REPORT OF THE GLOBAL CONSULTATION ON AN IMPLEMENTATION FRAMEWORK FOR SCALING UP NURSING AND MIDWIFERY CAPACITY

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World Health Organization
Department of Human Resources for Health
20 Avenue Appia
CH–1211 Geneva 27
Switzerland
www.who.int/hrh/nursing_midwifery/en/
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- Mrs Bertha Chipepo, Acting Registrar, General Nursing Council of Zambia
- Mrs Josephine Himoonga, Principal Tutor, University Teaching Hospital, School of Nursing, Midwifery and Theatre, Zambia
- Mrs Patricia Kamanga, Nursing and Midwifery Adviser, World Health Organization, Zambia
- Dr Miriam Libetwa, Human Resource Training and Development Specialist, Zambia
- Mrs Mercy Mbewe, Nursing Consultant, Lusaka, Zambia
- Mrs Jennipher Munsaka, Executive Director, Zambia Union of Nurses Organization
- Mrs Ruth Muzumala, Country National Representative, East, Central and Southern African College of Nursing (ECSACON), Zambia
- Mrs Dorica Mwewa, Chief Policy Analyst, Nursing Services, Ministry of Health, Zambia
- Mrs Catherine Ngoma, Head, Department of Post Basic Nursing, University of Zambia.

We wish to make special mention of the assistance rendered throughout the preparations and during the meeting by the secretaries – Mrs Katherine Sepa and Mrs Violet Yumba from the Ministry of Health and Mrs Annie Zulu from the World Health Organization – and for the information-technology (IT) support provided by Mr James Mkandawire from the Ministry of Health.

Last – but not least – we thank all those who are not personally mentioned above, but who contributed in one way or another to making this global consultation a success.

This report was compiled by Mrs Mwansa Nkowane.
INTRODUCTION

The World Health Assembly resolutions (WHA59.27 and WHA59.23) call upon Member States of the World Health Organization (WHO) to support countries in strengthening nursing and midwifery and in scaling up production of the health workforce. In response to this call, the Nursing and Midwifery Office of the WHO Department of Human Resources for Health in Geneva – in collaboration with the Ministry of Health of Zambia and the WHO Regional Office for Africa – held a global consultation in December 2007 on scaling up the capacity of nursing and midwifery. This consultation was a key step in the implementation of the 2007 Islamabad Declaration (Annex 3) that focuses on three main areas:

1) scale-up of nursing and midwifery capacity,
2) skill mix of existing and new cadres of workers,
3) positive workplace environments.

Prior to this consultation, an implementation framework on scaling up capacity for nursing and midwifery at the global level had been drafted at a WHO meeting in November 2006. Initial global efforts provided the foundation for this framework (which is still being discussed and reviewed).

The objectives of the Zambia consultation were to:

- discuss the draft framework for the global scale-up of nursing and midwifery capacity;
- share information and experiences on the scale-up of nursing and midwifery capacity at regional and national levels;
- produce a draft programme of work for the scale-up of nursing and midwifery capacity.

The achievements of the consultation included:

- further development of the framework for the global scale-up of nursing and midwifery capacity;
- sharing and documentation of lessons learned;
- the production of a draft programme of work for the scale-up.

A total number of 55 participants, representing a broad range of partners – anglophone, francophone and lusophone, from global, regional and country levels – attended the consultation (see Annex 1, list of participants). Bringing people together from around the world assured the global nature of the consultation and enriched the process of developing a programme of work for 2008–2009.
DAY 1 PROCEEDINGS

The consultation started with speeches and introductory remarks before proceeding to the technical sessions that formed the bulk of the deliberations. Dr Martins Ovbredejo, the WHO focal point for health and human resources in the United Republic of Tanzania, moderated all the sessions.

OPENING SESSION

The Chief Policy Analyst from the Ministry of Health of Zambia, Mrs Dorica Mwewa, welcomed the participants and thanked the invited delegates for coming to the consultation. She also thanked the World Health Organization for giving Zambia the opportunity to host the meeting.

Members of the panel in the opening session were: the Zambian Minister of Health, Brigadier General Dr Brian Chituwo (who delivered the keynote address), Nursing Professor Rachel Gumbi, Chairperson of the Global Advisory Group on Nursing and Midwifery (GAGNM), Dr Magda Robalo, WHO Representative (Acting) in Zambia, and Dr Jean Yan, Chief Scientist, Nursing and Midwifery Office, WHO, Geneva.

Dr Yan presented the objectives and anticipated outcomes of the consultation, indicating that the main achievement would be a draft programme of work comprising the following five key elements:

1) faculty development, education standards, educational guidelines and resources,
2) health-service provision,
3) talent management,
4) partnerships, and
5) the workplace environment.

Dr Robalo noted the disparities in human resources reflected in The World Health Report 2006. Based on the evidence presented in this report, 57 countries face a critical shortage of health workers – 36 of these countries are in Africa which has 24% of the disease burden but only 3% of the health workforce. Steps have been taken globally, regionally and at national levels to respond to the crisis in human resources for health, including the World Health Assembly resolutions (WHA59.27 and WHA59.23) on strengthening nursing and midwifery and scaling up production of the health workforce, the 2007 Islamabad Declaration on strengthening nursing and midwifery, the Global Health Workforce Alliance Plan, the Zambia Strategic Plan on Human Resources for Health 2006–2010 and the Congo Action Plan 2006. To meet this challenge, the WHO Regional Office for Africa developed a regional plan on strengthening nursing and midwifery in 2006.

Dr Robalo emphasized the important role that the WHO country office in Zambia plays in supporting the Government of Zambia in implementing the strategies for human resources for health.

In the following presentation Professor Gumbi stressed that health is the wealth of nations. Globally nurses provide 60% to 80% of the health care; in rural areas of Africa, however, this percentage can be higher, ranging between 70% and 85%.
Within the premises of the skill mix, nurses and midwives are the main providers of health care at all levels. It is critical for this consultation to explore mechanisms to provide a framework for scaling up the quality of service provision at all levels. Nurses are critical not only in the care and support of clients/patients but also in the role they play in advocacy. It is important that the health-care plans for nurses are research-oriented so as to contribute effectively to the achievement of the Millenium Development Goals (MDGs) – in particular, in combating HIV/AIDS to reduce child and maternal mortality. Nurses and midwives are not lone practitioners – they are members of the health team. “Health is the wealth of the nations.”

The role of Global Advisory Group on Nursing and Midwifery (GAGNM) is to advise the WHO Director-General on policy matters relating to nursing and midwifery. The GAGNM focuses on policy and decision-making on aspects such as service provision at all levels and support for the scale-up efforts. It aims to move from policy to action with regard to education, health-service provision, the workplace environment, talent management and partnerships, and to promote accessible holistic health care to improve the quality of life of the global community.

The Minister of Health, Brigadier General Dr Brian Chituwo, acknowledged the role of nurses and midwives and their contribution to the health of the people. Nurses and midwives in Zambia account for over 75% of its health workers. Their functions include the provision and promotion of preventive, curative, rehabilitative and/or supportive care to individuals’ families or groups. The Zambian Government has approved the establishment of a register for the Ministry of Health which: a) enables the Ministry to recruit staff to fill vacant posts, and b) expands the retention skim for doctors (introduced in 2004) to include other health workers, including nursing and midwifery tutors in training institutions. Under the new establishment, the target of the Ministry of Health is to recruit approximately 51,404 nurses and midwives; already 30,883 have been added to the payroll. In 2007 alone, 5,000 nurses and midwives were recruited. In an effort to train more nurses and midwives, more nursing and midwifery schools (that had been closed) will be re-opened in 2008; four schools were opened in 2007. As an added incentive, direct-entry midwifery will be introduced.

The Southern African Development Community (SADC) has a health protocol that requires specifications concerning the scale-up of nursing and midwifery capacity. Zambia is currently chairing the SADC and will ensure that a recommendation to include nursing and midwifery in the SADC health protocol is made. The Zambian Government has developed a 2006–2010 human-resource strategy to identify steps for health workforce development.

The Minister emphasized that this consultation was timely for Zambia. It fitted well with the aspirations of the country’s fifth National Development Plan which stipulates that, by 2030, Zambia will have become a middle-income country. The Minister stressed that the health systems and efforts to achieve the MDGs in Africa depend on nurses and midwives. Action-oriented strategies that focus on education for service excellence, health-care delivery that adheres to fundamental principles of primary health care, and a conducive environment for the health workforce are important elements in the provision of health services. Developed countries ought to make efforts to increase their own production of nurses and thus reduce migration from less developed countries; the recruitment of immigrant staff should, furthermore, be regulated between governments.

In conclusion, the Minister saluted the Zambian Nurse Association for its programme to assist the dependents of nurses who die from HIV/AIDS.
Session 1 aimed to highlight the various regional and country policies on human resources for health.

Members of the panel were:
- Thomas Allen
- Valerie Fleming
- Kathleen Fritsch
- Miriam Libetwa
- Sophia Mogotlane
- Mwansa Nkowane
- Bente Sivertsen
- Jane Winder
- Jean Yan

HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN 2006–2010
DR MIRIAM LIBETWA

Zambia cannot guarantee the provision of basic health care because of the human-resource crisis; it has an inadequate number of staff to deal with human immunodeficiency virus (HIV), malaria and tuberculosis. Zambia recognizes the need to address a wide range of issues, such as the skill mix, the working environment (dealing with demotivation, tardiness, etc.) and the provision of broader incentives. The 2006–2011 strategic plan for human resources for health is guiding the implementation of activities and strategies to meet human-resource objectives. The plan aims to:

- increase the numbers and equitable distribution of trained staff;
- increase productivity and performance of health workers;
- ensure an effective, ongoing and coordinated approach to human-resource planning across the sector;
- strengthen human-resource planning, management and development systems at all levels;
- recruit graduating students, retired health cadres, (Zambian) health workers in the region, foreign interns and retired expatriate specialists, and twin local and foreign institutions for the purpose of exchanging expertise in specialized areas and filling the human-resource gaps in the health sector.

Substantial progress has been made by the Zambian Ministry of Health in implementing the plan for human resources for health. The Ministry:

- is gearing to increase graduate output by re-opening selected training institutions;
- has worked out modalities to expand the Zambian Health Workers’ Retention Scheme;
- has developed indicators to monitor human-resource performance;
- is finalizing the development and implementation of an information system on human resources for health and a strategic human-resource planning tool;
- has finalized a draft HIV/AIDS workplace policy to support staff affected by the HIV pandemic.
Several challenges remain, however, including the mobilization of resources to implement and sustain the strategic plan for human resources for health, retention of skilled staff in health facilities, uneven distribution of staff between rural and urban areas, improvement of occupational health and HIV/AIDS workplace policies, weak human-resource management systems, improvement of conditions of service and the working environment, and meeting challenges such as poor performance, absenteeism, tardiness, and negative attitudes among health workers.

THE WHO REGIONAL OFFICE FOR EUROPE: IMPLEMENTATION FRAMEWORK FOR SCALING UP NURSING AND MIDWIFERY
BENTE SIVERTSEN

The key mandate for the scale-up of human resources for health in the European Region is its Regional Committee’s Resolution 57 on health workforce policies. This resolution addresses: a) information and knowledge (standards), b) strategies (skill mix, management), and c) migration (monitoring, ethics).

In her presentation, Mrs Sivertsen highlighted the strategies adopted to improve performance in the European Region.

- **Strategy 1**: Improving performance focuses on quality improvement, benchmarking, paying-for-performance, broader incentives, governance and management, the skill mix, substitution, delegation and innovation.

- **Strategy 2**: Education and training addresses licensing revalidation, the provision of incentives for continued education, harmonization of standards, the establishment of systems that respond to changing requirements and the application of “The Bologna process” (standardization of higher education in the 25 European Union countries and the 28 countries outside the European Union).

- **Strategy 3**: Regulating the framework for human resources for health by abandoning the “command and control” approach, integrating production, deployment, management and stakeholder involvement, and assuring coordination at different levels.

- **Strategy 4**: Information and evidence assures the availability of appropriate evidence for decision-making and focuses on the quality of data. Planning for human resources must be based on evidence but in many areas statistics and databases are inadequate and there is no uniform terminology.

The Health Ministers’ Conference in Tallinn, Estonia, in June 2008 will focus on the tripartite role of the health triangle – health, wealth and the health systems – looking at its impact and links, with nursing and midwifery as key factors. The conference will have input from nursing and include discussions on up-scaling.

Mrs Sivertsen stressed the need for collaborative partnerships.
WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC
KATHLEEN FRITSCH

The WHO Western Pacific Region includes 37 countries and territories. Economic trends are rising costs, fewer health workers, growing gaps between rich and poor, higher expectations from patients, a growing private sector and more competitive wages. Social forces shaping the health systems include globalization, migration, urbanization, consumer demands for health services and quality, pervasiveness of science and technology, and aging populations and health workers.

The Western Pacific Region has an average of 8.7 health workers per 1000 people, but some countries (including Cambodia, Papua New Guinea and the Solomon Islands) have less than 2 per 1000. The Western Pacific Region does not have the severe problems of illness in the workforce that affect some of the WHO regions but it does face challenges related to staff shortages, skill mix, imbalances, poor remuneration and work conditions, a weak knowledge-base, a lack of nursing contributions to policy formation, and high rates of maternal and child mortality in many countries (even though this is declining).

Most countries in the region are experiencing a shift to a higher burden of non-communicable diseases, with growing rates of heart disease, cancer, mental health problems and trauma. There is a recognized need to provide better services to patients – many studies have shown that people are not receiving safe care. An important aspect of scaling-up is that treating diseases is not the only requirement. Patients need help to deal with illness; they should be given a voice in decision-making and the opportunity to communicate privately. The costs of care are interfering with the ability to give people quality care.

The regional strategic plan for human resources for health includes the following principles for workforce development:

- a focus on the primary health care and referral system;
- equitable delivery of effective, affordable, good quality, safe health services, based on agreed core competencies and professional standards;
- the need to support the achievement of local and international goals and objectives such as the health-related MDGs;
- targeting the needs of vulnerable population groups first and foremost.

Countries in the region are moving from an uncoordinated approach to a coherent and consensus-driven partnership approach. A regional operational plan for nursing exists and key priority areas of work include comprehensive support for country-level improvements for human resources for health, strengthening education and accreditation.
DEVELOPMENT IN HUMAN RESOURCES FOR HEALTH
JEAN YAN

Nurses are essential to the achievement of the MDGs – especially Goal 4 on child mortality, Goal 5 on maternal health, and Goal 6 on HIV and other diseases. The vision and mission of WHO is closely linked to its definition of health “a state of complete physical, mental, and social well-being and not merely the absence of disease”. Yet there are two billion people worldwide with no access to health care!

The shortage of nurses and midwives is a systemic problem. It is caused by a number of factors, including:
- poor working conditions,
- a lack of professional development opportunities,
- a lack of promotion opportunities,
- the non-involvement of nurses/midwives in decision-making,
- a lack of support from supervisors,
- inflexible working hours,
- a fear of violence in the workplace,
- dissatisfaction with pension scheme changes,
- migration, and
- attrition due to HIV/AIDS.

The global response to the human-resource shortage is evidenced by the two resolutions passed by the World Health Assembly – WHA 59.27 on strengthening nursing and midwifery and WHA 59.23 on the rapid scale-up of workforce production – and supported by the Islamabad Declaration on strengthening the capacity of nursing and midwifery.

The Global Alliance on Nursing and Midwifery Communities of Practice (GANMCOP) has been established to allow nurses and midwives to participate in discussions globally. Its vision is to provide a global link between the 13 million nurses and midwives worldwide, the 6000 training institutions in nursing and midwifery, the 44 WHO collaborating centres, the 80 chief nursing officers and the 125 professional associations and regulatory bodies.
Panel members:
  Thomas Allen
  Valerie Fleming
  Miriam Libetwa
  Sophie Mogotlane
  Mwansa Nkowane
  Lise Talbot
  Jane Winder

SCALING UP THE NURSING AND MIDWIFERY WORKFORCE
VALERIE FLEMING

The Global Network of WHO Collaborating Centres (GNWHOCCs) has 39 centres worldwide, many of which have experience of working in Africa. The key strengths of the network are its established infrastructure, its global reach and its institutional and individual expertise. The network is ready to mobilize resources and work together to make a greater impact in building capacity.

The consultation provided an opportunity to generate a sense of commitment to the longer-term challenges and address some of the more immediate issues.

Challenges to scaling up the workforce include issues such as: a) the many classifications of nurses, midwives and/or related personnel, b) the fact that nursing and midwifery education is still hospital-based, c) curricula are often not designed to meet today’s needs, and d) no accreditation is given for previous learning or experience so there is little incentive for further study.

In support of WHO’s work on scaling up the capacities of nurses and midwives, the network is preparing a background document on development, together with training packages, for the following groups: preceptors, current nursing and midwifery tutors and managers, and leaders in nursing and midwifery education. Several WHO collaborating centres, including three in the African Region, have volunteered to develop modular programmes for these groups. The scope of outcomes include:
  - supporting local universities for accreditation;
  - development of modular programmes;
  - the creation of templates for programmes;
  - offering credits for each module and complete programmes;
  - establishing programmes for tutors and leaders, with some modules in common.
THE GLOBAL ALLIANCE OF NURSING EDUCATION AND SCHOLARSHIP (GANES) AND THE CANADIAN ASSOCIATION OF SCHOOLS OF NURSING (CASN)

LISE TALBOT AND JANE WINDER

The mission of the Global Alliance of Nursing Education and Scholarship (GANES) is to share resources, provide a strategic level of expertise and speak with a combined voice. The membership of GANES includes national associations of nursing deans and schools of nursing. The founding members come from Canada, the United Kingdom, the United States of America and the Council of Deans of Nursing and Midwifery in Australia and New Zealand.

The Canadian Association of Schools of Nursing (CASN) has a mandate of excellence in nursing. GANES is able to offer information, support and advice to health-care policy-makers and nurse educators across the world.

The mission of CASN is to lead nursing education and scholarship in support of healthier Canadians. It does this by fostering the highest standards in professional nursing education, promoting research and innovation that enhances the quality of nursing and health care, and contributing to sound public policies on nursing education, research and practice. CASN leads the nursing profession in the development and promotion of quality nursing education. It has been accrediting undergraduate nursing programmes in schools of nursing for 20 years (since 1987). CASN accreditation supports a quality-improvement philosophy.

The purpose of accreditation is to assess and review training institutions through a third party, looking at the structure, processes, outcomes, strengths, vulnerabilities and opportunities for improvement. Three countries in North America offer accreditation. Steps on accreditation evolve as follows: first, quality assurance for internal evaluation, followed by regulatory body approval and, finally, external evaluation. Accreditation is built on values – mutual respect, fairness, open communication/confidentiality, trust, transparency, acceptability, integrity. These values are recommended by international networks of quality assurance. The Accreditation Association in Canada has 31 accrediting bodies – for engineering, dentistry, nursing, etc. Many of these bodies require that students graduate from an accredited programme in order to be registered.

The principles underlying accreditation are non-prescriptive, flexible and a source of ongoing improvement; they are aligned with provincial regulatory requirements and congruent with CASN’s position statements; they assess structure, the process and outcomes (qualitative and quantitative) for graduates, learners and professionals, and have peer definitions of terms. The process for accreditation includes self-study by the schools, a pre-review, an on-site visit, a review report, a response to the report and, finally, a board decision.

Quality dimensions should be set up for accreditation. In Canada they look at: a) the curriculum – the framework, where the knowledge is coming from and the professional growth of the learners; and b) the administrative unit – leadership, governance, resources available, information systems used, environment and scholarship. The process of accreditation takes a year to prepare, one week to implement, then six to eight weeks to provide a report. The process provides inspiration; it reorganizes courses, clinical practices, time, and faculty deployment; it promotes excellence, provides benefits from external reviews and feedback, and raises the profile of the school.
The University of South Africa (UNISA) is an open distance learning institution which became a comprehensive institution in 2004 when it integrated technical programmes with university programmes. It has subsequently increased its student numbers to more than 230 000 and registrations in nursing have increased to over 9000.

The university offers bridging honours specialties (BSN), and research masters programmes in nursing. The bachelors degree bridging programme offers nurses with two years of training the opportunity to become professional nurses, and the choice to go on to follow a clinical honours programme or a masters programme in research. The honours programme covers intensive-care nursing and midwifery, trauma and emergency care, and a generic masters in education and management. Nursing programmes are now under the South African Ministry of Education. All nursing programmes offered at UNISA are accredited with the South African Ministry of Education and the South African Nursing Council.

A masters degree in public health is offered in collaboration with the University of Kwazulu Natal. In 2009 the focus will be on two streams – informatics and management. UNISA has a campus in Ethiopia where there has been a request to register 400 students. Even though access is open, UNISA may not be able to manage research dissertations for this many students.

Challenges are outlined below.

- The changing landscape in general education in South Africa – since the establishment of the new democracy in 1994 there have been many changes which affect the nursing programmes.
- In the past the nursing programmes were offered under the auspices of the South African Nursing Council. Now all nursing programmes are under the control of the Department of Education in a system that allows no exit points.
- Attracting students is difficult – diplomas were formerly awarded after two years of study so it was faster to get a diploma than a degree.

The bridging programme is very good for scaling up the workforce capacities. Each year UNISA qualifies 230 nurse educators, most of whom migrate. To curb the migration of nurse educators the Department of Health has developed retention strategies and is partnering with institutions of higher learning to produce more nurse educators. Attempts to recruit nurses from outside South Africa have not been successful. UNISA hopes to initiate accreditation of programmes in the near future.
SCALING UP PRODUCTION OF NURSING AND MIDWIFERY TUTORS IN THE WHO REGIONAL OFFICE FOR AFRICA

MWANSA NKOWANE

As Dr Robalo noted during the opening session, globally 57 countries are experiencing critical shortages of human resources for health – 36 of these are in Africa which has 24% of the disease burden but only 3% of the health workers. A total of 709,633 nurses and midwives are needed in these 36 countries, including Zambia. The need for more nurses and midwives is clear. The starting point is to increase the number of tutors and provide an adequate infrastructure to meet the demand.

The WHO Regional Office for Africa has developed an initiative to scale up the production of nurse and midwifery tutors in response to the critical shortage of nurses and midwives, in particular in the 10 sub-Saharan countries. Three pioneer countries have been selected – Malawi, Uganda and Zambia. WHO and/or the Global Health Workforce Alliance (which is funding the project) are implementing human-resource activities in these countries, each of also which meets the following criteria: a) a critical shortage of tutors, b) evidence of inadequate training skills among tutors, and c) a readiness to demonstrate results. Kenya and the United Republic of Tanzania have been included in the initiative as resource countries to support the scaling-up activities in the other three countries.

The initiative will evolve in four phases.

- Phase 1: Situational analysis – assessment of training institutions (not only for nursing), including infrastructure, curricula, capacity; review of the national plan for human resources for health and the nursing/midwifery act, and training needs to update the skills of existing tutors.
- Phase 2: Development of a training strategy.
- Phase 3: Monitoring and evaluation.
- Phase 4: Expansion of activities to other countries, based on lessons learned.

In general, the critical issue is to produce a fast-track programme to prepare nursing and midwifery tutors, using distance learning and other innovative models. Partnerships within and outside the African Region will be critical to the project.

On completion of phase 1 in the above countries, key considerations will be:

- the choice of institutions to undertake tutor training;
- the duration of the training programme (since it will be fast-track);
- the target audience;
- tutor coverage for rural areas;
- a retention package for tutors (to retain current tutors and attract others to the job);
- career ladder, upgrading skills and knowledge of existing tutors;
- forging of national and international partnerships.

Partners in the initiative include the Aga Khan University for East African countries, the Commonwealth Secretariat in London, the Global Health Workforce Alliance, the International Confederation of Midwives, the International Council of Nurses, WHO collaborating centres, sub-regional economic communities and other partners interested in development.

Lessons learnt from this initial exercise will influence and guide the future direction and adoption of the initiative.
Mr Allen’s presentation outlined innovative solutions to provide access to information on health.

1) The Blue Trunk Library has been developed by the WHO Library for installation in district health centres in Africa as a means of compensating for the lack of up-to-date medical and health information. The collection is organized according to major health subjects and contains more than one hundred books on medicine and public health. In order to make it easier to transport and store, the books are packed in a blue metal trunk. This approach is, however, costly because the references must be available in each of the official WHO languages, shipping costs have to be covered and the references updated.

2) Digital world, the HINARI project: provides access to 4000 medical journals online – much information exists only in digital or electronic format. This project requires users to have Internet access; this can sometimes be expensive – in Egypt, for example, Internet access costs US$ 15 per hour. Many documents are large and can be difficult and time-consuming to download.

3) The eGranary server: WHO is creating a partnership with the University of Iowa to create a new system for promoting access to information. This is a 750 gigabyte hard drive which contains 10 million downloaded web pages of quality information for distribution to areas that do not have good Internet connectivity. It is called an eGranary server and can be connected to a single computer or a group of computers. It offers users many of the benefits of searching the Internet without actually being connected to it. It offers organized, direct access and eliminates long download time. It can be customized to meet the needs of certain groups – for example, it is currently being customized for users who need access to information in Portuguese. It will also provide users with videos, documents and learning tools that can be used for training.

4) Many publications can also be accessed through the WHO website.
DIRECT-ENTRY MIDWIFERY TRAINING AND TUTOR TRAINING IN ZAMBIA

MIRIAM LIBETWA

The scale-up of training and development is one of the main strategies proposed in Zambia’s strategic plan for human resources for health. Training and production of health workers has not kept pace with health-sector needs. Other challenges that also need to be addressed include inadequate funding, infrastructure, and a shortage of teaching materials and staff. To address these challenges an initiative to introduce a direct-entry midwifery training programme and enhance tutor training has been developed in collaboration with key partners. A strategy for tutor training has been developed, with the support of WHO and its partners.

A two-year programme has been proposed for the direct-entry midwifery training. It begins with six months of general nursing training, followed by one year of midwifery training (theory and practice), and concludes with a six-month internship in a health facility and/or a community setting. The aim is to increase the number of midwives, in keeping with the Ministry of Health’s vision to provide Zambians with equity of access to cost-effective quality health care, as close to the family as possible. Available data show that current midwifery training institutions will produce 1500 midwives in 5 years, leaving a shortfall of 1800. Three sites have been identified to train 120 students a year; this is in addition to the current rate (300 graduates per year) from existing midwifery schools. Graduates will be certified midwives, eligible to go on for further training as general nurses.

The following four strategies have been identified for tutor training.

1) Increase the number of nursing students qualifying for a bachelor of science degree. There are currently 30–50 graduates who complete the required three years of study.

2) Increase the number of nursing students qualifying for a masters degree. The current number of graduates is 8–10 per year. This will provide a pool of graduates for recruitment by the Department of Post-Basic Nursing as lecturers for training institutions. The increased number of lecturers will permit an increase in the number of training institutions.

3) Create direct-entry bachelor of science courses in nursing. This will increase the number of teaching staff to be recruited.

4) Use distance learning for the bachelor of science nursing programmes.

The Zambian Ministry of Health is committed to the successful implementation of programmes to promote achievement of the MDGs. Implementation will demand the participation and sustained support of all partners.
A summary of the open plenary discussion that followed the technical presentations is presented below.

- The International Council of Nurses has generated a listing of competencies to try to provide international nursing with a clear idea of what is required for each of the five levels – nursing support work, enrolled practical nurse, generalist, specialist, and advanced practice nurse.

- The work of the WHO collaborating centres in drafting projects is appreciated but it appears to duplicate some of the work on systems that has already been done in Africa. External experts should not come to Africa to provide advice and programmes without involving Africans in the development of their own programmes. There is, for instance, a need to collaborate with the African chapter of Sigma Theta Tau which is running a one year masters programme for Kenya and the United Republic of Tanzania.

- CASN and GANES are non-profit organizations focusing on the Canadian system of accreditation, with 20 years of experience. Membership of GANES will soon be open to all countries.

- There is a bridging programme for enrolled nurses to become registered nurses, and for registered nurses to enroll in bachelor of science and masters programmes. Zambia only began its masters programme in for nurses 2004 so there have been only a few graduates so far. The other masters graduates were mostly those with masters degrees in public health. However, many of the graduating nurses have migrated or are not available. The Zambian Ministry of Health has embarked on a retention scheme to try to retain more nurses in the training institutions.

- There is a need to focus on the line of action that promotes prevention and promotion of health and not on the former – curative – approach to training nurses. Competencies must link at all levels. We need research-oriented education and a focus on collaboration.

- The Regional Office for Africa has developed an action framework which is the foundation for strengthening nursing and midwifery in the region. This will be disseminated to countries in the region.

- The representative from Rwanda shared an experience of collaboration between Rwanda and the University of Kwazulu Natal in South Africa, financially supported by WHO. Fourteen lecturers were trained in South Africa over a one-and-a-half year period and are now making a significant contribution in Rwanda. The cost to Rwanda of sending a student abroad to be trained as a lecturer is seven times more than the cost of providing teaching within the country.
Key milestones in scaling up nursing and midwifery were summarized as follows:

- **May 2006**: 300 government leaders and presidents of nurses’ associations and regulatory bodies met in Geneva to discuss common issues; the following week the World Health Assembly passed a resolution on scaling up nursing and midwifery.
- **November 2006**: WHO meeting on scaling up production of health workers, Geneva.
- **March 2007**: Islamabad Declaration of strengthening capacity of nursing and midwifery.
- **March 2008**: Meeting of the Global Advisory Group of Nurses and Midwives to review the output of the Zambia consultation.
- **May 2008**: World Health Assembly progress report on nursing.
- **June 2008**: Publication and dissemination of results from this consultation.

**GROUP WORK**

As consultants and experts in their respective fields, the consultants were invited to share their knowledge and expertise in working groups. A theme was assigned to each working group:

- Faculty development – Valerie Fleming (lead)
- Health-service provision – Rachel Gumbi (lead), with support from Kathy Fritsch
- Workplace environment – Fadwa Affara (lead)
- Talent management – Margaret Phiri (lead)
- Partnerships – Barbara Parfitt (lead)

A template to guide the work of each group provided a structure for the discussions – a goal, objectives, activities for 2008–2009, available tools and supporting mechanisms, indicators, and a list of partners and resources for each core element. Each group was encouraged to conduct side meetings to enhance the outcome of its discussions. The goal of the group work was to compile action plans for distribution to countries in the form of toolkits that can be adapted to meet country needs.

It was emphasized that the framework for scaling up capacity must identify the skill mix needed for a basic package of services. What to scale up depends on the context of the country but the focus should be on health workers such as nurses who have close client contact. It is necessary to consider who will provide the supervision.
DAY 2 PROCEEDINGS

RECAP OF DAY 1

Dr Nabil Kronfol briefly outlined the first day’s proceedings and listed the activities that had been identified.

1) Develop a conceptual framework according to contextual supply and demand.

2) Respond to community needs and focus on primary health care.

3) Align present curricula to the emerging needs of current dynamics, taking into account the duration of training without sacrificing quality.

4) Make adaptations at national, regional and global levels.

5) Support management change and strategic actions, including the development of career paths for nurses and midwives.

TECHNICAL SESSION 3:
HEALTH-SERVICE PROVISION

Panel members:
Peggy Chibuye
Veronica James

MALAWI CASE STUDY: MAIMWANA PROJECT
PEGGY CHIBUYE

The Maimwana project, based in the Mchinji District, was founded by nurses and is led by nurses. It is funded by the African Development Bank and has become a cornerstone for service delivery. It initially focused on a neonatal health research project and aimed to support evidence-based practice in neonatal health and promote intersectoral collaboration. It now also provides technical assistance to service delivery in public-sector and faith-based facilities.

The project has been changed to include trained traditional birth assistants (TBAs) and provide services to expectant mothers (“wa pakati” – mothers who are pregnant). In order to ensure sustainability, the project is integrated into the district plans and works with the Malawian Ministry of Education and the Ministry of Health.
Ms James gave two examples of collaborative practice. The first example: a project set up by a nongovernmental organization (NGO) for mental health in five countries; the second: the Lizzie Brain Practice Partner in a collaborative practice for diabetes management and reduction of chronic heart disease (CHD) complications associated with chronic diabetes. The latter is an example of task shifting – the nurse monitors the patients and helps energetic patients set up self-help groups; the care assistant collects the blood and the doctor attends to the complications. The patients bring in family members and carers. The benefits are that economic contributions overcome social stigmas and the setting-up of self-help groups leads to an overall reduction in CHD complications with diabetes. It is a demonstration of multidisciplinary collaboration in the management of community health problems.

Principles of effective collaborative practice include respect; sensitivity to the “protocols” of others; a focus on outcomes; appropriate leadership; sharing of work, responsibility and resources; clarity; continuity; accepting change; commitment; listening and acknowledging criticism; reduced need for power and control.

Key questions to address in collaborative practice are listed below.

- What do you know about the values and responsibilities of your collaborators?
- How do you get clarity of purpose?
- What external quality assurance do you have?
- How would you notice and resolve conflict?
- What help is there in dealing with uncertainty?
- When and why would you say “no” and/or “yes”?
There is a need to consider small projects – versus overall primary health care efforts – that are capable of impacting on the entire scope of health-service provision. We can learn from examples from other regions of the world. For instance:
- activities in Tajikistan are an example of how to restructure the overall health-care service to meet the needs of the people;
- in Quebec, Canada, doctors have reorganized the system from the top down, from tertiary to primary health care – this has been more of a private sector reorganization; nurses are not present at the government level to influence the implementation of primary health care;
- in the Western Pacific Region, long-standing development of mid-level nurses and midwives assures the provision of health-care services.

Concerning the recruitment and supervision of health surveillance assistants in Malawi and how this is managed in terms of task shifting, Dr Chibuye clarified that health surveillance assistants do not replace nurses, but are included as a means of utilizing available resources in areas of need.

There is a need to develop a framework to guide implementation of collaborative practice and differentiate between collaboration – that tends to divide the profession – and collaborative practice where professionals work together.

According to Karl Max it is necessary to focus on where the material resources are, in order to be able to understand where the power is. What is important is to use professional resources only for what is needed, and to refocus on what to do to scale up health-service provision for nursing and midwifery.

Scaling-up should respond to new roles and shelve the ideas of the past. This entails producing professional nurses and midwives who are innovative, responsive, good at managing resources, and who render services that are relevant to the population.

It is essential to focus on the future and to constantly amass evidence to determine what to do now, and find ways to do things better.
POLICY SESSION 4:
POSITIVE WORKPLACE ENVIRONMENTS

Panel members:
Fadwa Affara
Sheila Bandazi
Dorica Mweewa
Thom Yungana

Ms Affara began her presentation with a wake-up call, drawing attention to implications of the failure of more than 75% of the Member States to endorse the ILO Nursing Personnel Convention, 1977 (C. 149) and the accompanying Recommendation (R.157). The convention has been ratified by only 37 out of 157 countries. It is an important policy document that has existed since 1977 and was developed to address the situation of unhealthy workplaces, poor organizational structures and climates that weaken performance or alienate nurses from specific work settings. After a lengthy discussion on the subject, the meeting concluded that WHO should actively advocate for its ratification.

Ms Affara informed the meeting that a regional policy framework for nursing and midwifery and a catalogue of supporting strategies to promote positive workplace environments, as recommended in the Islamabad Declaration, the ILO Nursing Personnel Convention (C.149) and Recommendation (R.157), would be in place by the end of 2009.

The theme established by the International Council of Nurses for International Nurses’ Day 2007 was positive practice environments, “quality workplaces = quality patient care”.

To achieve quality workplaces, the following objectives were outlined:

1) Carry out concerted lobbying and advocacy efforts to encourage ratification of ILO Nursing Personnel Convention (C.149) and Recommendation (R.157).
2) Identify key policy areas necessary to promote and support positive workplace environments.
3) Develop guidelines to assist each country to: a) create a policy framework for positive workplace environments, b) implement selected strategies, and c) incorporate both (the framework and the strategies) into current and future nursing and midwifery national action plans.
4) Initiate a process for establishing a set of essential generic standards and indicators for positive nursing and midwifery workplace environments.
5) Create mechanisms in the WHO regional offices and at country level to disseminate and make available printed and web-based resources (including assessment and monitoring tools, research-based evidence and best-practice guidelines) on subjects related to the promotion of positive workplace environments.
6) Develop a plan for WHO regional offices to monitor and evaluate progress made towards achieving quality workplace environments.
Two main principles addressing the workplace environment from the Islamabad Declaration were emphasized.

1) Employment practices that address workload, scheduling, necessary infrastructure and support systems, and that provide safe, secure working conditions are necessary to assure occupational health and the safety of patients and health-care providers.

2) Policy frameworks that support participatory decision-making, autonomy, authority and accountability, along with positive interdisciplinary relationships and effective nursing and midwifery management, are essential to creating and sustaining positive practice environments.

INTERVENTIONS IN PLACE TO ADDRESS THE WORKPLACE ENVIRONMENT IN MALAWI
SHEILA BANDAZI

The Government of Malawi has a deployment policy stipulating that every health worker will be required to serve a minimum of two years in a rural area. In support of this policy, the United Kingdom’s Department for International Development (DFID) has funded the construction of umoyo houses for nurses. The houses are provided with solar power and water. A six-year training plan (now being implemented) aims to increase the intake of nurses and midwives and the number of graduates from training institutions. A stipulation is that, in order to participate in the training, an individual must have some form of previous training. Comfortable housing or other accommodation is provided, together with a 52% salary increase.

An infection prevention–control policy, developed in partnership with Johns Hopkins International Education in Gynaecology and Obstetrics (JHPIEGO), is also in place. A reward system – a shield of excellence – to encourage adherence to the policy has been established. Two institutions that are managed by nurses and midwives have been awarded the shield and have kept it for several consecutive years, indicating their adherence to the policy. The policy has been widely distributed among nurses and midwives, with follow-up to check if the standards are being implemented.

Malawi also has an HIV/AIDS policy on care for the carers. In the workplace, break rooms where nurses can have tea/coffee and read newspapers have been established. An infrastructure, with resources, is one of the pillars of a good workplace environment. Major challenges remain, however, with regard to nurses and midwives – staff shortages, negative attitudes, and difficulties with teamworking.
PERSPECTIVE FROM A PROFESSIONAL ORGANIZATION: THE ZAMBIA UNION OF NURSING ORGANIZATIONS
THOM YUNGANA

Zambia faces many challenges including the shortage of nursing and midwifery personnel, a demotivated workforce, no provision of care for the carers, inadequate sponsorship opportunities, a lack of medical and surgical supplies, low salaries and poor conditions of service in general.

The Zambia Union of Nursing Organizations (ZUNO) is responding to these challenges through interventions such as advocacy and lobbying, capacity-building programmes, a caring-for-the-carers programme that includes HIV/AIDs support groups, orphan support (Norwegian Nurses Organization/ZUNO), a girl-child education fund, a mobile library project, and a wellness centre for nurses, health workers and their families. Most of these projects are supported by the International Council of Nurses.

The wellness health centre provides social activities such as gym and recreation classes and offers services – counselling, care and support, HIV testing, rehabilitation, palliative care, prevention of mother-to-child transmission (PMTCT), access to information, education and communication, an antiretroviral treatment clinic, stress management, skill-training updates and home-based care. The range of services offered was based on the results of a rapid assessment.

THE PERSPECTIVE OF A CHIEF POLICY ANALYST ON NURSING SERVICES IN ZAMBIA
DORICA MWEWA

The Zambian strategic plan 2006–2010 for human resources for health focuses on two main strategies in the area of the workplace environment:

- to make jobs more attractive through improving conditions of service and the workplace environment; and
- to use staff more effectively and efficiently through human-resource management and practices.

Government interventions include the following:

- working towards improvements in the payment of salaries and other allowances;
- addressing staff welfare such as providing transport and other utilities, renovating staff houses and improving housing in rural areas;
- improving human-resource management practices;
- intensifying the rate of recruitment of nurses and midwives;
- improving supplies and communication;
- rehabilitating the infrastructure in health facilities;
- addressing the issue of HIV/AIDS in the workplace (the Ministry of Health has put a system in place to provide staff with free antiretroviral treatment and is encouraging staff to go for voluntary counselling and testing).
PLENARY DISCUSSION

- A suggestion was made that WHO should work with ministries of health to ensure implementation of the World Health Assembly resolutions (WHA59.27 and WHA59.23) pertaining to nursing and midwifery.

- Experience in francophone countries is that nurses do not have access to higher education and consequently do not contribute positively to the workplace environment. As a result the health services lose their nurses and midwives.

- There is a need to promote the agenda to ensure that ILO Nursing Personnel Convention (C.149) is ratified by other countries and made part of their regional strategies. This call should be repeated at strategic locations and events to bring it to the attention of representatives of governments. In the past (since 1977) the International Council of Nurses had been main lobbyist for the convention — but it seems that the time is now ripe for the convention to be more widely adopted.

GROUP WORK

JEAN YAN

Dr Yan stated that the group discussions should focus on goals, actions, solutions and support mechanisms; she stressed the need to focus on innovative ways to react in the midst of a crisis and to come up with models to reach the targets. She urged countries to submit case studies, using a standard template (that would be provided for the purpose) to showcase their efforts and contributions to primary health care. A year-long campaign to encourage individuals and groups to submit their cases will be awarded international recognition.

Participants were requested to critically address the following issues and questions and to base their replies on successful practices, focusing on goals, actions, solutions and supporting mechanisms.

1) What are the challenges today?
2) What can we do to scale up our area?
3) What challenges the group to be bold?

The scope of the group work is captured in the illustration below.
Scaling up nursing and midwifery capacity

**Goal**
- Increased number of competent workforce (nurses and midwives)
- Increased access to health care (HIV/AIDS, maternal and child health, malaria, etc.)
- Strengthened health care services (PHC)
- Improved global health (MDGs)

**Action**
- Crisis, urgent response
- Scale up, out of ordinary times
- Short term, with long-term implications

**Solutions**
- Not business as usual, think beyond "the box"
- Creative, innovative, based on successful practices
- "3 by 50" rule (practices)

**Supporting mechanisms**
- Infrastructure, processes, systems
- Resources, leadership, partnerships
- Regulations, guidelines

Why not the best? Wisdom (guided by the knowledge and experience of nurses and midwives in this great strategic room)
TALENT MANAGEMENT
OLIVE MUNJANJA

Talent management can mean different things to different people. For some, talent management is the management of high-worth individuals or “the talented”. For others it is about how talent is managed generally – assuming that all people have talent that should be identified and liberated. Talent management is usually associated with competency-based human-resource management and is often driven by a set of core organizational competencies and position-specific competencies.

Derek Stockley, a management consultant from Australia, defines talent management as a conscious, deliberate approach undertaken to attract, develop and retain people who have the aptitude and abilities to meet current and future organizational needs. Talent management involves individual and organizational development in response to a changing and complex operating environment. It includes the creation and maintenance of a supportive, people-oriented organizational culture.

Talent management is important as it can aid in the systematic, consistent development of leaders at all levels – horizontally across regions, and vertically between the various levels of nursing and midwifery practice. Talent management can also provide consistent understanding and the appropriate language to describe the necessary competencies and skills required at each level.

Challenges in talent management are listed below.

- Talent management has many prerequisites without which a programme can be undermined.
- There is a need to define the competencies, abilities and expectations required at each level.
- There is no clear career path of talent development for upcoming nurses and midwives.
- There are insufficient numbers of programmes to develop competences and meet the needs of people whose talent is to be developed.
- There are differences between recommended strategies for strengthening nursing and midwifery and what is happening on the ground.

There are many opportunities for talent management, including those outlined below.

- Networks of nurses and midwives already exist, as do the regional bodies through which to collaborate.
Countries are all focusing on the shortages of nurses and midwives at global, regional and country levels.

A number of resolutions on strengthening nursing and midwifery have been passed and all support talent management – WHA59.27, WHA59.23 and the Islamabad Declaration.

Funding mechanisms, such as the Global Fund, are supporting human resources for health.

There are national human-resource strategic plans and an environment for human-resource policies.

Technology and other distance learning methods can be used.

The objective of overall talent management is to have nurses and midwives in senior executive positions – inside and outside the health services – shaping public policy, health-care systems and nursing and midwifery services – thereby contributing to nursing and midwifery excellence through talent management at all levels.

Specific objectives of talent management are outlined below.

1) To advocate for talent management as a mechanism for scaling up nursing and midwifery services.
2) To develop mechanisms for identifying, nurturing, and rewarding talent in nursing and midwifery.
3) To develop and support effective models of sustainable talent management in nursing and midwifery.
4) To implement talent-management programmes that empower nurses and midwives to participate meaningfully in health policy and decision-making processes.
5) To identify mentors to support individuals or groups in the talent-management programme for nursing and midwifery.
6) To monitor the impact of the talent-management programme.

Nurses and midwives have a responsibility and an opportunity to influence the health policy agenda. Talent management should begin with nursing and midwifery leaders who can provide the role satisfaction and clarity required to take appropriate action on scaling-up and retention strategies.

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A PUBLIC–PRIVATE PARTNERSHIP (PPP) TO CONTRIBUTE TOWARDS NURSING/MIDWIFERY DEVELOPMENT IN EAST AFRICA

LAETITIA KING

The partnership to contribute towards nursing/midwifery development in East Africa is an example of the public–private partnerships (PPPs) initiated by the Aga Khan Development Network (AKDN), a worldwide organization covering 29 countries. PPPs involve everyone – the health services, donors, and the public and private sectors. Several initiatives are taking place through PPPs, as described below.

1) The PPP to Improve Nursing Education and Practice in East Africa (INEPEA) involves a knowledge network of higher education institutions concerned with the training of nurses and midwives in the public and private sectors in Kenya, Uganda and the United Republic of Tanzania (including Zanzibar). Partners include the University of Nottingham (United Kingdom), the University of Iowa (United States of America), WHO, ministries of health and various
professional bodies. Activities relate to the development of short courses with multiple entry and exit points, the use of programmes such as *Eluminate* and similar technologies that connect communities of practice, the development of international standards for nursing/midwifery education, the use of innovative approaches such as the distribution and use of eGranary servers in East Africa and the development of curricula and competencies from entry level to advanced practice nurse.

2) EDULINK is another PPP – the African, Caribbean and Pacific Group of States & European Union (ACP-EU) Cooperation Programme in Higher Education\(^1\). The goal of EDULINK is to foster capacity building and regional integration in the field of higher education through institutional networking, and to support a higher education system of quality that is efficient, relevant to the needs of the labour market and consistent with ACP socioeconomic development priorities.

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**SCALING UP THE CONTRIBUTION OF INTERNATIONAL PARTNERSHIPS**

**BARBARA PARFITT**

It is assumed that every partnership that will benefit or assist progress towards achieving our aims or goals should be utilized and that every person who contributes to the improvement of the health status of individuals is a potential partner. Our key priority is to align ourselves with the major international organizations and regional initiatives that are responsible for scaling up human resources. The primary concern is to ensure that the health services meet the needs of the people. Nurses and midwives can contribute to integrated health-care provision, working through partnerships within multidisciplinary teams. Teamworking is central to the concept of partnership, both in the working environment and within the professions of nursing and midwifery.

**Overall objectives**

1) To identify specific activities at all levels for the development of proposed partnerships that align with other initiatives relevant to the development of human resources for health, such as the Global Health Workforce Alliance.

2) To identify how to increase resources for scaling up activities through partnerships so as to maximize the benefits of partnership contributions.

**Specific objectives**

1) To identify existing and potential partners for each activity area.

2) To establish a functional relationship with other members of the multidisciplinary teams.

3) To consolidate the ideas generated at this consultation and other key meetings, using an effective communication strategy.

4) To monitor, evaluate and review projects so that they remain central to the scaling-up agenda and maximize partnership working.

5) To establish a community of practice of nursing and midwifery leaders at country, regional, interregional, national and international levels.

6) To identify funding for specific activities within the action plan.

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\(^1\) More information on EDULINK can be accessed at [www.acp-edulink.eu](http://www.acp-edulink.eu)
Challenges include the development of an evidence-base for nursing and midwifery education and interventions; creation and support of uniform indicators to measure progress at country, regional, and global levels; creation of solutions to global shortages of human resources for health and migration of nursing and midwifery personnel; provision of technical support to Member States; and the creation and support of alliances and networks to strengthen nursing and midwifery services.

WORKING GROUP PRESENTATIONS

Day 3 was the last day of the consultation and summaries of the working groups’ progress were presented. Only part of the groups’ work was reflected however.

Health-service provision
Professor Gumbi presented the following summary of the work on health-service provision, based on the template for scaling up capacity of nurses and midwives. The overall goal of health-service provision is to maximize the contribution of nursing and midwifery to culturally relevant, innovative, collaborative and sustainable health care.

The objectives of health-service provision are to:
1) efficiently produce greater numbers of competent nursing and midwifery personnel;
2) enhance nursing and midwifery skills to rapidly and effectively respond to the health needs of a changing population;
3) develop mechanisms and models of care (and support) to ensure an optimally efficient and effective skill mix;
4) strengthen regulation, monitoring and management of nursing and midwifery services to improve universal access and quality.

Workplan objectives
The working groups’ contributions to the workplan for 2008–2009 are outlined below.

1) Faculty development: To ensure adequate and competent faculty to educate competent nurses and midwives.
2) Health-service provision: To maximize the contributions of nursing and midwifery to culturally relevant, innovative, collaborative and sustainable health care.
3) Workplace environments: To ensure that a regional nursing and midwifery policy framework and a catalogue of supporting strategies to promote positive workplace environments (as recommended in the Islamabad Declaration, ILO Nursing Personnel Convention C.149 and Recommendation R.157) are in place by 2009.
4) Talent management: To contribute to excellence in nursing and midwifery through talent management.
5) Partnerships: To identify specific action at all levels for proposed partnerships that align with other initiatives and are relevant to the development of human resources for health such as the Global Health Workforce Alliance.

The word “competent” should be understood to incorporate aspects such as knowledge, attitude and skills.
PRESENTATION OF KEY MESSAGES AND ACTION PLAN

On behalf of the GAGMN, Dr Peggy Chibuye made a presentation to the Deputy Minister of Health of Zambia, Dr L. Puma (in the absence of the Minister of Health), highlighting the following key messages from the consultation:

- Nursing and midwifery are committed to the attainment of MDGs in the African Region, the region of greatest need, and recognize that urgent attention must be paid to scaling up the nursing and midwifery workforce by:
  - implementing a global strategic framework, and
  - creating essential partnerships.
- The group solicits political expertise, will and commitment to enable universal access to health care for all citizens through the strengthening of nursing and midwifery in the three key areas – education, service provision and enhancement of the workplace environment.
- The group counts on the Minister’s support in taking the framework forward during the upcoming meetings of the South African Development Community (SADC) and the African Union.
- Particular issues to address are: a) active nursing and midwifery involvement in health system planning at policy and operational levels, b) the need for Zambia and all other African countries to have national nursing directorates, including career pathways, and to plan policy changes to permit nurses of retirement age to be flexibly employed.

Dr Chibuye also outlined the framework and main components of the workplan for 2008–2009:
- the global situation,
- strengthening nursing and midwifery,
- the scaling-up framework,
- overall and specific objectives,
- the programme of work,
- action areas,
- deliverables for 2008–2009,
- core elements (issues and assumptions, overall objectives, specific objectives, activities, timelines and indicators, tools, supporting mechanisms, lead organization), and
- coordinating mechanisms.
PLENARY DISCUSSION

- HIV/AIDS is workplace issue and being silent about it is counter-productive.

- The roles of regional bodies such as South African Development Community (SADC) and West African Health Organization (WAHO) do not feature in the workplan.

- ILO recommendation R.157 should be translated into French and other WHO official languages then posted on the web to give it wider access.

- The aims of the Nightingale Declaration are to conduct a global campaign to gather at least two million signatures from the around the world (192 countries) to support a proposal for: a) two United Nations resolutions, one for 2010 to be the international year of the nurse and the second for 2011-2020 to be a United Nations decade for a healthy world; and b) a series of global consultations and regional education programmes.

- The private sector should be seen not only as a funder; it may have other roles to play.

- It is a challenge to know how to market nursing as an attractive career choice when the fields of business and information technology are such attractive alternative options.

- In many countries nurses retire at the age of 55. These retired nurses represent a resource of nursing/midwifery experience that should not be ignored; a system should be set up to bring them back into the health system so that they can pass on their knowledge and skills. The International Council of Nurses has a programme (golden nurses) that taps into the skills of retired nurses.

- There is a need to do more than manage talent– we also need to hunt for talent and look into aspects such as who comes into the profession and whether or not they have an aptitude for it.

- It is important for the development of leaders at all levels to: a) define talent management – it means different things to different people – and b) to describe the necessary competencies and skills required for leadership development. Leadership training needs to start early.

- The International Council of Nurses offers a programme entitled Leadership for Change that is targeted at mid-career nurses who still have 10–15 more working years. A career pathway, with recognition along the way, is needed. There should also be a focus on younger nurses and midwives – for example, the University of Alabama has enrolled 18 Latin American nurses to give them English language training and an opportunity to collaborate and develop projects with other faculties in the university. WPRO has modules on mentorship.

The meeting was closed by Dr Puma on behalf of the Minister of Health of Zambia.

3 For more details see www.nightingaledclaration.net
ANNEX 1: AGENDA


Moderator: Martins Ouberedjo

DAY 1: MONDAY, 3 DECEMBER 2007

8:30–9.00 Registration

9:00–10:00 Opening ceremonies
   Key note addresses:
   • WHO Representative (Acting Interim), Zambia
   • Coordinator, Human Resources for Health; Regional Office for Africa
   • Professor Rachel Gumbi, GAGNM Chairperson
   • Chief Scientist, Nursing, WHO, HQ (agenda and objectives)
   • Ministry of Health, Zambia

10:00–10:30 Break

10:30–11:30 Panel: Update on HRH development, policies, programmes
   WHO headquarters; WHO Regional Offices for Africa, the Eastern Mediterranean, Europe and the Western Pacific; Director of Human Resources for Health, Ministry of Health, Zambia
   Questions, discussion and summary

11:30–12:00 Panel: Faculty development, educational standards, accreditation guidelines, educational resources
   Panel members: GNWHOCCs (Valerie Fleming), GANES (Lise Talbot), UNISA (Sophie Mogotlane), WHO/HQ (Mwansa Nkowane), WHO Library (Thomas Allen)

12:00–13:00 Zambia case study
   Lead person: Valerie Fleming

13:00–14:00 Lunch

14:00–14:30 Questions, discussion and summary

14:30–15:00 Scaling-up framework and core elements, group-work guidelines

15:00–17:00 Group work

17:55–17:45 Group presentations

17:45–18:15 Wrap-up
DAY 2: TUESDAY, 4 DECEMBER 2007

8:30–9.00  Summary of day 1
Discussion and clarifications

9:00–10:00  Panel on health-service provision
Panel members: PHC (Peggy Chibuye), Collaborative Practice
(Veronica James)

10:00–10:30  Questions, discussions and summary
Lead person: Rachael Gumbi

10:30–11:00  Break

11:00–12:00  Group work

12:00–12:30  Group presentations

12:30–13:00  Questions, discussions and summary

13:00–14:00  Lunch

14:00–15:00  Panel on the workplace environment
Panel members: Dorica Mweewa, Sheila Bandazi

15:00–17:00  Group work
Lead person: Fadwa Affara

17:00–17:45  Group presentations

17:45–18:15  Wrap-up

DAY 3: WEDNESDAY, 5 DECEMBER 2007

8:30–9.00  Summary of day 2
Discussion and clarifications

9:00–10:00  Panel on talent management and partnership

10:00–10:30  Questions, discussion and summary

10:30–11:00  Break

11:30–12:00  Group work

12:00–12:30  Group presentations

12:30–13:00  Questions, discussion and summary

13:00–14:00  Lunch

14:00–15:00  Summary of framework and action plan

15:30–16:00  The way forward

16:00  Ministry of Health, Zambia
WHO Representative (Acting Interim), Zambia
ANNEX 2: LIST OF PARTICIPANTS AND FACILITATORS


Professor Oluyinka Adejumo, Head, School of Nursing, University of Kwazulu Natal, Durban 4041, South Africa  
Tel: +27 824436131; Fax: +27 8605108806; E-mail: adejunoo@ukzn.ac.za

Miss Fadwa Affara, International Nurse Consultant, International Council of Nurses, 3 Place Jean Marteau, 1201 Geneva, Switzerland  
E-mail: fadaaffara@btinternet.com

Mr Thomas Allen, Librarian, WHO Library, 20 Avenue Appia, Geneva, Switzerland  
E-mail: allent@who.int

Dr Ibtsam Al-Zaru, Assistant Professor, Jordan University of Science and Technology (JUST), Faculty of Nursing, P.O. Box 3030, Jordan  
Tel: +96 227201000; Fax: +96 227095123; E-mail: ibtsam@just.edu.jo

Dr Anne Akapelwa, Chief Nurse Officer, Ministry of Defence, P.O. Box 32191, Lusaka, Zambia  
Tel: +260 211 254559; E-mail: anneakapelwa@yahoo.com.uk

Dr Deva-Marie Beck, International Co-Director, Nightingale Initiative for Global Health, No. 302, 20 The Driveway, Ottawa, ON K2P1C8 Canada  
Tel: +613 564 0239; E-mail: devamarie@earthlink.net

Mrs N. Sheila Bandazi, Chief Nursing Officer, Ministry of Health, P.O. Box 30377, Lilongwe, Malawi  
Tel: +265 1 789400; E-mail: bandazi411@yahoo.co.uk

Ms Jeffries Carries, Public Health Advisor, USAID, P.O. Box 32481, Lusaka, Zambia  
Tel (mobile): + 260 979 272759; Fax: +260 211 254532; E-mail: jeffries@usaid.gov

Mrs Margaret Chambule, Senior Nursing Officer, St Francis Hospital, PB. 11, Katete, Zambia  
Tel (mobile): +260 977 154342; Fax: +260 6 252278; E-mail: scual francis@zamnet.zm

Mrs Margaret Muraa Chota, Commissioner of Health Services (Nursing), Ministry of Health, P.O. Box 7272, Kampala, Uganda  
Tel: +41 231 564; E-mail: chotamargret@yahoo.com

Dr Peggy Chibuye, PMTCT Technical Advisor, P/Bag 398, Lilongwe, Malawi  
Tel: +265 1788 414; Fax: +265 1756 000; E-mail: peggychibuye@yahoo.com

Mrs Nindi Bertha Chipepo, Acting Registrar — Preparatory Member Committee, General Nursing Council of Zambia,  
P.O. Box 33521, Lusaka, Zambia  
Tel (mobile): +260 979 407915; E-mail: bchipepo@yahoo.com

Dr Brian Chituwo, Minister of Health, Ministry of Health, PO Box 30205, Lusaka, Zambia  
Clemencia Ernesto Dgedge, Thermical Officer, Maputo Central Hospital, Ministry of Health, P.O. Box 1164, Maputo, Mozambique  
Tel: +258 823905870; Fax: +258 21311510; E-mail: amrmmoz@hotmail.com

Dr Daniel Gonzdlo Eslava, President of Asociacion Colombiana de Facultades de Efermeria (ACOFEN), Colombian School of Nursing Associations, Avenue 80 No. 23–86, Apto. 510, Bogota, Colombia  
Tel: +57 1 6351204; Fax: +57 1 2886754; E-mail: dgeslava@gmail.com
**Professor Valerie Fleming**, Secretary General, GNWHOCC, Glasgow Caledonian University, Cowcaddens Road, Glasgow G4U8A, Scotland
Tel: +44 141 331 3473; E-mail: v.fleming@gcal.ac.uk

**Mrs Kathleen Fritsch**, RA/Nursing, WHO Regional Office for the Western Pacific, P.O. Box 2932, Manila, Philippines
Tel: +63 2 528 9804; Fax: +63 2 521 1036; E-mail: fritschk@wpno.who.int

**Dr Fergal Flynn**, Senior Health Adviser, Provincial Health Office, 3 Saise Road, Box 32573, Long Acres, Lusaka, Zambia
E-mail: fergal.flynn@gamail.com

**Professor Rachel V. Gumbi**, Vice Chancellor, University of Zululand, Private Bag X1001, Kwanlangezwa 3886, South Africa
Tel: +035 9026624; Fax: +035 9026605; kadlam@pan.uzulu.ac.za

**Dr Lynda Harrison**, Professor and Deputy Director, WHO Collaborating Center on International Nursing, NB G019G E, University of Alabama at Birmingham, School of Nursing, 1530 3rd Avenue, South Birmingham, Alabama 35294-1210, United States of America
Tel: +1 205 934 6787; E-mail: Lyndaharrison@uab.edu

**Mrs Josephine Himoonga**, Principal Tutor, UTH Schools of Nursing, P.O. Box 50366, Lusaka, Zambia
Tel (mobile): +260 955 889948; Fax: +260 211 250305; E-mail: himonga@yahoo.com

**Professor Nicky Veronica James**, Nursing Studies and International Affairs, School of Nursing, Faculty of Medicine and Health Sciences, University of Nottingham, OMC Nottingham, NG7 24H England
Tel: +44 0 115 82 30814; E-mail: veronica.james@nottingham.ac.uk

**Miss Janice Kopinak**, Public Health Specialist, c/o CIDA, Canadian High Commission, 5199 United Nations Avenue P.O. Box 31313, Lusaka, Zambia
E-mail: jkopinak@hotmail.com

**Dr Jason Farley**, Assistant Professor, 3511 Rosekemp Avenue, Baltimore MD 21214, United States of America
Tel: +1 400 254 1964; E-mail: jfarley@son.jhmi.edu

**Mrs Patricia Kamanga**, NPO/NUS, World Health Organization, P.O. Box 32346, Lusaka, Zambia
Tel: +260 211 255322; Mobile : +260 977 773526; Fax: +260 211 252863;
E-mail: kamangap@zm.afro.afro.int

**Dr Desire Kamanzi**, Consultant, Kigali Health Institute, P.O. Box 3286, Kigali, Rwanda
Tel: +250 0806820207; E-mail: kamanzides@yahoo.fr

**Professor Dan C. Owino Kaseje**, Professor, Great Lakes University of Kisumu, P.O. Box 2224, Kisumu, Kenya
Tel: +254 722 645617; E-mail: director@tichinagfrica.org

**Dr Laetitia King**, Professor, Great Lakes University of Kisumu, P.O. Box 2224, Kisumu, Kenya
Tel: +254 722 645617; E-mail: director@tichinagfrica.org

**Dr Nabil Kronfol**, President, Lebanese Health Care Management Association, Clemenceau St 333, Building #4, Beirut, Lebanon
Tel: +96 11 374337; Fax: +96 11 374338; E-mail: dino@cyberie.nch.lb

**Professor Anne Lekeux**, Fedesue, Professor – Fine Vice President, International Coordinator Nursing Education Department, 100, Avenue Mounier, 1200 Brussels, Belgium
Tel: +32 494 466434, +32 295 67055, Fax: +32 22567055, E-mail: anne—lekeux@yahoo.fr

**Dr Miriam Libetwa**, Training and Development Specialist, Ministry of Health, P.O. Box 30205, Lusaka, Zambia
Tel: +260 211 254085, Mobile: +260 977 897 663, Fax: +260 211 253344, E-mail: mlbetwa@yahoo.co.uk
Dr Oliver Lulembo, Senior Health Advisor, USAID, P.O. Box 32481, Lusaka, Zambia
Tel (mobile): +260 978 861601, Fax: +260 211 254532, E-mail: olulembo@usaid.gov

Mrs T. Lastina Lwatula, Training Advisor, HSSP, P.O. Box 39090, Lusaka, Zambia
Tel (mobile): +260 977 763234, Fax: +260 211 254555, E-mail: lastinal@hssp.org.zm

Dr Isabel Mendes, Director, University of Sao Paulo, College of Nursing, WHO CC, Rua Francisco Cesar, 775 Apto. 82, Ribeirato Preto – SP, 14020–530 Brazil
Tel: +55 16 36023393, Fax: +55 16 36333271, E-mail: iamendes@EERP.USP.BR

Mrs Ndubu Milapo, Nurse Education Manager, Kitwe School of Nursing, P.O. Box 21994, Kitwe, Zambia
Tel: +260 212 220313, Mobile: +260 955 994865, E-mail: ndubumilapo@yahoo.com

Mr James Mkandawire, IT Specialist, Ministry of Health, P.O. Box 30205, Lusaka, Zambia
Tel (mobile): +260 977 807663, E-mail: jmkandawire@yahoo.com

Mrs M Sophie Mogotlane, Professor and Chairperson, University of South Africa, Department of Health Studies, P.O. Box 392, Pretoria 0003, South Africa
Tel: +12 429 6303, Fax: +12 429 6688, E-mail: mogotsm@uniso.ac.za

Mrs Jennifer Munsaka, Executive Director, Zambia Union of Nurses Organization, P.O. Box 50375, Lusaka, Zambia
Tel (mobile): +260 977 674385, Fax: +260 211 225135, E-mail: zuno@zamnet.zm

Mrs Olive Munjanja, HIV/AIDS Programme Officer, ILO, P.O. Box 31903, Lusaka, Zambia
Tel (mobile): +260 955 663134; E-mail: olive-munjanja@hotmail.com

Mrs Ruth D M Muzumala, Nursing Officer, Chainama Hospital, Ministry of Health, P.O. Box 30043, Lusaka, Zambia
Tel (mobile): +260 977 884137, Fax: +260 211 283824, E-mail: muzruth@yahoo.com

Mrs Dorica Sakala Mwewa, CPA-Preparatory Committee Member, Doctors’ Complex, H/No. 227, Great East Road, Lusaka, Zambia
Tel: +260 211 254067, Fax: +260 211 253344, E-mail: doricamwewa@yahoo.com

Mrs Catherine Mubita Ngoma, Head, Department of Post Basic Nursing, Post Basic Nursing, School of Medicine, University of Zambia, P.O. Box 50110, Lusaka, Zambia
Tel: +260 211 252453, Mobile: +260 966 652879, E-mail: catherinengoma@yahoo.com

Mrs Mwansa Nkowane, Technical Officer, World Health Organization, Department of Human Resources for HE, 1211 Geneva 27, Geneva, Switzerland
Tel: +41 22 7914314, Fax: +41 22 7914747, E-mail: nkowanemwansa@who.int

Dr Martins Ovberedjo, HRH Advisor, WHO Country Office, P.O. Box 9292, Dar es Salaam, United Republic of Tanzania
Tel: +255 752020469, E-mail: martinsovbe2000@yahoo.co.uk, ovberedjorn@tz.afro.who.int

Professor Barbara Parfitt, Professor, 11A Kirkintilloch Road, Lenzie, Scotland
Tel: +44 1413313460, E-mail: B.A.parfitt@gcal.ac.uk,

Mrs Margaret L. Phiri, Nursing Regional Advisor, WHO/Sub-Regional, Boite postale 7019, Ougadougou, Burkina Faso
Tel (mobile): +226 78022659, E-mail: phirim@bf.afro.who.int

Mr Chris Rakoun, Chief Nursing Officer, Ministry of Health, P.O. Box 30016, Nairobi, Kenya
Tel: +254 734 594675, Fax: +254 20 2725525, E-mail: cprakoum@yahoo.com

Dr Magda Robalo, WHO Representative, WHO Country Office, PO Box 32346, Lusaka 10101, Zambia
Tel: +260 1 255322
Ms Laurie Rogers, CIDA, Canadian High Commission, Lusaka, Zambia  
Tel (mobile): +260 966 860096, E-mail: laurierogers@international.gc.ca

Dr Naomi Mmapelo Seboni, Head, School of Nursing, University of Botswana, Private Bag 0022, Gaborone, Botswana  
Tel: +267 3552364/5, Fax: +267 318 5096, E-mail: sebonim@moppi.ub.bw

Mrs Bente Sivertsen, Policy Adviser, WHO Regional Office for Europe, Scher Figsvej 8, Copenhagen, Denmark  
Tel: +45 38171355, E-mail: bes@euro.who.int

Dr Lise Talbot, JOBIAO, President, GANES, CANADIAN ASSOCIATION OF SCHOOLS OF NURSING, 595 CH-Biron Ascot Corner, Quebec, Canada  
Tel: +819 620 4238/819 620 4238, E-mail: lise.talbot@usherbrooke.ca

Dr Donna Vivio, Senior RH Advisor, c/o Johns Hopkins International Education in Gynaecology and Obstetrics (JHPIEGO), 8 Ngumbo Road, Long Acres, Lusaka, Zambia  
Tel (mobile): +260 978 600619, E-mail: donna@hssp.org.zm

Ms Jane Winder, GANES and Canadian Association of Schools of Nursing, 478 Trooperis Road, RDI Tekuti, New Zealand  
Tel: +11 6478788495, E-mail: jandjwinder@rogers.com

Dr Mary White, (WHO HQ intern), 5432 Sandstone, Fayetteville NC 38311, United States of America  
E-mail: whitem@who.int/mary-white@viowa.edu

Dr Jean Yan, Chief Scientist, Nursing and Midwifery Office, World Health Organization, Geneva, Switzerland  
Tel: +41 22 791 1048, E-mail: yanj@who.int

Mr Thom Dauti Yungana, President, Zambia Union of Nurses Organization, P. O. Box 50375, Lusaka, Zambia  
Tel: +260 211 225135, Fax: +260 211 225135, E-mail: zuno@zamnet.zm/lzymongu@yahoo.com
ANNEX 3: WORLD HEALTH ASSEMBLY RESOLUTION 59.23

FIFTY-NINTH WORLD HEALTH ASSEMBLY
WHA59.23
AGENDA ITEM 11.12
27 MAY 2006
RAPID SCALING UP OF HEALTH WORKFORCE PRODUCTION

The Fifty-ninth World Health Assembly,

Recognizing the centrality of human resources for health for the effective operation of country health systems as highlighted in The world health report 2006;

Recognizing that these health-worker shortages are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO’s priority programmes;

Aware of alliances aiming at achieving a rapid increase in the number of qualified health workers in countries experiencing shortages through partnerships between industrialized and developing countries;

Recalling resolution WHA57.19 on the challenge posed by the international migration of health personnel;

Concerned that in many countries, notably those in sub-Saharan Africa, there is inadequate capacity to train sufficient health workers for adequate coverage of the population;

Concerned that many countries lack the financial means, facilities and sufficient educators to train an adequate health workforce;

Mindful of the need for a comprehensive national policy and plan on human resources for health, and that production is one of its elements;

Recognizing the importance of achieving the goals of self-sufficiency in health workforce development;

1. URGES Member States to affirm their commitment to the training of more health workers by:

   1) giving consideration to the establishment of mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving developed countries to support the strengthening of health systems, in particular human resources development, in the countries of origin;

   2) promoting training in accredited institutions of a full spectrum of quality professionals, and also community health workers, public health workers and paraprofessionals;

   3) encouraging financial support by global health partners, including bilateral donors, priority disease and intervention partnerships, for health training institutions in developing countries;

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5 For example, the Global Health Workforce Alliance, whose Secretariat is at WHO.
4) promoting the concept of training partnerships between schools in industrialized and developing countries involving exchanges of faculty and students;

5) promoting the creation of planning teams in each country facing health-worker shortages, drawing on wider stakeholders, including professional bodies, the public and private sectors and nongovernmental organizations, whose task would be to formulate a comprehensive national strategy for the health workforce, including consideration of effective mechanisms for utilization of trained volunteers;

6) using innovative approaches to teaching in developed and developing countries with state-of-the-art teaching materials and continuing education through the innovative use of information and communications technology;

2. REQUESTS the Director-General:

1) to provide technical support to Member States, as needed, in their efforts to revitalize health training institutions and rapidly to increase the health workforce;

2) to encourage global health partners to support health training institutions;

3) to encourage Member States to engage in training partnerships intended to improve the capacity and quality of health-professional education in developing countries;

4) to encourage and support Member States in development of health-workforce planning teams and use of innovative approaches to teaching in developing countries with state-of-the-art teaching materials and continuing education through the innovative use of information and communications technology;

5) to report to the Sixty-third World Health Assembly in 2010 of progress made in the implementation of this resolution.
The Fifty-ninth World Health Assembly,

Having considered the progress report on strengthening nursing and midwifery;\(^6\)

**Recognizing** the centrality of human resources for health to the effective operation of country health systems as highlighted in *The world health report 2006*;\(^7\)

**Recognizing** the crucial contribution of the nursing and midwifery professions to health systems, to the health of the people they serve, and to efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO’s priority programmes;

**Recalling** resolution WHA57.19 on the challenge posed by the international migration of health personnel;

**Recognizing** the impact of “push” and “pull” factors in the countries concerned;

**Concerned** at continuing shortage of nurses and midwives in many countries, and its impact on health care, and more widely;

**Mindful** of previous resolutions to strengthen nursing and midwifery, including resolutions WHA42.27, WHA45.5, WHA49.1 and WHA54.12, and the strategic directions for nursing and midwifery services in place for the years 2002–2008;\(^8\)

**Concerned** that some Member States do not yet give full recognition to the contribution of nursing and midwifery in their programmes and practices;

1. **URGES** Member States to confirm their commitment to strengthen nursing and midwifery by:
   1) establishing comprehensive programmes for the development of human resources which support the recruitment and retention, while ensuring equitable geographical distribution, in sufficient numbers of a balanced skill mix, and a skilled and motivated nursing and midwifery workforce within their health services;
   2) actively involving nurses and midwives in the development of their health systems and in the framing, planning and implementation of health policy at all levels, including ensuring that nursing and midwifery is represented at all appropriate governmental levels, and have real influence;
   3) ensuring continued progress toward implementation at country level of WHO’s strategic directions for nursing and midwifery;

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\(^{6}\) Document A59/23


4) regularly reviewing legislation and regulatory processes relating to nursing and midwifery in order to ensure that they enable nurses and midwives to make their optimum contribution in the light of changing conditions and requirements;
5) to provide support for the collection and use of nursing and midwifery core data as part of national health information systems;
6) to support the development and implementation of ethical recruitment of national and international nursing and midwifery staff.

2. REQUESTS the Director-General:
   1) to ensure the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nursing and midwifery personnel;
   2) to provide continuing support for the work of the Global Advisory Group on Nursing and Midwifery, and to recruit nurses and midwives in all relevant WHO programmes to ensure the contribution of nursing and midwifery in the development and implementation of WHO’s policy and programmes;
   3) to provide support to Member States, in collaboration with local and global partners to strengthen the application of ethical recruitment guidelines;
   4) to provide support to Member States in optimizing the contribution of nursing and midwifery to meeting national health policies and the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
   5) to encourage and support Member States in the provision of workplace environments that are safe and support the retention of nurses and midwives;
   6) to report to the Sixty-first and Sixty-third World Health Assembly in 2008 and 2010 on progress made in the implementation of this resolution.
REPORT OF THE GLOBAL CONSULTATION ON AN IMPLEMENTATION FRAMEWORK FOR SCALING UP NURSING AND MIDWIFERY CAPACITY

LUSAKA, ZAMBIA
3–5 DECEMBER 2007