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*Fifth annual meeting of
the European Forum of
Nursing and Midwifery
Associations and WHO*

Report on a WHO Meeting

Andorra-la-Vella, Andorra
9-10 March 2001

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ABSTRACT

The Fifth Annual meeting of the European Forum of Nursing and Midwifery Associations and WHO was held in Andorra on 9-10 March 2001 and was attended by representatives from 19 WHO European Member States, observers from international associations and representatives of nongovernmental organizations. The two main issues discussed were "Poverty, its reduction and elimination, and the contribution of nurses and midwives"; and a Statement was endorsed by the Forum on this issue, urging nurses and midwives to support approaches to alleviate the causes of poverty, and urging Governments to recognize the roles which nurses and midwives can play.

Keywords

SOCIETIES, NURSING – congresses
NURSING – trends
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Business meeting

Introduction

The Director-General of WHO, in the latter part of 2000, launched the new WHO global initiative under the slogan “Ill health and poverty: the massive effort”.¹ The major focus of the initiative is to link poverty with sustainable development. This includes stamping out the three poverty-linked killer diseases, tuberculosis, malaria and AIDS, which affect huge proportions of the population in many third world countries. This will be done by attacking the root cause, i.e. poverty. She has called on the international community to join forces to this end, including industry, nongovernmental organizations and health professionals as key players.

While those killer diseases are also of concern in the WHO European Region,² the numbers are much lower than in the less developed parts of the world. Nevertheless there is acute recognition that poverty in itself is a true evil in all Member States. The number of people living in poverty ranges from 1% in some countries up to 70% in others. Throughout the Region, such people lack adequate housing, sufficient means to guarantee a nutritious diet, and rewarding and remunerative employment. As a result, they suffer poor health, have less access to appropriate health and other related services, and are marginalized and often even excluded from society. Key groups at risk are women, children, the elderly and those suffering from mental illness. Being exposed to poverty in childhood can affect the whole life cycle of the individual.

There is thus a huge need to tackle the issue head-on if we are to create an equitable and healthy society. Several countries, for example Sweden³ and the United Kingdom,⁴ have already identified poverty as a key government priority and have set targets to work towards its resolution. Some nurses and midwives⁵ have recognized the contribution that poverty makes to ill health and are playing a significant role in helping to alleviate it. Nevertheless, the majority of nurses and midwives have not yet acknowledged such a role, nor have they been adequately educated and prepared for it. Indeed the subject is conspicuous by its absence from undergraduate and postgraduate curricula. Yet if the professions are to play their rightful role they need at the very least to be aware of the potential of that role as well as be aware of (and be in possession of) the necessary competencies to enable them to carry out the role efficiently and effectively. For example, they need to be aware of the difference between helping people to live with poverty and helping them to escape from it.^{6, 7}

The Fifth Annual Meeting of the European Forum of National Nursing and Midwifery Associations and WHO was held in Andorra on 9–10 March 2001 and was attended by representatives from 19 WHO European Member States, observers from international associations and representatives of nongovernmental organizations (Annex 1).

¹ WHO calls for a massive effort against poverty. Press release WHO/63, 3 October 2000 (<http://www.who.int/inf-pr-2000/en/pr2000-63.html>).

² HEALTH21: the health for all policy framework for the WHO European Region. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).

³ ÖSTLIN, P. & DIDERICHSEN, F. *Equity-orientated national strategy for public health in Sweden. A case study*. Copenhagen, WHO Regional Office for Europe, 2000 (Policy Learning Curve Series, No. 1; document EUR/00/5019128).

⁴ SEYMOUR, J. *Poverty in plenty. A human development report for the UK*. London, UNED-UK, 2000.

⁵ *Portfolio of innovative practice in primary health care nursing and midwifery*. Copenhagen, WHO Regional Office for Europe, 2000 (document EUR/00/501939/60).

⁶ MOCCIA, P. & MASON, D. Poverty trends: implications for nursing, *Nursing outlook*, Jan.–Feb. 1996.

⁷ KENDALL, J. Fighting back: promoting emancipatory nursing actions. *Advances in nursing science*, December 1992.

Welcoming addresses

Ms Lourdes Font, President of the National Association of Nurses and Midwives in Andorra, welcomed the Forum members. Dr Josep Goicoechea, Director of the Division of Country Support at the Regional Office, drew attention to the fact that that public health played a prominent role in the Munich Declaration; poverty was the major cause of ill health and nursing had a major impact on the situation of the underserved.

Mr. Casadevall Medrano, Minister of Health and Welfare of Andorra, gave a short overview on relations between WHO and Andorra. Andorra had become a member of WHO in 1997. Poverty was not an acute problem in Andorra but there were nevertheless people who lacked resources or had family problems, in particular those belonging to the newly arrived immigrant groups. He welcomed the representatives of so many European countries to Andorra.

Ms Jette Soe, Chairperson of the Forum, was elected Chairperson of the meeting. The programme was unanimously adopted (Annex 1). Mr Franz Wagner, Executive Director of the German Nurses Association, was nominated Rapporteur.

Address by the Chairperson

Ms Soe, in her welcoming address, thanked the Andorran Nursing Association for hosting the meeting.

The meeting's theme of poverty was in follow-up to the fourth meeting's theme of equity. Ms Soe stated that during the first four annual meetings of the Forum considerable time had been devoted to operational principles. She expressed a wish that there would be more time at the current and future meetings for technical discussion and debate. She highlighted the importance of the Munich Declaration, and the role of the Forum in disseminating and implementing the recommendations in the Declaration. She highlighted the fact that the Forum had the potential to represent six million nurses and midwives in the 51 countries of the WHO European Region. Evidence about the impact of nursing and midwifery on the health status of people was clearly available and the professions had the opportunity, through WHO, to influence health policy throughout Europe, with a positive knock-on effect on the alleviation of poverty.

Amendment to the Operational Principles

Mr Liam Doran, General secretary of the Irish Nurses Organization, introduced the amendment to the Operational Principles. It was proposed that that the wording contained in the document in the participants' pack should be replaced with the following: *In the event of a midwife being elected as a chairperson, another midwife should be co-opted to replace her on the steering committee in which case the number of members would increase to nine.*

After a short discussion, the Danish representative requested a secret ballot on the amendment. Of the 23 associations eligible to vote 20 voted; there were 12 votes for the amendment and 8 against. The amendment was thus carried (Annex 3).

Elections to the Steering Committee

Letters requesting nominations had been sent out to all member associations three months in advance of the meeting, as required by the Operational Principles. Five valid nominations had been received, but one nominee had subsequently withdrawn. Kerstin Belfrage (Sweden), Liam Doran (Ireland) and Merete Thorsén (Denmark) were therefore confirmed as candidates and were duly elected by affirmation. Liam Doran was unanimously elected Chairperson of the Forum. Karlene Davis was unanimously elected Vice-Chairperson.

Membership fees and budget for 2002/2003

Kerstin Belfrage, Treasurer, presented the financial situation of the Forum for 2000/2001 (Annex 4) and the budget for 2002/2003 (Annex 5). She reminded the meeting that, after much deliberation, the Steering Committee had agreed that a three-stage fee formula based on GNP was appropriate. She also reminded the member organizations that during the meeting of the Forum in the year 2000 it had been agreed that the Forum was an important vehicle for nurses and midwives and that it should continue to be supported. The Steering Committee had been asked to prepare suggestions for funding the future work of the Forum.

The Steering Committee had investigated, as requested, how other WHO forums were funded. Such comparisons had proved difficult, since the other forums functioned very differently and were also supported in a range of ways by their member organizations. As far as the EuroPharm Forum was concerned, the membership comprised wealthy organizations that could contribute financially much more through a higher membership fee. The Steering Committee therefore proposed that the fees be increased to US \$1500/1200/800, respectively.

During the ensuing discussion, several member associations expressed concern at the proposed fee increase. Ms Christine Hancock, President of the Standing Committee of the Nurses of the European Union, expressed concern that the proposed increase in fees would place a heavy burden on the less well-off countries. This view was supported by Ms Velka Gavrovska, President of the Macedonian Association of Nurses, Midwives and Technicians (the former Yugoslav Republic of Macedonia). It was also noted that affiliate associations and observers did not currently pay a fee.

The Steering Group agreed to reconsider the paper and propose an alternative to the GNP methodology of calculating fees. It was suggested by several member associations that it might be preferable to base fees on the number of members of a nursing or midwifery association; it was felt that smaller associations would find it very difficult to pay the proposed new fees. Associations from eastern Europe and some smaller associations had already requested a reduced fee, and the Steering Committee had considered this suggestion in the past. It was further suggested that a rise of more than 50% would be very hard to explain to members within the national organizations. Ms Kirsten Stallknecht, President of the International Council of Nurses (ICN), asked the Steering Committee to explain to the Forum the consequences if the fees were not increased. An alternative proposal was put forward to increase the fees in two steps – 10% in the year 2002 and another 10% in 2003 – and then evaluate the consequences for the work of the Forum.

After a short meeting the Steering Committee advised that it was not possible to develop alternative proposals in such a short time and that a decision needed to be taken for the year 2002 at the current meeting. The Steering Committee also stated its view on the consequences should fees not be raised: a reduction in the number of Steering Committee meetings, a reduction in collaboration with other WHO forums and non-participation in ministerial conferences.

The Steering Committee's original proposal was adopted, with an agreement that a subgroup be established within the Steering Committee to develop a new approach to calculating fees and funding the work of the Forum. The subgroup membership was agreed as Liam Doran, Kerstin Belfrage and Merete Thorsén.

Twining for equity

Ms Ainna Fawcett-Henesy, Secretary to the Forum, reminded the meeting of the statement made by the Chairperson at the WHO Regional Committee in Copenhagen in 2000 of the

Forum's commitment to develop twinning agreements between member associations in the east and the west of the Region. She referred the participants to the conference pack, which included three excellent examples of twinning among nursing associations and where joint contracts had been agreed. These were between Sweden and the Russian Federation, between Denmark and Lithuania, and between the Royal College of Nursing (United Kingdom) and Hungary and Poland. Other examples were cited where no official agreement existed, for example between Germany and Slovakia and between the Royal College of Midwives (United Kingdom) and the Romanian Midwives Association.

Ms Fawcett-Henesy brought to the attention of the meeting those countries that were in desperate need of support from western European countries, and especially help of nursing and midwifery associations: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Tajikistan, Ukraine and Uzbekistan.

Ms Fawcett-Henesy advised that Ireland had indicated an interest in twinning with the Republic of Moldova, Denmark with Kyrgyzstan, Spain with Uzbekistan and Slovenia with Kazakhstan.

HEALTH21 pledge

Ms Fawcett-Henesy reminded the meeting of the commitment the Forum had made one year before to promoting the role of nurses and midwives in public health through HEALTH21. This had been further reinforced at a special session during the Ministerial Conference on Nursing and Midwifery held in Munich in June 2000.

She highlighted the fact that some member associations had been very active while others had been less so. In Germany, nursing students are asked at the end of their training to sign the HEALTH21 pledge and they receive a HEALTH21 pin. The Andorran Nursing Association had done likewise, producing a HEALTH21 pin for all nurses and midwives who committed themselves to the sentiments implicit in the pledge. Associations in the former Yugoslav Republic of Macedonia used the pledge each time they engaged in discussions with the Government on nursing and midwifery legislation. The pledge was distributed to training institutions for midwives and nurses. In Spain, a national workshop had been organized in which all nursing schools and hospitals and the ministry of health were invited to participate; the pledge had been translated into Spanish in combination with the HEALTH21 objectives. In Ireland, a multidisciplinary conference based on HEALTH21 had been held and the nursing association would contact graduating students to inform them about the pledge. The German Midwifery Association promoted the pledge at all meetings and used the Munich Declaration in its political work.

Ms Fawcett-Henesy urged the participants to work with the pledge and to evaluate what had been achieved. It was agreed that an update be given at each Annual Meeting.

Munich update

Ms Fawcett-Henesy updated the participants on what had happened since the Munich Conference. Several countries had translated the Declaration and many had also held conferences and meetings to introduce the Declaration to a wider audience. A follow-up meeting would take place at the Regional Office with some of the participants who were on the drafting group of the Munich Declaration. A policy analyst would lead the work and undertake the drafting of the guidance document to the implementation of the Munich Declaration, which would be sent to ministries of health and nursing and midwifery associations.

Reports by Forum task force groups

Chronic diseases

Ms Irene Feet and Dr Ruth Northway presented the report from the task force and explained that in their view the work was not yet complete and that the report to the meeting should be considered interim. It was seen as a first step to highlight the importance of the topic. The methods used to develop the report were explained and the results shared with the participants.

Four key aspects were: service; indicators of achievement; the role of the European Forum of National Nursing and Midwifery Associations and WHO; and a framework to gather information. This report was seen as a baseline on which the role of nurses and midwives could be developed. Advice and comments would be sought from the Regional Office CINDI Programme. The final report would be available mid-2001.

Care of older people

Professor Myriam Ovalle explained how the work of the task force had been organized to date. The Steering Committee had suggested that a position paper on the role of nurses in the care of older people be prepared, and that the conclusions reached be adopted by the Forum. The Steering Committee was asked to send the paper to all Forum members and their comments requested as well as recommendations on how best to develop a final version of the report. Eventually, a portfolio of examples of best practice should be developed. Professor Ovalle urged the Steering Committee to find ways to accelerate the work of task forces in order to produce faster and better results.

Women and children

Ms Kerstin Belfrage, in presenting her report, advised that there had been some problem with the work of this task force, owing in no small part to the fact that the members gave their services on a voluntary basis. Little progress was reported over the last year. Eventually support has been promised from the Royal College of Midwives in the United Kingdom, and the meeting was assured that the report would be properly referenced in the next few weeks and sent to all member associations.

The focus of the task force was on abortion. This could be related to several targets of HEALTH21:

- target 1: solidarity for health in the European Region
- target 2: equity in health
- target 3: healthy start in life
- target 4: health of young people
- target 9: reducing injury from violence and accidents.

Examples were collected from a range of countries, including Albania and Slovenia.

Smoking cessation

Ms Jennifer Percival presented the tool kit as the outcome of the task force. The tool kit was distributed on diskette to representatives of all countries present. The countries that had participated in the work on smoking cessation were Iceland, Spain, Sweden and the United Kingdom. The task force had had some financial problems at the outset, but eventually received some funding from the European Union.

“We understand the nature of addiction!” was the main message being propagated. The aims of the task force were:

1. to endorse the role of nurses and midwives in tobacco control;
2. to influence the smoking habits of health professionals, a good example being the self-help booklet produced by the Royal College of Nursing in the United Kingdom; and
3. to maximize the effectiveness of professionals in smoking cessation.

During the ensuing discussion, Ms Merete Thorsén stated that smoking cessation was a very important issue for nurses and midwives. The work of the task force was very much appreciated, but she was concerned about the use of expensive mood-altering drugs. Ms Percival replied that governments would prevent people starting to smoke and motivate people to stop if the price of cigarettes was increased. Nurses must know about the possibility of doubling the success rate by using nicotine replacement.

Ms Katriina Laaksonen, President of the Finnish Nurses Association agreed with Ms Thorsén's concern about the use of drugs. Because of the lack of preventive nursing interventions, there should be guidelines at least as a background. She stated that an evidence-based approach could be crucial. Ms Percival replied that prevention is very different from intervention and it is a way of prioritizing to focus on cessation. Ms Anne Marit Tangen, President of the Norwegian Midwives Association, said it was very hard to make pregnant women stop smoking, and highlighted the need for special guidelines for that group. Ms Percival explained that the guidelines could easily be adopted to different countries/settings. Ms Eva Fernvall Markstedt, President of the Swedish Association of Health Officers, supported the use of pharmacotherapy if it was effective. She pointed out that there were no side effects of nicotine replacement drugs, and informed that there was a very good tool kit for pregnant women available in Sweden. Ms Clare Spillane, President of the Irish Nurses' Organization, supported the use of pharmacotherapy and reported that in Ireland prescriptions for a six-week period were paid for by the health service.

The guidelines on tobacco cessation were adopted by the Forum with some caveats. It was agreed that Ms Fawcett-Henesy would approach Martin Raw (Leader, Evidence-Based Treatment, WHO Europe Partnership Project to Reduce Tobacco Dependence) through Ms Percival to ask if the concerns expressed could be addressed in the guideline document.

Technical discussion

Mrs Ainna Fawcett-Henesy gave an introduction to the topic of the technical discussion, poverty and health (Annex 6) and referred the participants to the background paper that she had prepared for the meeting. She highlighted the following:

- people are sick because they are poor;
- it is a matter of being powerless and voiceless that builds a "poverty trap";
- the body is very often the only asset of poor people and is therefore a major source of insecurity in case of ill health; and
- poverty and health are also a matter of gender inequity.

In addressing the issue of poverty and health, one needs to realize that there are several levels – the macro, intermediate and micro levels – at which policies and interventions should be applied. Nurses and midwives needed to be aware of all three levels and of their contribution and added value at each level. They also needed to have the related competencies.

Dealing with poverty and health includes keeping a balance between:

- biomedical and social approaches

- community-based and individual health development
- preventive, promotive and curative health care
- physical and mental health.

She referred to a statement made by Dr Marla Salmon, an eminent Professor of Public Health Nursing, during the Munich Conference that “policy is the most important single determinant of health”, shaping systems, creating access to services and influencing the environment in which people live and work. Accepting things as they are, especially policies that are known to affect adversely those living in poverty, is as much a political activity as pushing for change. She gave several practical examples whereby nurses and midwives are addressing poverty in the European Region at all three levels. One example was of immigrants living in unlicensed housing in Lisbon, trying to improve their quality of life but unwittingly making it worse in the process. The area in which they had settled was without proper sanitation or water and lacked basic infrastructure. Nurses worked with the people to improve their health, and at the same time worked with the city authorities to improve or create an infrastructure. Nevertheless, there was not a great deal of evidence from the international literature to support the view that the majority of nurses and midwives actively engaged themselves in the poverty debate.

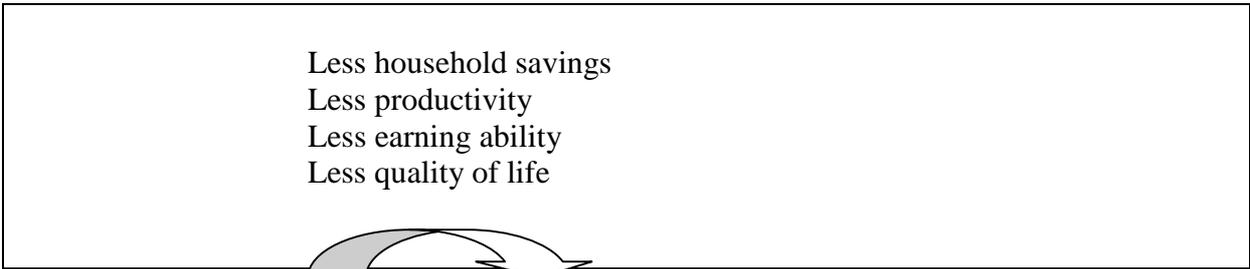
In concluding her introduction, Mrs Fawcett-Henesy highlighted the importance of recognizing that nurses and midwives belong to the poor in many of the countries in Europe. Many of them have to do three jobs to survive, either because they have not received a salary for several months, because their salaries are extremely low, or because of a combination of both factors.

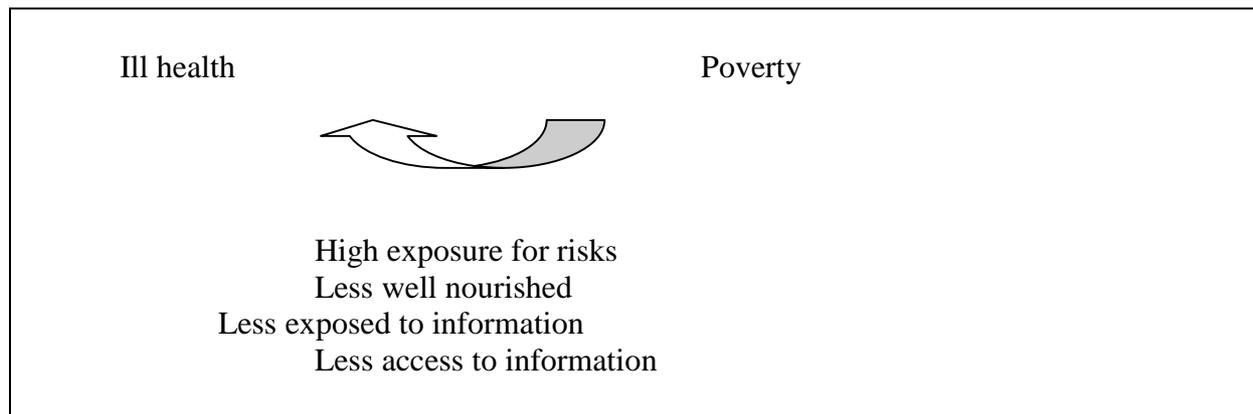
“Health and poverty – a challenge in health systems development”

Dr Mazuma Banda, Medical Officer in the Department of Organization of Health Services Delivery at WHO headquarters, provided background information on the challenge of poverty. Some 1.3 billion people lived on less than one US dollar a day, while 2.8 billion lived on less than two dollars a day. Poverty affected more than 50% of people on the earth. The number of poor people had increased over the last 10 years, with the highest numbers found in South Asia and Africa. Ill health was both a cause and consequence of poverty

Those living in poverty are five times more likely to die before the age of 5 years, and 2.9 times more likely to die between the ages of 15 and 55 years. In addition, maternal mortality was higher than average.

The data also showed that women were more affected by communicable diseases than men.





Dr Banda explained that a recent study on poverty by the World Bank indicated that illness was one of the leading factors responsible for the descent of many households into poverty. The major determinants of health included food security, household caring practices, female literacy, access to water and sanitation, work demand, fertility control services, access to preventive health programmes, and access to basic curative care. This showed that improving the health of the poor required efforts far beyond the health sector. It was not only a multidimensional but also a multisectoral problem.

Dr Banda mentioned several strategies that had failed in the past.

- Expansion of health infrastructure to reach the poor. The weakness of this approach is that the resources required are extremely high and therefore the aim is very often not achieved.
- Targeting of diseases that mostly affect the poor (e.g. tuberculosis). Even when a great effort is made to do this, it is the “richer” who benefit more than the “poor” because of an inherent inequality in access to health services.
- Universal coverage of services. This makes a difference when complete coverage is achieved. Where universal coverage is not achieved, as is the case with many health programmes, it is still the poor who are left out.

The WHO strategic approach to addressing health and poverty was to:

- act on determinants of health by influencing development policy, taking into consideration the broader economic and social developments (structural issues);
- reduce risks through a broader approach to public health (addressing issues such as violence, and access to water and sanitation);
- focus on health problems that affect the poor most (tuberculosis, malaria, HIV infection); and
- ensure health systems that serve the poor more effectively (e.g. how the performance of the health service is measured).

Finally, Dr Banda highlighted some possibilities for action by nurses and midwives. They should:

- act as advocates for the poor (with government, health services, individuals);

- work towards empowerment of the poor (through compassion, information and respect; and by assisting the poor to appreciate that they have rights and that they have a choice); and
- work for the expansion/extension of services (distribution of services and a critical appraisal of how much these services address the needs of the poor).

Nurses and midwives contributing to reducing poverty

During the ensuing discussion, it was pointed out that the Royal College of Nursing in the United Kingdom had distributed a publication in preparation for the general election. One of the important issues included in this document was that of inequality.

There followed presentations of four examples from different European countries of how nurses and midwives can contribute to reducing poverty.

Ireland

Mr Liam Doran gave an example of community health nurses working with the travelling community. Related problems included an infant mortality rate three times higher than in the average population, a birth rate twice the average and a much lower life expectancy. These people had less access to general practitioner services and their access to education was limited. The project was implemented by a dedicated team of public health nurses. The aim was to improve access to all health services by empowering the travelling community. The project involved significant education components, including:

- antenatal programmes
- intensive contact in the first three months after birth
- development of preschool programmes under the direction of the public health nurses.

In addition, a mentor/motherhood programme had been developed, sex education programmes and literacy and numeracy classes were being held, and a targeted infrastructural programme (i.e. provision of running water and toilets) had been implemented.

The project has resulted in less infant morbidity, a higher school attendance, a lower birth rate, a higher average maternal age, greater involvement of the travellers in the provision of social services and local governance, and a lower rate of hospital admission.

Problems with the project were the high costs and labour intensiveness, a high turnover of staff and a continuing resistance within the settled community. The full review of the project will be available in 2002.

Switzerland

An example from Switzerland was presented by Ms Magali Bertholet-Pradervand, Vice-President of the Swiss Nurses' Association. She began by explaining that although Switzerland was one of the richest countries in the world, there were nevertheless areas with real poverty. Many people were left out of the job market and there was a high number of refugees. As a result, the Government had created special services, an example of which concerned the large community of homeless people who lived behind the central station in Geneva.

Five years ago, visiting nurses in the area had decided to take action. A shop had been changed to a comfortable "welcome centre" with nursing staff. This was a place to rest, to warm oneself and to chat. Information spread by word of mouth and the demand increased.

After a few months, a new building was found that also offered baths, hairdressing, laundry, dental care, foot care and a medical service.

Slovenia

Ms Veronika Pretnar Kunstek of the Nurses Association of Slovenia explained the historical background to and the political view of poverty in a socialist society. Poverty did not officially exist, because it was seen as incompatible with the socialist ideal of society and a symptom of capitalism. Nevertheless, poverty had always existed and because of the socioeconomic changes it was now a bigger problem than ever.

United Kingdom

Concluding the short presentation session, Ms Frances Day–Stirk of the Royal College of Midwives presented several examples. Drop-in centres had been created for pregnant women and those who had recently given birth. One of the effects had been a lower smoking rate. Another project treated addicted women and women in prostitution, and another was a drop-in centre for teenagers (both girls and boys) that provided sexual information. She explained that it was crucial to establish a partnership between several institutions and groups to work towards reducing inequalities. Very often a midwife was the first health professional a woman met.

During the discussion, Ms Eva Fernvall Markstedt, President of the Swedish Association of Health Officers, reported the problems of the “hidden refugees”, especially pregnant women, a problem that seemed common in the United Kingdom too. Professor Myriam Ovalle reported large problems with immigrants/refugees and poverty and ill health. She suggested this be considered this in the Forum’s statement on poverty and health. Ms Andrea Stiefel, Vice-President of the German Association of Midwives, reported on the problems of delivering refugees who gave wrong names and who disappeared after giving birth. The possibility of anonymous treatment had been introduced to reduce this problem.

An example of a nongovernmental organization

Mr Paddy Maguinness, Deputy Chief Executive of CONCERN, a nongovernmental organization based in Ireland, reported on the work of the organization. CONCERN had been involved in poverty issues for a very long time and worked within Ireland as well as abroad. Its main aim was to relieve the effects of disaster.

Mr Maguinness explained that CONCERN was a very poverty-focused agency. It worked mainly in sub-Saharan Africa, Asia and South America. It very often dealt with refugees, often in large numbers, with interventions based on women’s education and public health.

He explained that poverty was a global issue, as illustrated by the fact that in the United Kingdom about 5 million people lived in poverty while in the Russian Federation the figure was some 40% of the population. The main causes of ill health and death were communicable diseases such as diarrhoea, tuberculosis and measles.

The United Nations and several other associations and organizations had agreed that by 2015 absolute poverty would be reduced by 50% and that maternal and infant mortality rates would also be reduced. In his view, these targets seemed unreachable at present, because they depended on economic growth. For example, sub-Saharan Africa would need 6% growth to reach those goals, but had at present a negative growth of 7%. He explained that CONCERN saw the need for a new model based on redistribution of wealth, a change in the power structure between east and west and between north and south in Europe, the involvement of the state in market forces, and governments spending on social and health issues.

Mr. Maguinness stressed the high level of respect in the global community for nurses and midwives, a strength that they did not make enough use of. In his view, it was an added value to use this reputation and to be able to tell stories from real life. Nurses and midwives should move from their large potential to power, and the only reason for power was to change policy. He reminded the participants that Florence Nightingale was somebody who challenged the social norms of her time and that nurses and midwives had the potential to do the same today.

Open space meeting

An introduction to the open space meeting (Annex 6) was given by Mr Julian Pratt. In setting the agenda, he explained that the general topic was: “How can nurses and midwives contribute to poverty reduction?”. The outcome of the open space meeting is given in Annex 7.

Concluding comments from the open space meeting were the following.

- The Council of Midwives in Spain would suggest that the Ministry of Education include poverty in the curriculum for the training of midwives.
- German midwives would place health and poverty on the agenda of their association’s next meeting.
- Ms Jette Søe from Denmark suggested using the Forum’s home page as a place to network activities on poverty issues. Mr Paddy Maguinness would provide a list of key websites.
- Professor Myriam Ovalle explained the need to build strategies nationally and internationally to use the power of nurses and midwives.
- Ainna Fawcett-Henesy suggested developing a portfolio on the work of nurses and midwives with nongovernmental organizations on poverty. She reported that the portfolio on primary health care had been a major success.

Forum statement on poverty reduction

A revised version of the draft statement was adopted unanimously (Annex 8). A further revision would include a women’s perspective on the topic. The statement would be edited by WHO and the final version circulated within one week.

The Chairperson advised the meeting of the new structural arrangements at the WHO Regional Office for Europe. He outlined the possible negative implications for nursing and midwifery in the light of the imminent transfer of the nursing programme to Barcelona. A statement was tabled to this effect, and it was agreed that the Chairperson would bring the concern of the Forum to the attention of the Director of Country Support at the regional Office.

Closure of the meeting

Ms Rosa M. Mandico Alcobe, Director of Health and Welfare of Andorra, addressed the Forum. She explained that the impression that Andorra was a rich country without poverty was only partly true. There were several groups of the population that were at risk. Poverty on a short-term basis existed for single parents, elderly people and families with alcohol problems. In her view, it was the responsibility of health professionals to be aware of the problem and to work together with other professions to reduce it. She pointed out that this is a great challenge for nurses and midwives. The statement on poverty would be welcomed by the Andorran Government and many other governments. Finally, she thanked the Steering Group, the Regional Adviser and all the participants for having convened the meeting in Andorra.

In bringing the meeting to a close, Mr Liam Doran highlighted the strong engagement in networking and friendship-building during the meeting. He thanked all the speakers, the Rapporteur and Mr Julian Pratt for organizing the open space meeting. He expressed special thanks to Ms Ainna Fawcett-Henesy and her team. He closed the meeting by thanking the National Nursing Association of Andorra for its hospitality and for organizing and preparing for the meeting.

It was announced that the Sixth Annual Meeting of the Forum would be held on 8–9 March 2002 at the WHO Regional Office for Europe in Copenhagen.

- Annex 1 List of participants**
- Annex 2 Programme**
- Annex 3 Financial statement for 200/2001**
- Annex 4 Budget for 2002/2003**
- Annex 5 “Poverty, its reduction and elimination – the contribution of
nurses and midwives”. Position paper by Ms Ainna Fawcett-Henesy**
- Annex 6 Guidelines on the open space meeting**
- Annex 7 Outcome of the open space meeting**
- Annex 8 Statement on the role of nurses and midwives in poverty
reduction**

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Annex 2: Programme

Thursday 8 March 2001

20.30: Hotel Mercure. Welcome reception hosted by the National Association of Nurses and Midwives of Andorra.

Friday 9 March 2001

08.00-08.45 Registration at the Congress Center

Business meeting

09.00-09.30

Opening session

Welcome addresses:

- Mr Forne i Molne, *Head of Government of Andorra*
- Mr Casadevall Medrano, *Minister of Health and Welfare of Andorra*
- Ms Rosa M. Mandico Alcobe, *Director of Health and Welfare of Andorra*
- Ms Lourdes Font, *President, National Association of Nurses and Midwives*
- Dr Goicoechea, *Director, Division of Country Support, WHO Regional Office for Europe*

09.30-09.45

- Nomination of Chairperson, adoption of the Programme and announcement of Rapporteur
- Address of Ms Jette Söe, *Chairperson, European Forum of National Nursing and Midwifery Associations and WHO*

09.45-10.45

- Amendment to the Operational Principles
- Election of the Steering Committee Members

10.45–11.10

Coffee/tea break

11.10-11.30

Membership fees and budget for 2002/2003

11.30-11.45

Twinning for Equity

11.45-12.00

- HEALTH21 Pledge
Update from the National Nursing Associations and the National Midwifery Associations

12.00-13.00

- Reports by Forum Task Force leaders
- Endorsement of the *First European Guidelines on the Treatment of Tobacco Dependence*

13.00-14.00

Lunch break at the Congress Center, hosted by the Andorran Service of Sanitary Attention

Technical Discussion Session

“Poverty, its reduction and elimination – The Contribution of Nurses and Midwives”

14.00-14.15

Introduction to the Technical Discussion
Ainna Fawcett-Henesy, *Regional Adviser for Nursing and Midwifery, WHO Regional Office for Europe*

14.15-15.15

Poverty Reduction
- “Health and Poverty”: A Challenge in Health Systems Development”,
Dr Mazuma Banda, *Medical Officer, Department of Organization of Health Services Delivery, World Health Organization Headquarters*
- Mr Paddy Mc Guinness, Deputy Chief Executive, Concern, Ireland

15.15-15.45

Coffee and tea break

15.45-16.45

Nurses and midwives contributing to poverty reduction
Examples from 3 European countries: Ireland, Switzerland and Slovenia

16.45-17.00 Round-up of Day 1 – Preview of Day 2 work
(Rapporteur)

19.00 *Concert of the Little Singers of Andorra, hosted by the Private Bank of Andorra*
20.30 - *Dinner hosted by the Ministry of Health and Welfare of Andorra*

Saturday 10 March 2001

09.00-9.20 “What contribution can Nurses and Midwives make to poverty reduction?”
Introduction to the Open Space Meeting
Mr Julian Pratt, Urban Partnerships Group, London School of Economics
Ainna Fawcett-Henesy, *Regional Adviser for Nursing and Midwifery*, WHO
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09.20-12.30 Open Space Meeting
(refreshments will be served during the session)

12.30-13.00 Plenary session
Feedback from the open space meeting

13.00-14.00 *Lunch break at the Congress Center hosted by the SAAS*

14.00-15.00 Conclusions and recommendations: The Nursing and Midwifery Contribution to
Poverty Reduction – Consensus on a draft Forum Statement.

Chairperson, European Forum of Nursing and Midwifery Associations and
WHO

15.00-15.15 Dates of the 6th Annual Meeting of the Forum
Chairperson, European Forum of Nursing and Midwifery Associations and
WHO

15.15-15.30 Closure of the meeting

Annex 3: Financial statement 2000-2001

INCOME	US \$
Transferred from 1999	2774,00
Membership fees 2000	20 260,00
Membership fees 2001 02 28	12 536,00
	35 570,00
EXPENSES	
Steering Committee Meetings:	
Secretariat:	
Part time C3 sec.	21 623,13
Annual Meeting	
Travel costs	932,23
Programme Support Cost	2 650,00
	25 205,36
Net balance 2001 02 28	10 364,64

Annex 4: Budget Proposal for the European Forum of Nursing and Midwifery Associations and WHO for 2002-2003

1. Introduction

1.1 Financing the Forum

Membership Fees as well as a Standard Contribution from the WHO Regional Office for Europe have mainly financed the work of the Forum since 1996.

The membership fees were calculated on the basis of what was considered affordable and reasonable, at the time, and were in line with fees for example for membership of other international organisations e.g. PCN and ICN or ICM. The fees were also set at three different levels to accommodate the different stages of development of the Member States in the Region (based on the World Bank Development Report 1993). Because of the relative size of Midwifery Organisations it was agreed that the fees for such organisations would be set at the intermediate level. The income of the Forum was estimated on the basis of all eligible National Nursing and Midwifery Associations paying the full fee at the agreed rate.

Due to a variety of reasons the estimated income has fallen far short of what was projected either because some NNAs have failed to pay or are paying a much reduced subscription. This has resulted in the Forum being unable to cover its running costs as well as limiting its opportunities for further development.

At the 4th Annual Meeting of the Forum the poor financial state of the Forum was brought to the attention of the meeting.

It was also stated that if the NNAs and NMAs wished the Forum to continue to develop and grow then membership fees would need to be increased. A funding proposal offering three options was put forward for 2001.

It was the general consensus that the Forum should continue and the Steering Committee was requested to prepare a Budget Proposal for consideration and adoption at the fifth Annual Meeting. The Steering Group was also requested to explore other options for fund raising for Forum activities. In view of the timing it was agreed that the current membership fee rates should be retained for 2001.

The matter was discussed at the first Steering Group Meeting following the Annual meeting and the following conclusions were reached:

- (1) There was a need for strong arguments to substantiate the case for an increase in membership fees.
- (2) The methods used by the other Forums, for example the Medical and Pharmaceutical Forum, for funding their activities should be explored.
- (3) The Forum should consider alternative sources of income generation.
- (4) One budget proposal only should be presented at the Fifth Annual Meeting for adoption.

2.0 Realizing the potential of the Forum

Since the establishment of the Forum in 1996, it has played an important role in influencing the profession across the whole European region. It is through the Forum that the *Health for All* message is being disseminated to grass roots nurses and midwives. Because of the value with which WHO views the Forum a special request was made by the WHO Regional Director to all Ministers of Health to include the President or Chief Executive of the Nursing and Midwifery Associations in their official delegation at the Munich Conference in June 2000.

The Forum has undoubtedly the potential to act as an effective channel through which nurses and midwives can influence the public health policy agenda both in WHO and at country level. Whilst this

is happening to some extent at the current time it is far less than its potential. To exploit that potential to maximum effect the Forum needs to create a higher profile for itself and become much more visible through the development and dissemination of policy statements as well as credible technical guidance. The Forum also needs to be increasingly perceived by the various WHO Programmes as the appropriate entity to represent the nursing and midwifery professions in WHO Expert Groups and Committees. The new Futures Fora are also an important vehicle through which the Forum should influence WHO policy. Additionally the Forum needs to improve its visibility and position of influence by actively participating in other European meetings. Alongside that Forum representatives need to make themselves available to address national and international conferences in the name of the Forum.

2.1 Rationale for an increase in Membership Fees

As stated in the introductory section the expected income to allow the Forum to function even at minimum level has not been possible due to the inability of some NNAs to pay their membership fee whilst others have only been able to pay a proportion of the total fee due. There is no reason to believe that these Associations will be in a better financial position in the next year. Yet if the Forum is to operate at a minimum level then funds will have to be forthcoming from some source for 2002 and beyond.

Having explored the possibility of additional funds through the WHO European Office it seems unlikely that such funds will be available. Indeed to ensure the continued independence and partnership arrangement of the Forum with WHO it is important that it continues to be self-financing.

This therefore leaves us with little option, in the immediate term, but to propose that the membership fees are increased to cover our basic needs for example in line with our terms of reference. This includes: developing, communicating and disseminating information to the membership; costs for annual meetings; funding the chairperson travel and per diem to attend the meetings of the other forums as set out in both our own Forum as well as the constitutions of the other forums; to cover the costs of editing, translating and publishing the documents of the Forum Task Forces and finally to cover the administrative costs of the Forum. To ensure the continued development of the Forum as outlined in para 2.0 further consideration will need to be given to external fund raising.

2.2 Funding and Administration arrangements of the Medical and Pharmaceutical Forums

With reference to using the Pharmaceutical Forum as a model to emulate it should be noted that the nature of this Forum is very different from the Nursing and Medical Forum. Its membership is mainly from the commercial sector and therefore the ability to pay would be much greater than that of NNAs and NMAs. Currently the rates for this forum are as follows: 10.000/5000/1000 USD yearly. However, the Medical Forum has always suffered from a funding shortage and therefore would not be an appropriate model to follow at this stage.

Currently the professional work of the Nursing and Midwifery Forum is done mainly by the Regional Adviser (in addition to her full time job for WHO) and the Forum Task Forces members who work on a voluntary basis and without any additional funding. The appointment of a professional member of staff therefore is worthy of consideration in line with the EUROPHARM model where a professional and administrative secretary are employed to lead and support the Forum work, funded by the Danish Pharmaceutical Association and other voluntary donations. An alternative approach is also worthy of note as used to support the professional work of the Medical Forum. For example the British Medical Association, UK, since the inception of the Forum has provided office accommodation and other support services for the Professional Secretary to the Medical Forum, himself a retired physician who works on a voluntary basis. The Swiss Medical Association will provide similar support when the current incumbent retires this year.

2.3 Alternative Sources of Funding

Seeking alternative funding for the Forum is a worthy ideal and should be explored. However this is a longer-term strategy and will involve investment in time by the Chairperson and Members of Steering Group and will not solve the immediate problems of the Forum. Careful consideration will also need

to be given re the use of commercial sponsorship, which should be in line with WHO policy. A person would need to be assigned to develop credible funding proposals as well as to arrange meetings with possible donor agencies.

2.4 Solidarity across the Region

It has always been the intention of the Forum to support nurses and midwives in the less well developed parts of the region, through their Associations, to develop their potential so that they in turn can do the best possible for the communities, families and individuals with whom they work.

To this end efforts have been made to offer financial support for representatives from Associations from the CEE and the NIS to attend annual meetings of the Forum. In the short term this is no longer a viable objective due to high costs of travel and insufficient Forum funds. However, it is crucial, in the interests of solidarity and equity, principles and values espoused by WHO and endorsed by the Forum, that this ideal is pursued and mechanisms found for example through twinning arrangements. This will then ensure that there is true European representation and everyone benefits.

3.0 Proposed Budget for 2002/2003

Attached as appendix A

The Annual Meeting of the Forum is asked;

To receive this paper and attached budget

To approve the budget for 2002/2003

To agree a strategy for raising voluntary donations

Appendix A

**European Forum of Nursing and Midwifery Associations and WHO
Proposed Budget for 2002-2003**

<u>Income</u>				
Membership fees:	USD	1,500		
	-	1,200		
	-	800		
			estimated	USD 36,000
<u>Expenses:</u>				
Steering Committee Meetings:				
Miscellaneous	USD	120		
Administrative support:	USD	17,000		
Chair person (travel etc.)	-	11,500		
Printing/mailing	-	1,000		
Newsletter	-	1,000		
Annual Meeting:				
Coffee	USD	360		
Printing/mailing	-	500		
Secretary per diem	-	400		
speaker travel + per diem	-	2,000		
Task forces:				
Printing/publishing/other	USD	2,000		
Miscellaneous	-	120		
			total	USD 36,000
<u>Balance</u>				0

Annex 5: Poverty, its reduction and elimination – The contribution of nurses and midwives

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How can we work together to realize the full potential that better health can make to improve dramatically the lives of poor people? ...This is [...] a plea for a shared vision of the future. A future in which we develop new ways of working together at a global and national level. A vision which has poor people and poor communities at its centre. And a vision which focuses action on the causes and consequences of health conditions that create and perpetuate poverty.

– Dr Gro Harlem Brundtland, November 2000

Introduction

In January 2000, the WHO Director-General presented to the Executive Board a report entitled *Poverty and health (1)*, which outlined a strategic framework applicable to both the WHO secretariat and to Member States and proposed a series of principles to guide country support. The report stressed the well known link between poverty and ill health, but also pointed to the other side of the coin: that better health can prevent or offer a route out of poverty. A great deal of evidence now shows that better health translates into greater wealth by building human and social capital and increasing productivity. Healthy children are better able to learn, while healthy adult breadwinners are more able to work and provide for their families. Seeing health as a means of combating absolute poverty places WHO's work in a broader context of development.

In identifying strategies that are effective in reducing poverty, WHO recognizes the importance of addressing inequalities in health and that the means for bringing about improvements in the health of the poor will depend on developments within and beyond the health sector. A new approach is proposed, which **combines** investment in health more broadly with better focused investment in health systems. The components of such a health strategy should ideally include: acting on the determinants of health by influencing development policy, reducing risks through a broader approach to public health; focusing on the health problems of the poor and ensuring that health systems serve the poor more effectively.

The Director-General has called on the International community to join forces in the efforts to bring health to the centre of the development agenda by strengthening collective action and building partnerships between a broad range of actors including Member States, NGOs, the private sector and health professionals.

The European dimension

In the European Region, addressing inequities in health has been central to the work of WHO and features prominently in the targets for health for all set by Member States (2). Despite these efforts, however, there is today acute recognition that poverty itself is a true evil in all 51 countries in the Region. The number of people living in poverty ranges from 1% in some countries up to 76% in others (3). Such people also suffer from inadequate housing, insufficient means to guarantee a nutritious diet and the lack of rewarding and remunerative employment. As a result, they suffer poor health, have less access to appropriate health and other related services, and are marginalized and often even excluded from society. Those living in the countries of central and eastern Europe and the newly independent states, whose economies are in transition, are at special risk as a result of their poverty, and many cannot now use the health care system because of an inability to pay. The under-the-counter payment systems run by health professionals are also acting as a deterrent to those in need (4). Key groups at risk are women, children, and the elderly and those suffering from mental illness.

WHO has highlighted an important role for health systems and for health professionals, among others, in tackling the poverty agenda. Several countries, such as Sweden (5) and the United Kingdom (6), have already identified poverty as a key government priority and have set targets to work towards its resolution. Evidence from the literature indicates that nurses and midwives (7) in some countries have recognized the important role that poverty plays in the health of individuals and are making efforts to help fight its alleviation. The vast majority, however, are unaware of the link between poverty and health and unlikely to have the appropriate competences and skills to make an effective contribution. Yet the professions constitute the largest group of health sector workers in most countries. They also comprise the group most likely to be in contact with large sections of the population who experience poverty and whose circumstances may be unknown to any other health worker or related agency. In this regard, they may be a useful source of intelligence especially on hidden poverty. This information, if channelled appropriately, may in turn have relevance for health and related policy-makers and service planners. It seems appropriate therefore to explore the contribution nurses and midwives could usefully make both at macro and micro levels in poverty alleviation. Furthermore, there is a need to identify what needs to be put in place to make such a contribution a reality. This paper draws heavily on the recent WHO literature on the subject

Defining poverty

Poverty is a complex, multidimensional concept. It is also a political issue for most governments. Its complex nature has concentrated the minds of academics over many years in debates on precise definitions. Arguably the issue of definitions lies at the heart of the task of understanding poverty. Emphasis has primarily been on defining the term *absolute poverty*, but more recently greater emphasis is being placed on *relative poverty*, a concept perhaps closer to more developed societies. If nurses and midwives are meaningfully to embrace poverty as an important part of their agenda they too must understand the concept, difficult though that might be. As Alcock suggests, “we must first know what poverty is if before we can identify where and when it is occurring or attempt to measure it, and before we can do anything to alleviate it” (8). In the policy paper of the WHO Division of Intensified Cooperation with Countries in Greatest Need (ICO), the Chambers definition of poverty (9) is perceived as a helpful way of unravelling the concept. Poverty in this context refers to “a lack of physical necessities, assets and income. It includes more than being income-poor. Poverty can be distinguished from other forms of deprivation such as physical weakness, isolation, vulnerability and powerlessness with which it interacts” (10).

It can be analysed at three levels: the macro, the intermediate and the micro level. Poverty at the macro level is influenced by national and transnational events. On the national level, poverty can be seen as a result of processes and structures such as lack of social and economic infrastructure (roads and transport, water, sanitation and health care facilities). Transnational events, such as the breakdown of economic, demographic, ecological, cultural and social systems, can result in poverty-producing processes (10).

The intermediate level of analysis refers to the assessment of particular groups and people in society. It is important to recognize which groups are most affected by poverty and what the possible determinants are (e.g. ethnic, religious, political and geographical affiliation). The analysis at intermediate level helps to distinguish the moderate poor from the absolute poor and to assess the size of those groups (10).

The micro level refers to persons or families at the community level who are the most vulnerable and the most in need. Chambers and others (such as the Child Poverty Action Group in the United Kingdom) argue that stronger emphasis and consideration of the reality of poor people, as experienced and expressed by themselves, will offer insights essential to poverty reduction efforts (11). Social scientists and others have made more effort in recent years to understand poverty from the perspective and experience of the people themselves. These experiences highlight important psychological aspects of poverty and include: social inferiority, isolation, physical weakness, vulnerability, seasonality, powerlessness and humiliation (10): “Poverty is humiliation, the sense of being dependent, and of being forced to accept rudeness, insults, and indifference when we seek help” (12). Evidence suggests

that the poor are acutely aware of their lack of power and independence, which in turn subject them to exploitation. Their poverty leaves them vulnerable to rudeness, humiliation and inhumane treatment by both private and public agents of the state from whom they seek help. Poor people also speak about the pain brought about by their violation of social norms and their inability to maintain cultural identity. Their failure to participate in social life leads in turn to a breakdown in social relations and creates social isolation and often social exclusion.

This level of analysis and understanding is emphasized in the scope and purpose document of the European National Nursing and Midwifery Associations Forum. The paper suggests that, for nurses and midwives to fully understand and then deal with the multidimensional nature of poverty, the subject needs to be broken down into its constituent parts.

Linkages between poverty and health

Illness is often dreaded by those in poverty because it plunges families into destitution because of the lack of health care, the costs of available health care and the loss of livelihood (12). Linkages between health and poverty can be approached from different perspectives: “I became poor because of my sickness”; “Well, I became sick because of my poverty” (13). Economic development and income poverty reduction are not ends or goals in themselves. They are important in so far as they enhance the individual’s capability to live a healthy, decent and creative life. The attainment of health capability needs to be considered as a key goal of development. Dr Brundtland, WHO Director-General, quotes a report of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (14): “Aid to health still remains low in relation to the contribution of health to increasing growth, and to reducing other manifestations of poverty. It remains even lower in relation to estimated needs”.

This statement reinforces the belief that health promotes growth and, by implication, the reduction of poverty. More intensive health interventions can protect poor people from sudden slippage into poverty; improved health leads to higher productivity and subsequently to higher income and reduced poverty. Community-based health care can trigger processes of community empowerment that may strengthen community’s coping mechanisms and anti-poverty initiatives.

Conversely, ill health can help increase poverty, because it leads in some cases to reduced productivity; a sudden illness keeps the breadwinner away from work and poor families have few options in dealing with sudden health shocks (13). International Council of Nurses stressed the impact of poverty on health to the G8 leaders in July 2000 (15).

Health and poverty are linked to development: The International Meeting on Partnership in Health and Poverty defined development as better life conditions and not only economic growth. Health should therefore be interpreted as a measure of the outcome of policies (16). Another definition made during the meeting was that ill health is poverty, which is evident from measurement of the level of absolute poverty. Another study indicates that official health care systems often do not reach the poor. The meeting discussed analytical tools of poverty research that had different goals and paradigms than the usual medical and economic approaches, in which the measure of a daily income of US \$1 predominates. Issues such as human rights, equity, education, gender policy, labour market policy and trade are integral to the examination of linkages between health, poverty and development (16).

Policies on poverty reduction

In line with the increased understanding about how effectively to combat poverty, poverty reduction policies must shift from an assistance-based approach to one that enables communities and people to develop their own potential (13). Many poverty reduction programmes are already building on established partnerships between local government, the business community, the poor, international and national nongovernmental organizations (NGOs) and health professionals. From the business perspective, there is growing recognition of not only the ethical imperative to reduce poverty but also the contribution of improved health to higher productivity and national economic growth. The literature highlights a broad range of ideas and policies. Some of the strategies proposed lie outside the health sector and can be summarized as follows (10):

- land reform;

- policies for increasing the economic asset-base of the poor: credit schemes;
- promotion of education – investing in women;
- poverty alleviation programmes and targeting the poor (e.g. food subsidies, supplementary feeding programmes, employment and public works programmes, etc.); and
- partnerships with NGOs and civil society organizations and community groups.

The Child Poverty Action Group (11) considers the involvement of poor people an essential part of policies for poverty reduction. On the government level, greater commitment to tackling poverty, increased investment and more effective anti-poverty programmes are some of the strategies proposed. For example social and employment sector involvement is required for reforming housing, child support and child care policies and creating better job opportunities (education and training). Another issue raised by poor people is that of accountability and representation. This is related to these people's perception of decision-makers and politicians. They want them to be accountable for the decisions they make and to know what living with poverty is like. Efforts to reduce poverty must therefore begin at the local level. Local networks can become the building blocks for national and international action. Efforts should be well grounded in social services, safety nets and linking the social infrastructure to the social development agenda. Three strategies are proposed: to put equity alongside economic growth as the goal of development, to provide the resources to ensure human security founded on basic needs and to empower people to act in their own development process (16).

It is no longer appropriate to ask whether the health sector should be involved in processes of poverty reduction and eradication; the question should now be how it should be involved. The health sector is already deeply involved in coping with the consequences of increasing poverty. Experiences in both north and south show that development of human capital (education), social capital (rebuilding of community life) and greater female empowerment (increased educational and job opportunities) are seen as key factors having synergetic effects on economic growth, nutrition and health status (13).

The role of health care professionals

Because of the links between health and poverty, health care professionals are urged to develop their role in poverty reduction. To do so it is important to listen to the voices of the poor. The World Bank conducted a study using participatory research methods with over 60 000 poor men and women in 60 countries including several in eastern Europe. Key findings were (16):

- poverty is multidimensional, and powerlessness and voicelessness emerge as trapping poor people in an interlocking web of poverty;
- the body is sometimes poor people's only asset and is a major source of insecurity;
- gender inequity and domestic violence against women remain widespread;
- state institutions, including health care institutions, are experienced as corrupt and ineffective; NGOs are appreciated where they exist but are not perceived as empowering or accountable to the poor; as a result, poor people end up depending primarily on their own informal networks of family and friends.

This has implications for the health care system in general and health care professionals in particular to consider.

- Affordable health protection services, curative services and innovative health insurance programmes for poor men and women. Health care providers must give caring health care to poor people and not treat them in ways that violate basic norms of humanity.
- The body has to be seen as an asset and an energy system that is constantly expending more than is available to it.
- New partnerships between public authorities, the private sector and community groups must be formed in order to provide clean water and basic sanitation as the foundation for good health.
- Violence against women must be seen as a public threat and addressed by health care professionals. Social spaces and counselling services need to be developed to help both men and women better cope with changing social roles and economic conditions.

- The issue of HIV/AIDS needs to be addressed as a social, emotional, medical and health care problem in both prevention and care.

The Meeting of the Advisory Group of the International Poverty and Health Network (IPHN) (13) discussed the issue of the best approach at the health system level in dealing effectively with poverty. The most appropriate approach was believed to be one that strikes a balance between: biomedical and social approaches; community-based health development and individualist emphasis; disease prevention, health promotion and curative health care; and physical and mental health. It is increasingly obvious that non-health factors are important to mental health. People with common mental disorders are doubly disadvantaged: they suffer from ill health and have to bear the stigma of mental disorder. Increasing health inequalities (in terms of access and status) show the need to rethink the medical model of primary health care, as well as the importance of bringing people back into community life.

Linkages between nursing and poverty reduction

The linkages are on several fronts. One link is between the macro, country level of poverty and the availability of educated nurses. The WHO study group on nursing beyond the year 2000 stated that the ratio between nurses and the population is 1 to 2180 in low-income countries and 1 to 140 in high-income countries (17). If nurses are not available to the community, they are unlikely to uncover hidden poverty or to be able to work with individuals and communities to help them move out of the poverty trap.

Another important link is between nursing and midwifery practice, education and research. The link between nursing and midwifery and poverty is primarily, although not entirely, related to the micro-level perspective. Because of their closeness to the people and the community, nurses and midwives gain useful insights into people's lives. Because they are trusted professionals in most communities, they have intimate knowledge of the individual, the family and their social and economic circumstances. They have a role in assessing community needs and identifying pockets of poverty or indeed large sections of the population may be affected by poverty (18). They also have a crucial role in empowering people to get out of the poverty trap through community development methods, involving them in the decision-making processes by helping them to identify their own needs, as well as accessing health care provision. They have a role in helping poor people navigate their way through the health care system, acting as their advocates and their health resource as and when necessary. Nurses and midwives who work with schoolchildren have a particular role in helping them to make healthy choices, to build up their self-esteem and to help them and their families to gain access to the services they need and want.

At the macro level, nurses and midwives have a major role in influencing policies in favour of the poor. Policy, according to Salmon (19), is the single most important determinant of health; it shapes systems, creates access to services and influences the environments within which people live and work. Some nurses and midwives might fight shy of taking a social change role, but it is important to bear in mind that accepting present policies and present situations is as much a political activity as seeking to bring about social change (20).

The literature suggests that nurses and midwives have faced the issue of poverty over several years and in several ways. Midwives have studied experiences of low-income mothers on breastfeeding. The women especially valued prompt responses to emergency calls, home visits, knowledge about breastfeeding, hands-on assistance and caring care (21).

A considerable number of studies follow a qualitative approach. This allows for insights of experiences and perceptions of the poor and shows that nurses can build a research base on people previously neglected by the formal health care system (22,23).

In the United States, a strategy has been developed to assist homeless individuals who have an interest and aptitude for nursing to achieve career mobility in nursing: the Nursing Careers for Homeless

People Project (NCHPP). Although homeless people have to face many challenges and obstacles, NCHPP has succeeded in decreasing welfare rolls, unemployment and poverty (24).

In the portfolio of innovative practice in primary health care (7) developed by the WHO European nursing and midwifery programme, a range of examples demonstrates how nurses and midwives single out those experiencing poverty and adapt their services accordingly or create new services where existing ones fall short. In Portugal, nurses identified groups of people who had left the city to make a better life for themselves through community assessment approaches. These people's expectations were not quite realized, as they built unlicensed homes in places without proper infrastructures for sanitation and water and were, as a result, worse off. Nurses worked with others to improve the environment, and took action to work with the communities to promote their health. Nurses in Northern Ireland targeted vulnerable families with health and social needs and as a consequence achieved improved health outcomes. Nurses in other countries have worked with homeless people and created accessible services that were previously denied them. There are several examples where nurses and midwives have worked with pregnant women from deprived backgrounds and have helped them to access a whole range of health and social services. Nurses and midwives have worked with mothers to teach them about family nutrition using low-cost foods. Nurses have helped to initiate lending libraries for toys and equipment, thus reducing the need for families to get unnecessarily into debt.

These efforts are laudable but patchy. Many are one-off of examples that have rarely been integrated into mainstream services. There is a need now for all nurses and midwives to be made aware of their role in working with people living in or experiencing poverty. There is also a need for the professions to understand their role as agents of social change and influences on policy. They also need to understand and accept their responsibilities in creating effective partnerships with poor people, other professionals, other agencies and organizations, and other sectors.

Curricula must now be adapted to shift the emphasis in nursing and midwifery education from the individual to the wider family and the community (25,26) to overcome what Symonds describes as the "structural constraints of professionalism ...[which] confines the professional to the narrow responsibility of the client ... ignoring the adverse health effects caused by our present social and economic organisation of society" (27). Nurses and midwives must also refocus their efforts away from the curative towards the preventive in order to be able to encompass social concerns. Further, there is a need to revisit and further develop the research and the evidence base and to ensure that the professions are able to operate from a position of strength and credibility.

Nurses and midwives in poverty

In concluding this paper, it would be an oversight not to bring attention to the poverty suffered by thousands of nurses and midwives in the WHO European Region. In several of the countries in transition, nurses and midwives have been without salaries for months, some for as much as 18 months. In many other countries, nurses receive salaries that either put them near or below the poverty line. As a result, nurses and midwives need to have several jobs to sustain themselves and their families. Even in western European countries, sections of the professions engage in moonlighting so that they can earn a realistic wage. Such pressures on individuals results in tired nurses and midwives who are unlikely to be able to give high-quality care to their patients and clients. In addressing the poverty agenda, WHO and all partners involved in the eradication of poverty in society must pay attention to the needs of the professions in this regard.

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ANNEX 6: Guidelines for an open-space meeting

Attached, please find a general description of what an Open Space meeting generally comprises. Due to the short time span allotted during the Technical Discussion, we will be using the same approach as described in the attached brief, however, with some aspects left out.

In principle, the steps would be:

- Introductory PLENARY session to:
 - * introduce the theme
 - * identify specific topics of interest to participants for discussions in groups
 - * identify Convenors for group work.
- *Convenor names and topics for group discussion are put on sheets of paper and placed on a notice board for all participants to view.*
- *Participants sign up to the group with the topic of most interest to them.*
- The groups will convene for approximately 45 minutes
(It may be that one group decides to split to work out a “sub-topic” to the original topic)
(It may be that you are bored with a group and want to move on to another group)
- The Convenor of the group will then note the results of the group discussion.
- The Convenor reports will be placed on the notice board for all meeting participants to add their comments.
- Final PLENARY session to:
 - * share conclusions
 - * clarify collective and individual responsibility
 - * next steps to continue action

Annex 7: Outcome of the Open Space Meeting

Collaboration with nongovernmental organizations (NGOs)

Collaboration with NGOs was identified as a primary goal for nurses and midwives in order to detect and contribute to the reduction of poverty. Basic actions that facilitate this collaboration include the following.

- Establish relationships with NGOs
 - Identify and contact key stakeholders within and among NGOs
- Identify common strategic issues
 - Research and understand missions of NGOs
 - Coordinate efforts for strategic quality programmes
- Share perspectives and raise awareness through joint activities
 - Ensure collaborative nature of relationship
- Evaluate regularly the collaborative process and outcomes
 - Continually improve the collaborative process
 - Develop effective evidence-based programmes and report on outcomes to ensure continuous improvement

Links between international nursing and midwifery associations

Cooperation between nursing and midwifery associations was emphasized as an important continuing goal in promoting interdisciplinary approaches to the challenge of poverty.

- Partnerships
 - Establish open dialogues and collaborative programmes
 - Incorporate a multinational perspective and develop international cooperation
- Sharing experience
 - Collect and distribute examples of good practice, documentation methods, and assessment and practice guidelines
 - Develop a forum for continued sharing of experience
- Priorities for action
 - Establish common priorities for action and develop, implement and evaluate a plan of action
- Support research
 - Disseminate research among professional groups
 - Develop multi-professional research agendas and projects
 - Develop initiatives supporting and encouraging research on poverty
- Develop multi-professional guidelines
 - Collaboratively establish guidelines that put multi-professional practice into operation

Hidden poverty

The hidden nature of poverty emerged as a challenge for nurses and midwives. It was noted that targeted tactics are necessary to reach those affected by poverty and understand their circumstances.

- Develop tools and skills to detect hidden poverty
 - Investigate and understand the tactics that groups use to hide poverty
 - Illegal refugees, travellers, working poor, substance-dependent, homeless, mentally ill

- Respect privacy and autonomy
- Communications training
 - Develop relationships with liaison persons within the groups affected by poverty
 - Avoid jargon
 - Assess education and literacy
- Mobile nurses and midwives
 - Provide accessible care with flexible and informed providers
 - Develop collaborative strategies to maintain continuity with the population
- Mobilization of policy-makers
 - Informed policy-makers via media, research reports, field visits
 - Political action by nursing and midwifery organizations
- “De-fragment” the health care system
 - Identify gaps in the health care system
 - Apply intersectoral approaches to problem-solving and health care reform
 - Work with policy-makers to address health system gaps

Partnering with the community

An essential element of the strategy to reduce poverty and improve health among those affected by poverty is to establish partnerships with the community. This key group is an essential member of the health care team.

- Communication with the community
 - Utilize the language of the community
 - Respect privacy and autonomy
 - Share information
- Identify community leaders
 - Seek out marginalized community leaders who may not be immediately visible
- Identify community needs and risks
 - Collaborative information gathering with community to identify concerns
 - Utilize centralized statistical measures, hospital and community health centre data
 - Seek out hidden populations for inclusion
- Integrate and coordinate community resources
 - Develop intersectoral and multidisciplinary goals for community inclusion
 - Focus on targeted objectives based on community concerns and evaluation
- Collect and distribute information
 - Strategic gathering, analysis, synthesis and distribution of information to community, stakeholders, intersectoral actors and policy-makers
 - Utilize media and other forums accessible to the population for consciousness-raising, to inform the public about the circumstances of the poor and the implications
- Professional activities
- Develop educational curricula aimed at poverty prevention, reduction, intervention and policy

Educational programmes

Nurses and midwives agreed that educational systems must address the issue of poverty within curricula.

- Involve target populations in the education and curriculum process

- Ensure input from the groups affected by poverty
- Ensure curricula have sufficient breadth of subject
 - Ensure adequate coverage of all the relevant factors related to poverty
 - Link theory, practice, research, policy and education
- Innovative curriculum development
 - Up-to-date curricula that are relevant and engaging
 - Incorporation of the community into the training methods
 - Clinical placement with populations affected by poverty to ensure direct exposure to the target population

Influencing policy

Developing and using power to influence policy was cited as one of the most important steps in addressing the challenge of poverty. Nurses and midwives agreed that there are many ways for professionals and professional organizations to influence policy.

- Influence of national organizations
 - Continually develop and expand policy within the organization that incorporates efforts to affect poverty-related policy at all levels
- Strategy building
 - Use intersectoral approach to develop stakeholder coalitions to influence policy related to poverty reduction
- Make nurses' concerns known at all levels of policy-making
 - Lobby groups for support
- Nursing activity in broader social organizations
 - Expand the collaborative efforts of nursing and midwifery organizations by partnering with NGOs and other groups with similar interests
 - Be open-minded about potential collaborative efforts
- Networking
 - Establish and maintain a living network devoted to affecting policy that reduces poverty
 - Establish means for regular communication among members of the network
- Nurses and midwives in policy-making positions
 - Support and encourage nurses and midwives in policy-making positions
 - Recognize and utilize opportunities to influence policy
- Training in politics
 - Develop training and education opportunities for all nurses and midwives regarding policy-making and procedure
 - Establish advanced training and continuing education regarding policy-making and policy review

Annex 8: Statement on the role of nurses and midwives in poverty reduction

The European Forum of Nursing and Midwifery Associations and WHO,

CONSCIOUS that poverty has many faces, is caused by many factors and cannot be viewed from an economic perspective alone;

UNDERSTANDING that poverty has a European dimension while being a complex global problem that differs in nature between developing and developed countries;

AWARE that poverty is a dynamic concept or circumstance rather than a condition, which affects women more than men;

UNDERSTANDING that the complexity of the problem requires intersectoral approaches within a global strategy;

CONCERNED that ill health is one of the major causes of increased poverty and that poverty is the greatest single cause of ill health in the world today;

RECOGNIZING that health is one of the most important assets of poor people and their key to escaping poverty and sustaining livelihoods; and

RECOGNIZING that health can contribute to reducing poverty in several ways and to promoting overall social and economic development,

URGES nurses and midwives to:

- accept their responsibility in addressing the issue of poverty;
- recognize the important role they can play in protecting and promoting the health of poor people;
- commit knowledge, skills and experience in practice and research; and
- support and initiate multisectoral participatory approaches to tackling poverty;

so as to ensure that:

- health systems effectively address the needs of poor people, developing mechanisms to meaningfully involve poor people in analysis and decisions;
- policies are developed to tackle the causes of disadvantage or deprivation and to improve the life circumstances of the poor; and
- partnerships are developed that link the health community with other development actors.

URGES governments to:

- identify the causes and characteristics of poverty in their countries;
- provide resources to tackle the root causes of poverty;
- recognize that nurses and midwives can, because of their close proximity to the public and by using empowering and health promoting approaches, contribute significantly to programmes of social development and poverty reduction as well as provide accessible, comprehensive and coordinated health care services and continuing care; and
- initiate sector-wide and multisectoral approaches to ensure that the protection and promotion of health becomes a key strategy in national poverty reduction plans.

