/actions on SBAs, training of trainers on HIV/AIDS, guidelines for malaria and injury.
- EURO is working to raise the public's awareness of nursing and midwifery.
- EMRO is supporting the improvement of access to quality services and has developed professional practice models.
- WPRO is coordinating with the International Council of Nurses (ICN) in nursing leadership workshops and advocating safety practices. It is also working on SARS infection control with other units and supporting quality improvement of services.

#### KRA 4: Education of health personnel for nursing and midwifery services

All regions are concerned with standard/quality of pre-service education, shortage of teachers, the lack of opportunity for continuing education and the limited funding for research.

#### Regional responses

- AFRO intends to reorient the training of second-level nurses and increase production with limited teachers.
- AMRO has produced a teachers' manual and is supporting research.
- SEARO has identified core competencies for nurses and midwives and developed a curriculum and accreditation guidelines for a nursing education institution.
- EURO – nursing departments in universities in the region are doing more research.
- EMRO has revised the basic nursing curricular to focus on PHC and has upgraded the admission requirements.
- WPRO has supported learning centres, developed self-learning modules and published a sourcebook.

#### KRA 5: Stewardship and governance

Many countries have neither a council nor an act/regulation for nursing/midwifery. The focus of KRA5 will be to assist in the development and implementation of a nursing act/regulation; this will include working more closely with professional organizations, ministries of health, WHO Collaborating Centres on Nursing and Midwifery, WHO/HQ (various technical units and the Nursing and Midwifery Office) on policy and other global changes in WHO headquarters, WHO regional offices and partners for resource mobilization.

## 4.2 Global Network of WHO Collaborating Centres for Nursing and Midwifery Development

### *Professor Barbara Parfitt, Secretary General, WHO Collaborating Centres for Nursing and Midwifery Development, Global Network Secretariat:*

The Global Network of WHO Collaborating Centres for Nursing and Midwifery Development consists of 38 WHO collaborating centres (WHOCCs) whose strength lies not only in a collective expertise and knowledge of nursing and midwifery issues but also in the variety of global locations. A summary of their activities follows.

#### 4.2.1 Global network meetings and conferences

The thirteenth biennial meeting of the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development took place in June 2006. This meeting provided an opportunity for the members of the network to fully debate and discuss the issues of relevance to the group. The aim of the meeting was to monitor, review and re-set strategic goals, identify mechanisms to strengthen regional and global collaboration, maximize opportunities for development of partnerships and participation in project work, and consider the internal infrastructure of the network to enable a cohesive, rapid response to development needs.

The WHO collaborating centre based at Glasgow Caledonian University is hosting a conference entitled "Resourcing global health". This conference is to be held in collaboration with the global network of WHOCCs and in partnership with the Royal College of Midwives and the Royal College of Nursing. The theme of the conference was chosen to augment the WHO 2006 campaign message – "working together for health". The aim, aside from providing the opportunity for intellectual exchange and networking, is to prepare a position statement that underlines opinions expressed by the nurses and midwives at the conference on the global HRH shortage. This statement will be fed back to governments.

#### 4.2.2 Community of practice – development phase

At least seven collaborating centres are participating in the developmental phase of the Global Alliance for Nursing and Midwifery Community of Practice (being conducted by the WHO Nursing and Midwifery Office and Knowledge Management Systems). Subject areas include making pregnancy safer, HIV/AIDs and, potentially, family health nursing.

### 4.3 Report of the International Council of Nurses and WHO in partnership

#### **Mrs Judith Oulton, Executive Director, International Council of Nurses (ICN):**

The report of the International Council of Nurses (ICN) highlighted its most recent activities, outlined below.

**Girl-Child Education Fund (GCEF):** The GCEF supports the primary and secondary schooling of orphaned daughters of nurses by providing for the costs of school fees, uniforms and books. National nurses' associations (NNAs) in Kenya, Swaziland, Uganda and Zambia are coordinating the funding for 40 students – 15 in primary schools and 25 in secondary grades. To date, nurses have contributed US\$ 128 000 to this much-needed initiative.

**Workplace violence in the health sector:** In cooperation with the Norwegian Nurses' Association and using the education materials from the ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, ICN is providing technical assistance in a three-year project that aims to reduce workplace violence in Botswana, Lesotho, Mauritius, Namibia, Swaziland and the United Republic of Tanzania.

**Leadership for Change™ Programme (LFC):** ICN offers the basic LFC programme as well as a “training of trainers” (TOT) whereby certified trainers implement LFC through a licensing agreement with a provider organization. To date ICN has certified 102 trainers and licensed 19 providers. LFC is now operating in over 20 countries, in 13 of which WHO is a partner. New programmes began in 2006 in the British Virgin Islands, Jordan, Papua New Guinea, Seychelles, South Africa, and Trinidad and Tobago.

**Global Nursing Review Initiative:** In March 2006 ICN and the Florence Nightingale International Foundation (FNIF) issued the final report of The Global Nursing Review Initiative: Policy Options and Solutions that examined nursing shortages and identified priority areas for intervention<sup>12</sup>. ICN and FNIF will now begin to address issues within the following five priority areas:

- 1) macroeconomics and health-sector funding policies;
- 2) workforce policy and planning, including regulation;
- 3) positive practice environments and organizational performance;
- 4) retention and recruitment; addressing poor in-country distribution, and out-migration; and
- 5) nursing leadership.

**International Centre on Nurse Migration:** This Centre is an international resource for the development, promotion and dissemination of research, policy and information on migration of nurses. A successful conference on Positive Practice Environments for the International Nurse, co-sponsored by the International Centre for Nurse Migration (ICNM), the Royal College of Nursing (RCN) and the Commonwealth Secretariat, was held in February 2006 in London<sup>13</sup>. A similar conference is planned for the United States.

**ICN mobile libraries:** To date over 130 mobile libraries have been sent to 16 countries. ICN is collaborating with the United Nations High Commission for Refugees (UNHCR) and Merck to supply mobile libraries in refugee camps in the United Republic of Tanzania and Zambia. Fifty libraries will go to camps this year. Progress on the Portuguese mobile library is well under way and their first 15 libraries will be shipped in the near future. Work has begun on the French library and the Spanish version is also under way. ICN worked with the Swaziland Nurses Association (SNA) in developing the Wellness Centre of Excellence for health workers and their immediate families. This first centre, supported in part by the Danish Nurses Organization and the Stephen Lewis Foundation, will deliver training, post-exposure prophylaxis (PEP), comprehensive HIV and TB treatment, stress management and other services. Phase 2 will see the Govern-

<sup>12</sup> The complete set of papers is available on the Internet at: <http://www.icn.ch/global>

<sup>13</sup> For the associated monograph on best practices and a consensus statement from the conference see <http://www.intnursemigration.org>

ment of Swaziland roll out centres throughout the country. ICN will shortly start working with other NNAs in Africa to establish similar centres.

**TOT in TB prevention and care:** ICN, in partnership with Eli Lilly and NNAs, offers a TB TOT programme for TB high-burden countries. By the end of 2006 TOT will have been implemented in Malawi, Philippines, Russia, South Africa and Swaziland. ICN has also developed TB guidelines for nurses, a tool kit on TB-related stigma, a fact sheet on workplace issues and TB, and a web-based TB resource centre.

**ICN Observatory on Licensure and Registration:** The ICN Observatory on Licensure and Registration was established in 2005. It will provide leadership in influencing policy on global regulatory matters with the aim of enabling ICN and the nursing profession to anticipate and respond in a timely and appropriate manner to international regulatory developments. The Observatory carries out regular trend scanning, analyses the impact of emerging regulatory policies/issues, identifies priority issues related to licensure and registration which should be addressed by ICN, assists ICN to develop a sound policy related to licensure and registration, and promotes strategic thinking and research on regulation as well as collaborative action in the regulatory field. The Observatory met for the first time in 2005 and will report to the Council of National Representatives (CNR) in 2009.

**The International Confederation of Midwives/International Council of Nurses (ICM/ICN) Regulators' Forum:** This forum of government and independent competent authorities met in Madrid 2005 for the first time, providing an opportunity to bring together the full spectrum of those that determine the practice of nursing, including independent, multi-professional and government regulators. The aim of the forum was to identify key trends and issues, share experiences and explore challenges facing regulatory practices. Planning for a second such forum is currently under way.

**Tuning project:** The European Union has been working on nursing competencies for a number of years and nurses are now taking part in this. Nursing work was previously conducted mainly by educators with limited input from chief nurses, regulators or NNAs. There is thus, at present, a great deal of discord as to what nursing competencies are. The project has now gone beyond the boundaries of the European Union and is engaging countries further afield – in wider Europe and in 17 Latin American countries. ICN and the European Foundation of Nurses (EFN) have produced a statement supporting the concept but highlighting a number of concerns. Importantly, these concerns include the need for wider involvement of stakeholders, the need to ensure that the competencies more accurately reflect the role of the nurse, and the need to consider the wider impact of introducing these changes to services.

**New publications 2005–2006 and forthcoming events:** See the ICN web site: <http://www.icn.ch>

#### 4.4 International Confederation of Midwives

**Mrs Kathy Herschderfer, Secretary General, International Confederation of Midwives (ICM):**

Projects are being implemented to assist young midwives take on leadership roles in their own countries. The aim is to build capacity by preparing midwives for management, leadership and policy positions, not only in midwifery but in the broader health services.

#### 4.5 International Labour Organization (Office)

**Mrs Susan Maybud, Health Services Specialist, Sectoral Activities Programme, International Labour Organization (Office) (ILO):**

Mrs Maybud's presentation focused on the Nursing Personnel Convention (C 149) which she described as an up-to-date instrument, reaffirming its relevance in today's socioeconomic climate despite the fact that it was drawn up in the 1970s. This Convention was classified by the ILO in 2002 and, although now nearly 30 years old, sadly not much progress has been made in the improvement of nurses' working conditions in many countries. The same concerns that prompted international attention on working conditions in health services in the 1970s still unfortunately prevail today. The health-care profession is not attracting enough new recruits – neither in developed nor developing countries. It is, furthermore, losing large numbers of trained personnel to areas outside the health sector. Although drafted decades ago, the spirit of Convention 149 is consistent with the 2001 World Health Assembly resolution on strengthening nursing and midwifery (WHA 54.12). The Convention recognizes the vital role of nursing personnel and other health workers for the health and well-being of populations. It sets minimum labour standards specifically designed to highlight the special conditions in which nursing is carried out. To encourage countries to ratify the Convention there is a need to raise awareness – through lobbying, involving the media and holding consultations.

ILO can help constituents that are interested in the ratification and application of Convention 149 in a number of ways, such as:

- providing promotional material and facilitate workshops and discussions to develop a better understanding of the Convention;
- giving technical support to government officials in establishing a consultation mechanism; and
- assisting governments, employers' and workers' organizations in providing guidance and training on social-dialogue processes.

#### 4.6 Office of Nursing and Midwifery (WHO Secretariat)

**Dr Jean Yan, WHO, Chief Scientist, Nursing and Midwifery Office (NMO), WHO:**

In its work, the NMO operates closely under the umbrella of Article 1 of the WHO Constitution that states: "The objective of the World Health Organization ... shall be the attainment by all peoples of the highest possible level of health". The mission of the NMO is to enable Member States to provide equitable access to an adequately educated, skilled and supported workforce to meet health needs.

At headquarters level, NMO works with priority programmes, including HIV/AIDS, Making Pregnancy Safer, Stop TB, Malaria, Mental Health, Chronic Diseases and Child and Adolescent Health. Other activities focus on advocacy and developing/strengthening partnerships.

#### 4.7 WHO Global Advisory Group on Nursing and Midwifery

**Professor Joyce Thompson, Lacey Professor of Community Health Nursing, Bronson School of Nursing, West Michigan University, United States of America:**

The Global Advisory Group on Nursing and Midwifery (GAGNM) is a multidisciplinary group of visionary and strategic thinkers who are experts and leaders in nursing, midwifery, economics, law, health systems, management and health policy. Following the resolution to strengthen nursing and midwifery (WHA 54.12), the GAGNM was established to advise the WHO Director-General on all matters pertaining to nursing and midwifery. The WHO/NMO is the focal point for the GAGNM and serves as the secretariat for its work. The GAGNM met in Geneva in October 2005, by teleconference in April 2006 and, between meetings, has maintained electronic communication.

In collaboration with the Office of the Senior Scientist for Nursing and Midwifery, GAGNM's most recent challenges have included consultation and participation (including monitoring) in the preparation of the World Health Report 2006, Human Resources for Health, and the interim report of progress on WHA54.12 for the 2006 World Health Assembly. Several suggestions on the recognition of the professional midwife as the prototype skilled attendant were in keeping with World Health Report 2005, Make every woman and child count, with its emphasis on MDGs 4 and 5.

In keeping with the Strategic Directions for Nursing and Midwifery Services 2002–2008, GAGNM members keep an eye on the ongoing challenges at regional, national and local levels in their home countries and support Member States in their efforts to improve their nursing and midwifery services. Examples of such challenges include:

- limited visibility of nurses and midwives in health-policy decision tables,
- limited nurses' voices in health-system development and regulation,
- issues of migration and workplace safety, and
- continuous attempts to put nursing and midwifery services under the title of "human resources for health", without any recognition that nurses and midwives are the backbone of every health system.

The national and regional issues are often replicated in the global arena and provide evidence/support for recommendations made to the WHO Director-General to strengthen nursing and midwifery and increase its visibility within WHO programmes and priority areas of work — especially in policy roles. GAGNM was pleased to note that this visibility has recently been increasing within WHO headquarters – in programmes such as Making Pregnancy Safer, HIV/AIDS, and Stop TB. Furthermore, the new Director of HRH has requested GAGNM's advice and has promised to work in partnership with nurses and midwives in improving the availability of quality nursing and midwifery services. However, much room for improvement still remains.

The members of GAGNM welcome ongoing collaboration with chief nursing and midwifery officers on issues related to nurse/midwife services and how to strengthen these within countries. GAGNM underscores the need for ongoing collaboration with government, education experts, health economists and health policy-makers as nurses and midwives take on their rightful leadership roles in health systems and services.

## 5. Conclusions: Forum statement . . . . .

### 5.1 Strengthening health systems and patient safety

In the conclusions and recommendations on **strengthening health systems and patient safety**, the delegates and participants:

- 1) supported the intention of the WHO Patient Safety Programme to create a nursing alliance for patient safety, but were concerned that this could restrict nurses and midwives to discussions with one another only;
- 2) expressed the wish to be actively involved in discussions with other key stakeholders on actions needed to advance the patient-safety agenda;
- 3) expressed an interest in ways in which countries could apply evaluation data and lessons learnt from the European study of the family health nurse (FHN) initiative in their respective countries and regions; it was assumed that development of similar initiatives would be customized to the needs, systems and cultures of respective countries/regions.

### 5.2 HIV/AIDS/TB

In their conclusions and recommendations on **HIV/AIDS/TB**, the delegates and participants:

- 1) committed to work with other health leaders in their respective jurisdictions and/or regions to develop and implement the strategies needed to advance HIV/AIDS programmes; they further indicated their belief that nurses would be valuable and capable candidates for HIV/AIDS national officer posts;
- 2) requested WHO to ensure the systematic scale-up of nursing/midwifery preparation to assure that nurses and midwives are able to fulfil the critical role they are required to play in the successful prevention, care and treatment of HIV/AIDS, malaria, tuberculosis and other opportunistic infections;
- 3) expressed strong support for the need to treat and support infected nurses, midwives, other caregivers and their families as a priority in the overall human resources strategy for HIV/AIDS;
- 4) indicated interest in ways in which they could apply key aspects of the Zambia/Norway Care for the Caregiver Initiative in their respective jurisdictions.

### 5.3 Partnership for maternal, newborn and child health, making pregnancy safer, child and adolescent health and development, reproductive health and research

In their conclusions and recommendations on the above issues, the delegates and participants:

- 1) agreed that MDG Goals 4, 5 and 6 cannot be achieved without more strategic engagement of nurses and midwives at all levels (WHO headquarters, regional, country) in programme planning and implementation; evidence to support the value and efficacy of nursing/midwifery involvement exists and must be acted upon by policy-makers and decision-makers;
- 2) acknowledged that global, regional, country and cross-sectoral collaboration is needed to benefit communities and the maternal child agenda; nurses and midwives need to be an integral part of this process;
- 3) urged that a forum of ministers of health and GCNMOs be convened to resolve the scope of practice issues that are impeding effective response to the challenges of maternal and infant mortality (the Lillian Carter Center made a commitment to provide an opportunity to discuss some of these issues at the next partnership meeting).



WHO Regional Office for the Western Pacific. Module on Gender-Based Violence. *Integrating Poverty and Gender into Health Programmes*. A Sourcebook for Health Professionals. Manila, World Health Organization, 2005.

WHO Regional Office for the Western Pacific. A report on surveys of health ministries and educational institutions. *Integrating Poverty and Gender into Health Programmes*. Manila, World Health Organization, 2005.

WHO Stop TB Partnership. *Actions for Life. Towards a world free of tuberculosis. The Global Plan to Stop TB 2006–2015 information package*. Geneva, World Health Organization, 2006.

WHO Stop TB Partnership. *Tuberculosis 2006*. Geneva, World Health Organization, 2006 (WHO/HTM/STB/factsheet/2006.1).

WHO. Strategic directions for strengthening nursing and midwifery services 2002–2008. Geneva, World Health Organization, 2002. Available at: [http://www.who.int/hrh/nursing\\_midwifery/en/](http://www.who.int/hrh/nursing_midwifery/en/)

WHO. *Working together for health: The World Health Report, 2006*. Geneva, World Health Organization, 2006.

### WHO networks of government nurses

**WHO headquarters database:** In countries which have a post for a chief nurse officer, the governments generally nominate her/him to be the official focal point for coordination with WHO on nursing activities. WHO maintains a database that is regularly updated and subject to continual development at headquarters. Data comprises contact details, biographical details and any other relevant information.

The nursing and midwifery pages of the WHO global website (<http://www.who.int>) have regular postings for nurses/midwives. For more information and/or access to the database, contact the Nursing and Midwifery Office, World Health Organization, 20 Avenue Appia, 1121 Geneva 27, Switzerland; telephone +41 22 791 4781, fax +41 22 791 4747, e-mail [nmo@who.int](mailto:nmo@who.int)

**WHO regional databases:** WHO regional offices also maintain data on government nurses and, in some countries, hold regular meetings for nurses. For more information contact the nursing adviser in the relevant regional office.

**Annex 1: WHO implementation of recommendations based on the 2004 GCNMO Forum statement**

Priority area	Conference statement	Progress
Building leadership capabilities	<p>Build links and identify mechanisms for joint work with the Health Leadership Service (HLS) Programme in the Department of Human Resources for Health, WHO, Geneva.</p> <p>Encourage more WHO fellowships for nurses and midwives.</p>	<p>✓ First HLS class started in 2005. One of the participants had a nursing background.</p> <p>✓ From 2002 to 2003, WHO offered 3601 fellowships; 352 (9.8%) of these were for nurses and midwives. Data for 2004 to 2005 will be available in June 2006.</p>
Human resources for health (HRH)	<p>Strong input and involvement of nurses and midwives (NM) in effectively tackling the issue of migration, staff deployment, equitable access to services and making best use of skills.</p> <p>Government chief nurses welcomed proposals to work in close cooperation with WHO/HQ and HRH on healthy and safe workplaces.</p>	<p>✓ Minimum nurse/midwife (NM) involvement in HRH regional consultations, very limited resources to address NM issues.</p> <p>✓ The World Health Report 2006 and World Health Day 2006 on the theme “Working Together for Health” had substantial information on NM.</p> <p>✓ WHO headquarters and regional involvement of nurses in collaboration with ILO on workplace violence, the Convention on Nursing Personnel (C 149) and guidelines on health services and HIV/AIDS.</p>

Strengthening health systems	Opportunities to demonstrate how NM were leading new models of service development for strengthening primary health care.	<ul style="list-style-type: none"> <li>✓ Introduction of family health nursing in 13 European countries.</li> <li>✓ Nurse-managed care to be introduced.</li> </ul>
Maternal and newborn health	Continued collaboration in providing quality maternity care and outcomes through use of trained birth attendants.	<ul style="list-style-type: none"> <li>✓ Joint statement on skilled birth attendants.</li> <li>✓ Data on health workers save lives.</li> </ul>
WHO HIV/AIDS and the "3 x 5" initiative	<p>Pledge to appoint nurses to new HIV/AIDS posts throughout WHO (headquarters, regional and country offices).</p> <p>Government nurses offered the opportunity to work with WHO to document and disseminate modes of good practice.</p>	<ul style="list-style-type: none"> <li>✓ One nurse assigned to work in the HIV/AIDS Department at WHO headquarters for two years.</li> <li>✓ There are 60 HIV/AIDS officers at the national level.</li> <li>✓ Need feedback from priority countries.</li> </ul>
Making, monitoring and reporting progress	<p>Pilot the formulation of country NM profiles as part of the national planning process, using a minimum data set.</p> <p>Report to World Health Assembly on progress towards the strategic directions for NM services.</p>	<ul style="list-style-type: none"> <li>✓ Need information from countries.</li> <li>✓ Progress report to the 2006 World Health Assembly.</li> <li>✓ Global Survey on Nursing and Midwifery available in English, Spanish and French.</li> <li>✓ NM resources supporting Mental Health Programme at the country level (a mental health atlas on nursing is under preparation).</li> </ul>

Strengthening government nurses' networks	<p>Government chief nurses expressed commitment to network globally and regionally.</p> <p>Re-convene Forum in 2006.</p>	<ul style="list-style-type: none"> <li>✓ Regional meetings of Chief Nursing Officers convened in the following regions: AMRO/PAHO (Caribbean), SEARO, EURO, EMRO and WPRO.</li> <li>✓ The second Global Forum for Government Chief Nursing and Midwifery Officers held in May 2006!</li> </ul>
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**Annex 2: Keynote speech by Dr Sylvia T. Masebo, MP,  
Minister of Health, Zambia**

*This speech was presented at the opening session of the GCNMO Forum on 17 May 2006 on behalf of Dr Masebo by His Excellency Love Mtesa, Ambassador of Zambia to the United Nations, Geneva.*

Greetings to you all, distinguished participants.

It is a pleasure for me to address this meeting on this important day, “the World Health Organization Forum for Government Chief Nursing and Midwifery Officers”. On this day, we remember our Government Chief Nursing and Midwifery Officers (GCNMOs) as professional leaders playing strategic, managerial roles in your countries and catalysts for health development.

I would like to thank the World Health Organization for inviting me to address this Forum for representatives of Government Chief Nurses and Midwives. It is my hope that this international Forum will provide an opportunity for detailed interrogation of many issues affecting your profession and maternal health in Africa in particular.

It is critical that there is regular interaction between representatives of Government Chief Nurses and Midwives in order to ensure that there is mutual understanding of the challenges facing various countries in the area of nursing and how these challenges should be tackled. I am pleased that the World Health Organization has made efforts to facilitate this interaction and build the relationship which we believe is critical in addressing the health and social challenges which our countries are currently going through.

This meeting comes at the right time as we are involved in global discussion on finding a long-lasting solution to the human resources crisis which has crippled most countries. In view of the ever-increasing disease burden arising from HIV and AIDS, the need for nurses and midwives cannot be over-emphasized.

Maternal deaths demonstrate high levels of inequities that still exist within our society and between the developed and developing world. In many developing countries, maternal deaths account for up to 25% of all deaths among women of reproductive age. While only 11 % of women of reproductive age are found in Africa, Africa counts for 40 % of the world’s maternal deaths.

Coming back to this Forum, it is important that we discuss policy advancement and health system issues that impact on maternal and neonatal health services. Of late there has been some realization in less developed countries that obstetric fistulae are increasingly becoming a problem. Deliberations on this and other issues are important in informing further interventions to improve the health of women in particular. It is critical to implement strategies such as advanced midwifery training, emergency obstetric care, appropriate use of the partogram and good antenatal care services at all levels.

As you know, the health of women and children is also an important indicator in the world’s efforts to meet the Millennium Development Goals relating to health. These goals include addressing the challenges of hunger and lack of access to safe water, reducing maternal and child mortality and beginning to reverse the prevalence of infectious diseases like HIV and AIDS, tuberculosis and malaria by 2015.

However, you will note that the proportion of births that were attended to by a trained health professional in most less developed countries is still less than 65%. This can be attributed to the lack of access to health services, in terms of availability of both health facilities and midwives in various communities.

The negative developments around maternal and child mortality indicate that we are far from achieving our target and that we need to scale up our efforts to further improve the lives of women and children. We need to ensure that the basics are there for midwives to provide quality services to our people. This includes adequate blood supplies and necessary medicines and equipment.

All midwives and supportive health-care providers need to keep abreast of the developments in the management of various health conditions that have implications on maternal health – such as HIV and AIDS,

hypertension, obstetric haemorrhage, pregnancy-related sepsis and other pre-existing medical conditions. We have read and understand the policies and management guidelines and protocols to respond appropriately to the health challenges facing us.

At this juncture, let me thank the World Health Organization for having chosen Zambia to host the commemoration of World Health Day 2006, with the theme “Working Together for Health”, and the global launch of the 2006 World Health Report in Lusaka.

The World Health Report of 2006 – on human resources for health – seeks to address critical issues of staff shortages and career paths, as well as effective recruitment and retention strategies. It is important that we all remain committed to doing everything in our power to progressively improve the working conditions and staffing levels for nurses and midwives. We believe that nurses and midwives are the backbone of health-care service delivery.

Government Chief Nursing and Midwifery Officers need to provide leadership and ensure that policies are translated into programmes and activities and, where possible, that those requiring government interventions are standardized into government workplans and activities.

This year – 2006 – is a very important year for nurses and midwives. A resolution – WHA54.12 – is going to be reported on in the World Health Assembly. Progress made on this resolution depends on many players in each country and in each region, but Government Chief Nursing and Midwifery Officers are officially responsible for driving the outcome of this resolution.

In order to function optimally as Government Chief Nursing and Midwifery Officers, it is my hope that you will together identify the core competencies necessary for effectively leading nursing and midwifery in your respective countries and that you will not just stop there, but will also identify ways of strengthening the acquisition of these competencies through the many strategies available to you, such as distance learning, exchange visits and mentorship programmes.

Health systems cannot be strengthened without strengthening nursing and midwifery. As Government Chief Nursing and Midwifery Officers you need to revisit the role of nursing and midwifery in strengthening health systems. In some instances this will require expanding roles or re-defining them. Whatever the case, current issues in context need to be taken into account to constantly make nursing and midwifery relevant. These actions may call for some introspection and collaboration with other stakeholders in health.

I wish to call for action from the World Health Organization, observers and donors’ representatives and reiterate the need for advocacy, with accompanying resources (human and financial), to support countries to move the agenda forward and for the provision of technical support in making plans on strengthening human resources for health operational.

In conclusion, I wish to remind you that the challenges facing Government Chief Nursing and Midwifery officers are many but I am convinced that all of you can live up to the challenges. None of you is an island so together you can surmount whatever obstacles may come your way.

I urge you to position yourselves appropriately within the Ministry of Health and support and work with other senior management teams in your respective Ministries of Health or boards.

It is my hope that you will implement whatever resolutions you come up with from this meeting.

Thank you very much.

### Annex 3: Forum evaluation

Participants submitted confidential written evaluations at the end of the Forum. Their main conclusions are outlined below.

#### Strengthening nursing and midwifery

The government chief nurse and midwife officers (GCNMOs) greatly appreciated the theme of this year’s World Health Assembly (WHA) – working together for health – and its focus on strengthening nursing and midwifery. WHO’s renewed and revised commitment to the Office of Chief Nurse Scientist was evident throughout the meeting, as was the collaboration between departments.

Participants appreciated the opportunity to learn more about WHO – in particular the addresses by its leaders, their introduction to the WHA and their briefing in preparation for it. Their observations anticipated the WHA resolution to formally strengthen nursing and midwifery, announced within days after the Forum (WHA 59.27).

Forum participants appreciated:

- the benefit of sharing similar country responses and the commitments of respective governments to nursing and midwifery;
- the wide range of information gained from the presentations from different regions;
- the sharing of updated information between CNMO colleagues;
- the value of WHO technical expertise shared within the Forum in several key areas where nursing and midwifery are making – and can make – major contributions;
- the discussions that linked the contributions of nurses and midwives worldwide with the worldwide support for them; they saw this as an essential element in the achievement of the Millennium Development Goals, particularly numbers 4, 5 and 6.

Based on the above observations, participants recommended that future forums focus particularly on issues of nursing retention, human resources for health (HRH), workforce management and the HRH impact on priority agendas.

Many participants appreciated the contributions that focused on nursing leadership – especially Dr Salmon’s presentation on the strengthening of GCNM offices and officers (Emory University) and Mrs Oulton’s contributions on the activities of the International Council of Nurses.

#### Forum objectives

The majority of participants agreed that the objectives of the Forum were clear and the presentations extremely informative. They noted the high quality of papers presented and considered the panel sessions excellent, with a good selection of speakers.

However, they considered that the list of objectives was fairly ambitious since, given the time-frame, in-depth coverage of the objectives was “a huge challenge.”

#### Forum programme design

The majority of the participants liked the organization of the Forum. They observed that, although the time management of the presentations had been efficient and despite the fact that programmes had been condensed, the amount of time allocated was inadequate. Several noted that more time was needed for each presenter. The consensus of opinion on this was aptly summed up by a participant who wrote that the Forum was “extremely well managed [but] could have been better [with] more time for sessions”.

Although many expressed appreciation for the wide variety of topics, the length of the sessions and the allowance for overlap during the discussions, there was a recurrent request for more opportunities to participate in discussions.

Participants liked the inclusion of technical sessions, with the format that allowed for their full participation and, in the words of one [facilitating] chair, enabled “everyone to express their views in this session”. They also noted, by name, the value of the presentation by Mark Jones, the newly-appointed chief nurse officer (CNO) of New Zealand. One respondent noted that a nurse/midwife officer (NMO) “... [need] not have to chair every session to allow ... [him/her] to listen to discussions”.

The effectiveness of ending each session with an official “forum statement” and the inclusion of final action points was consistently noted. Participants also expressed appreciation for the reception they received and the organizers’ commitment of the to the proceedings.

#### **Networking is significant**

A high percentage of respondents noted the value of networking and sharing experiences, formally and informally, and expressed the need for more specific time to network with each other. “Sometimes,” one evaluator noted, “we need time to just meet and talk.” They wanted to meet other CNMO colleagues from various countries. In this context, several participants responded that they would have liked the CNMOs to have been formally introduced, with an initial discourse from each CNMO attending.

#### **What is needed to facilitate home-country follow-up?**

When asked what they needed for their own action plans in “home-country follow-up,” participants gave the following replies:

- a data base on and for nurses and midwives;
- formulation of a nursing alliance;
- sharing of current WHA and WHO resolutions related to nursing and midwifery with permanent secretaries and ministers of health so as to gain their support in implementation;
- regular dissemination of relevant information to nurses and midwives;
- support to review each country’s strategic plan on nursing and midwifery;
- follow-up information on topics presented, including strengthening of health systems and patient safety, HIV/AIDS/TB, maternal and child health (MCH), pandemic preparedness, HRH and building health leadership;
- facilitation of the ability of GCNMOs to make links with colleagues in other countries.

#### **Observations for logistics of upcoming meetings**

In a positive critique on how to improve the next forum programme, participants requested that the points outlined below be taken into consideration.

- Longer sessions convened over “three days, not two days”, allowing for a longer stay that could include the entire World Health Assembly.
- Introduction of delegates/participants early during the forum, with a more formal means of identifying each other in place, especially on the first day.
- A clearer orientation for people attending for the first time.
- Sufficient copies of forum documents available for everyone attending the forum.
- Content of sessions to focus on a few technical topics. This would allow more time for sharing of country perspectives and, if only two or three main issues were addressed, there would be more time not only to discuss these issues in depth, but also to generate forum recommendations.

- Inclusion of a “break-out session format” to allow participants more time to discuss issues related to their own countries and to facilitate group work that could be accomplished together during the forum.
- The forum venue located close to their accommodation.
- Arrangements for morning tea and lunches to be served at the venue itself.
- Inclusion of and some social activities within the actual programme.
- Time allocated for participants to develop action plans for review at the subsequent forum.

#### Annex 4: List of participants

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Caribbean Managed Migration Project

Global Network of WHO Collaborating Centres for Nursing and Midwifery Development

Global Workforce Project

International Council of Nurses

Lillian Carter Center for International Nursing, United States of America

Nightingale Initiative for Global Health (NIGH International), Canada

Nursing projects from the WHO Region of the Americas and Western Pacific Region; and from

WHO headquarters:

Essential Health Technologies Programme,  
HIV/AIDS and Home Care Activities,  
Human Resources for Health Research,  
Infection Control,  
Knowledge Communities and Strategies,  
Patient Safety Programme,  
Partnership for Safe Motherhood and Newborn Health,  
TBS/Stop TB, and the Nursing and Midwifery Office

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