World Health
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GENEVA, SWITZERLAND

REPORT OF THE FORUM FOR GOVERNMENT CHIEF NURSES AND MIDWIVES

NURSING & MIDWIFERY

HUMAN RESOURCES FOR HEALTH

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ACKNOWLEDGEMENTS

ACRONYMS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral treatment
CNO	Chief Nursing Officer
COP	communities of practice
GAGNM	Global Advisory Group on Nursing and Midwifery
GCC	Gulf Cooperation Council
GCNMO	Government Chief Nursing and Midwifery Officer
GHWA	Global Health Workforce Alliance
GPW	Global Programme of Work
GNWHOCC	Global Network of WHO Collaborating Centres
HCW	health-care worker
HIV	human immunodeficiency virus
HRH	human resources for health
ICM	International Confederation of Midwives
ICN	International Council of Nurses
ILO	International Labour Organization
KRA	key result area
MDG	Millennium Development Goal
NM	nurses and/or midwives
PAHO	Pan American Health Organization
PHC	primary health care
SBA	skilled birth attendant
SDNM	Strategic Directions: Strengthening Nursing and Midwifery Services
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization
WHOCC	WHO Collaborating Centre
AFRO	WHO Regional Office for Africa
EMRO	WHO Regional Office for the Eastern Mediterranean
SEARO	WHO Regional Office for South-East Asia
WPRO	WHO Regional Office for the Western Pacific

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1. FORUM INTRODUCTION AND CONTEXT

The World Health Organization (WHO) convened its third Global Forum for Government Chief Nursing and Midwifery Officers (GCNMOs) in Geneva from 14–15 May 2008. Over 80 delegates and observers attended, representing a 50% increase in participation from the 2006 inaugural event. Forum invitees and participants represented 55 countries from the six WHO regions; observers from WHO headquarters and regional office staff; and members of the WHO Global Advisory Group on Nursing and Midwifery (GAGNM), the Global Health Workforce Alliance (GHWA), the Global Network of WHO Collaborating Centres (GNWHOCC), International Confederation of Midwives (ICM), the International Council of Nurses (ICN), the International Labour Organization (ILO), the American Journal of Nursing and the Victorian Order of Nurses of Canada (see Annex 1 *List of participants*).

FORUM OBJECTIVES

The objectives of the 2008 GCNMO Forum were to bring nursing and midwifery leaders together to:
1. provide input into the development of the Global Programme of Work (GPW) for Scaling Up Nursing and Midwifery Capacity 2008–2009 and the Strategic Directions for Strengthening Nursing and Midwifery Services 2009–2015 (SDNM);
2. actively engage GCNMOs in primary health care (PHC) and WHO priority programmes at global, regional and national levels;
3. foster collaboration and partnerships among GCNMOs and map out strategies for successful implementation of priority programmes;
4. gain increased understanding of policy formulation, implementation and evaluation; and
5. provide an orientation to the 61st World Health Assembly in May 2009.

FORUM PROGRAMME

Background material related to the Forum was provided (see Annex 2 *Forum background material and recommended references*). In order to achieve the stated objectives, the Forum programme was organized and delivered through eight major themes. Table 1.1 outlines the Forum themes and related sub-objectives identified for each thematic area.

TABLE 1.1 FORUM THEMES AND SUB-OBJECTIVES	
Forum theme	Identified sub-objectives for thematic area
Theme 1: Global Programme of Work (GPW) for Nursing and Midwifery 2008–2009	• Provision of advice and feedback • Support for development of the GPW • Identification of general and specific strategies to assist GCNMOs to take an active role in implementation and communication of the GPW at the national level
Theme 2: Strategic Directions for Strengthening Nursing and Midwifery 2009–2015	• Questions and comments on framework, vision and key result areas • Identification of gaps or suggested changes
Theme 3: Building Partnerships for Strengthening Nursing and Midwifery	• Identification of partnership models in action • Strengthening an understanding of partnership development
Theme 4: Development of Global Network for Government Chief Nurses and Midwives	• Provision of advice on the benefit, feasibility and structure of a global network for GCNMOs
Theme 5: WHO Priority Programmes	• Provision of programme information to GCNMOs • Identification of success factors that could lead to programme success
Theme 6: Primary Health Care	• Provision of information on PHC to GCNMOs • Identification of leadership strategies that could lead to positive change in the role of nursing and midwifery in implementation of PHC at a national level
Theme 7: Roles and Functions of GCNMOs	• Provision of information on the role of GCNMOs • Identification of challenges and strategies related to implementing the proposed role of the GCNMO at a national level
Theme 8: Marketplace	• Discussion of programmes, projects and organizations • GCNMO networking • Exploration of partnership opportunities within and among regions

Participants were encouraged to actively participate in the Forum as consultants and experts. The meeting strategy invited individuals to share their knowledge and expertise, sought their advice and provided the opportunity to become more informed about the progress of the GPW and more actively engaged in national implementation.

Group work provided the participants with opportunities to collaborate, provide input and ground their plans and programmes in national level realities. The programme design facilitated the transformation of information into future plans and action. The Marketplace theme offered individuals the informal opportunity to showcase innovative and diverse programmes and consider partnership opportunities.

FORUM OUTCOMES

The Forum outcomes will support and stimulate initiatives to strengthen nursing and midwifery capacity including:
- final draft of the Global Programme of Work 2008–2009 and Strategic Directions for Nursing and Midwifery Services 2009–2015;
- partnership and resource mobilization strategies;
- development of a network for GCNMOs;
- participation in the 2008 celebrations for 60 years of WHO and 30 years of PHC.

This report provides an overview of the presentations and discussions that took place during the two-day Forum. *Part 1* describes the context shaping the Forum discussions. *Part 2* outlines two foundational initiatives focused on strengthening nursing and midwifery to contribute to the Millennium Development Goals (MDGs). *Part 3* summarizes the technical sessions, *Part 4* describes key actions on primary health care, and *Part 5* presents the Plan for Action and Forum statement through which GCNMOs are called to become engaged and exercise leadership in addressing national, regional and global priorities.

INTRODUCTORY ADDRESSES

DR CLARISSA ETIENNE, ASSISTANT DIRECTOR-GENERAL, HEALTH SYSTEMS AND SERVICES, WHO

As this Forum convenes, WHO is celebrating its 60th anniversary and the 30th anniversary of the Declaration of Alma-Ata. At the midpoint of the 2015 deadline for achieving the MDGs, there is a renewed call for PHC and recognition of the responsibility and contribution of nurses and/or midwives (NM) to health and development worldwide. Persistent health challenges remain and new health challenges are emerging (e.g. climate change).

Nurses and midwives are key members of the health team comprising 60% of the health workforce. Nurse leaders must determine NM role and provide input on Human Resources for Health (HRH) encompassing recruitment, retention, migration, service provision and education. Nurses and/or midwives have extensive hands-on experience in planning and service delivery.

There is a need to recognize strategies that will ensure PHC does not fail, given that past experience with health sector reforms did not fully embrace PHC and only selectively implemented it. In the future, strengthening health systems should be based on PHC and be responsive to national needs. In particular, improved care is required for marginalized communities and populations.

In view of the issues and demands, task shifting is also being discussed. How will nurse leaders view and support this initiative? Is there a need to look at new cadres on the health team, especially in rural settings? The role of the NM leaders is to ensure appropriate and adequate support, recognition and supervision.

Disease-specific programmes have had limited success and might not be adequate to meet the MDGs; for this reason, teamwork must be embraced and nurses must contribute as team leaders and team members. The nursing and midwifery sector must be engaged at the highest level of decision-making and move beyond the traditional health realm to contribute in the economic, social, political and development sectors. GCNMOs must move recent declarations forward by influencing and implementing action within national systems.

DR MANUEL DAYRIT, DIRECTOR, HUMAN RESOURCES FOR HEALTH AND HEALTH SYSTEMS STRENGTHENING (HRH/HSS), WHO

Human Resources for Health (HRH) is a political as well as a technical issue. The importance of GCNMOs is well recognized given that nursing and midwifery provide the link between health systems and service delivery in most countries.

Dr Dayrit reaffirmed his support for resolutions on strengthening nursing and midwifery and expected that recent commitments would put them in a strong position within the health professional community. The NM agenda is becoming better understood through direct participation in GAGNM and interaction with key stakeholders. As a department, HRH is in a strategic position to move NM into the mainstream so that it is a critical voice for health professionals.

Over recent years, resolutions and declarations have repeatedly emphasized the role of nursing and midwifery at the global level. However, the key is to make these documents come alive, especially at the country level. GCNMOs have an important role to play in addressing the national HRH challenges and influencing national action (e.g. over-supply in the midst of shortages, increased worker migration, low salaries in countries where shortages exist, etc.).

It is time to examine the health system as part of a continuum that connects different sectors in society (i.e. health, finance and education) and demands intersectoral collaboration. Innovative solutions are needed to address the HRH issues (e.g. quality of education, regulation, public and private employment, low salaries, limited incentives and often inadequate workplace environments).

WHO is beginning a dialogue with partners (e.g. ILO and the United Nations Educational, Scentific and Cultural Organization (UNESCO)), which should be mirrored at the country level. In promoting universal access, it must be recognized that often more than 80% of health resources are under the direction of nurses and midwives. Nurses and midwives are being called to action with growing opportunities for cross-sector partnerships.

DR JEAN YAN, CHIEF SCIENTIST, NURSING AND MIDWIFERY OFFICE (NMO), WHO

Over 2 billion people worldwide lack access to health care, in particular in rural areas. If struggling countries are not supported, it could take more than 138 years to achieve the MDGs. The scaling up of nursing and midwifery through PHC is a strategy targeted to increase universal access to health care. Achieving success would improve global health and result in health-care services being provided by a competent, motivated, supported and sustained health workforce. Efforts by nurses and midwives will be measured through the MDGs (1990–2015), in particular:
- Goal 4: Reduce child mortality (target: reduce by two-thirds under-five mortality rate);
- Goal 5: Improve maternal health (target: reduce by three-quarters the maternal mortality rate);
- Goal 6: Combat HIV/AIDS, malaria and other diseases (target: halt by 2015 and begin to reverse spread).

The need for rapid scaling up of health workforce production, including strengthening nurse and midwife capacity was emphasized in World Health Assembly (WHA)

Resolutions on Strengthening Nursing and Midwifery (WHA59.27) and *Rapid Scaling up Health Workforce Production* (WHA59.23). The WHO Nursing and Midwifery Office, Department of Human Resources for Health, has been working towards their operationalization. Through partnership, several key initiatives have been undertaken to move from policy to action.

- In March 2007, the then Federal Minister of Health for Pakistan, Mr Mohammad Nasir Khan, held a global consultation on nursing and midwifery in Pakistan in collaboration with ICM, ICN and WHO. The resulting Islamabad Declaration identified three key areas requiring urgent attention and outlined key principles to guide future action addressing: (i) scaling up nursing and midwifery capacity; (ii) skill mix of existing and new cadres of workers; and (iii) positive work environment.

- In 2007, the Zambia consultation on scaling up the capacity of nursing and midwifery resulted in the development of a draft Global Programme of Work 2008–2009, which provides an implementation framework upon which to base national plans. The GPW has five core elements – education and training, health care provision, workplace environments, talent management/leadership capacity and partnerships.

- In February 2008, the Chiang Mai Declaration was issued following the International Conference on New Frontiers in Primary Health Care: Role of Nursing and Other Professions in Thailand. The Declaration re-emphasizes that nursing and midwifery make a vital contribution to the accelerated achievement of PHC and the MDGs. There is an ongoing need for explicit action and partnership across the health system, in particular policy, education, workforce deployment and workplace environment areas.

- In March 2008, the first Global Forum on HRH was convened in Kampala, Uganda. The Kampala Declaration and Agenda for Global Action calls for immediate and urgent actions to address and resolve the accelerating crisis in the global health workforce needed to deliver essential health care. The GHWA is committed to advocating such action and monitoring progress.

- The WHO Nursing and Midwifery Office and regional advisers are leading a year-long project to maintain, improve and scale up the contribution of nurses and midwives to PHC worldwide by reviewing past and present contributions; identifying and disseminating care models and examples of best practice; and recognizing and rewarding outstanding individual and team contributions.

GCNMOs are important national and international leaders of health systems development who contribute to strategic, management and policy formulation functions. They also act as key WHO partners in the advancement of national, regional and global priorities aimed at strengthening health systems and, in particular, adopting the PHC principles.

DR LIZ WAGNER, NURSING UNIT, PROFESSIONAL INSTITUTE OF CLINICAL RESEARCH, DENMARK (GAGNM MEMBER)

Nurses and midwives act as ambassadors of health contributing more than 80% of health services in developing countries. Strong leadership is required in order to maximize their contributions. It is believed that the current shortage of NM reduces the opportunities for individuals to achieve improved health outcomes. One of the recommendations from GAGNM 2008 was to strengthen and contribute to PHC effectively, given the focus on the celebrations of the 30th anniversary of the Declaration of Alma-Ata.

Since GAGNM supports nurse leaders and is in a position to make recommendations to the WHO Director-General, nurse leaders' discussions at such forums provide important perspectives and advice. Individuals are challenged to consider the following quotation, which encourages shared leadership to take strategic action and achieve tangible results.

> *"We must stay in our core business… I think it is important that we have a shared vision, that we can add value and that we can get synergy from all these partnerships… What is important to me is, are we getting the results that matter? Are we doing the right things to make an impact on the health of the populations that we are serving? These questions have to be asked."*
> *Dr Margaret Chan, Director-General, WHO, 2007*

2. STRENGTHENING NURSING AND MIDWIFERY TO CONTRIBUTE TO THE MILLENNIUM DEVELOPMENT GOALS

GLOBAL PROGRAMME OF WORK FOR NURSING AND MIDWIFERY 2008–2009

DR LIZ WAGNER, NURSING UNIT, PROFESSIONAL INSTITUTE OF CLINICAL RESEARCH, DENMARK (GAGNM MEMBER)

Dr Wagner introduced participants to the Global Programme of Work (2008–2009). The GPW is the result of a collaborative effort between WHO and its many diverse partners. Although begun in 2007, further revisions to the GPW occurred during the GAGNM meeting in March 2008.

GPW is a comprehensive call for action to scale up nursing and midwifery capacity to contribute to the achievement of the MDGs and use the leadership of GCNMOs to advance priorities that strengthen health systems and PHC.

The five core GPW elements are: education and training, health service provision, workplace environment, talent management and partnerships. Although 15 deliverables are identified, there are five key outcomes of the GPW for the period:
1. increased numbers in the nursing and midwifery workforce in the six countries of implementation;
2. nurses and midwives upgraded with knowledge and skills in the delivery of accessible PHC programmes in at least six countries;
3. productive nursing and midwifery workforce retained in locations of greatest need ensuring patient safety, improved productivity and health worker satisfaction;
4. competent nursing and midwifery leaders contributing to quality health care delivery with emphasis on the PHC approach;
5. a network of a wide range of partnerships.

Action plans have been developed for each key element and the GPW will be implemented through partnerships with WHO, Member States, international agencies and stakeholders. The five key implementation steps are identified as:
1. selection of participating countries (March 2008);
2. meeting of country focal persons (July 2008);
3. funding of activities in selected countries (July 2008);
4. implementation of core elements of the GPW (December 2008);
5. review of progress (January 2009).

Dr Wagner highlighted the need for GCNMOs to take an active advisory role in policy-making through leadership and strategic thinking. In order to enhance professional credibility and partnerships, GCNMOs must become politically knowledgeable and secure the resources and support required to be effective. Part of the solution is to value and work towards strengthening GCNMO networking.

Zambia is one of the 36 countries experiencing a critical shortage of skilled human resources, in particular NM due to migration, limited supply of new NM and attrition due to illness. Poor HRH management systems and limited career and professional opportunities have resulted in the inappropriate distribution of NM personnel, skill mix imbalances, increased workload and low productivity due to absenteeism, illness and burnout. According to the Human Resource for Health Strategic Plan 2006–2010, in 2006 the country was operating with only 50% of the recommended staff needs, including only 37% of the NM needs.

A Global Consultation on Scaling-up Capacity in Nursing and Midwifery was convened in Zambia (December 2007) with the purpose of engaging various constituencies to develop a national plan of action and GPW. The global workplan and accompanying framework address the five core GPW elements. The Government of Zambia has now embarked on several initiatives to increase the capacity of nursing and midwifery services within the core GPW areas.

1. **Education and training**: A National Workshop on Development of the Curriculum for Scaling-up Training of Nursing and Midwifery Tutors was held in December 2007. The gaps in the post-basic nursing curriculum have been identified. The Government is committed to increasing the training intake by re-opening closed schools and introducing training for "direct entry midwifery".
2. **Recruitment**: There are intensified efforts to increase recruitment of health workers. The Ministry of Health has approved the establishment of an optimal number of human resources, 22 323 of whom will be nurses and midwives. Graduates and retired nurses and midwives are all being targeted for employment and re-employment.
3. **Retention**: Different incentives are being offered to nurses and midwives. Although the recruitment scheme was originally developed in 2003 and targeted at doctors, the beneficiaries now include nurse tutors. It is expected that the scheme will be expanded to recruit and retain nurses and midwives practicing in rural areas where they are needed the most.
4. **Workplace environment**: The increased recruitment drive is expected to ultimately reduce stress resulting from excessive workload, long working hours and high nurse/patient ratios. Equipment and supplies are being made available in health facilities in support of quality health services and to motivate nurses and midwives to perform effectively.
5. **Human Resource for Health Strategic Plan (2006-2010)**: The Ministry of Health has intensified the implementation of strategies that address the human resource crisis affecting NM.

There continues to be a critical need to increase nurse lecturers and improve the quantity and quality of nurses and midwives to support implementation of agreed national and international policies and health-related goals.

Collaborative group work

The Forum organized five collaborative working groups and assigned each with one of the five key elements of the GPW to review. The groups offered feedback/advice and specifically addressed the leadership role of the GCNMO in the implementation and communication of the GPW at tional level. Emphasis was placed on identifying barriers and strategies to assist a GCNMO to take an active role in making a difference. Table 2.1 outlines the advice received from the working groups' presentations.

TABLE 2.1 GLOBAL PROGRAMME OF WORK AND SUGGESTED STRATEGIES FOR GCNMO INVOLVEMENT IN NATIONAL IMPLEMENTATION AND COMMUNICATION	
Working groups	**Identified strategies for consideration**
Education and training	1. Establish community of nursing and midwifery practice 2. Develop more WHO Collaborating Centres (WHOCC) (e.g. francophone countries and eastern Europe) 3. Focus on nursing and midwifery programmes 4. Disseminate global education standards to the country level 5. Advocate for nursing and midwifery to be part of the Ministry of Health budget
Health service provision	1. Build capacity (e.g. develop competencies, and strengthen education and training in PHC, PHC leadership, and information management using data and evidence to support change) 2. Strengthen systems through direct influence of the GCNMO on policies and strategies or in partnership with others 3. Set standards based on guidelines and protocols 4. Improve access to nursing and midwifery care: carefully examine the issue of task shifting keeping control of practice yet making changes in non-nursing areas in order that NM can focus on core nursing and midwifery role 5. Implement incentives and other motivational strategies 6. Establish a strong monitoring and evaluation system
Workplace environments	1. Address the challenge facing the solitary GCNMO in countries with many subunits, education agencies and professional associations 2. Determine the fit of the GPW with national health issues and the role of nurses and GCNMOs related to the MDGs 3. Identify a national networking strategy to support GCNMOs 4. Identify appropriate staffing ratios (including the night shift) and staff incentives 5. Identify NM recruitment and retention incentives in partnership with public and private sectors, including salaries, car loans and building loans 6. Increase the number of NM schools and tutors 7. Consider upgrading nurses to Master's degree level 8. Introduce policies and legislation to protect NM safety (e.g. workplace violence and other hazards, especially in remote areas) 9. Increase public education including the media 10. Increase the need for and visibility of the GCNMO to promote standardization of practice and strengthen communication with decision-makers
Leadership/talent management	1. Establish a working group with regional representation on the role of nurses in PHC 2. Form a regional network to share best practices among GCNMOs 3. Develop a training programme for policy development and implementation 4. Establish a mentoring programme for GCNMO and other NM leaders

Partnerships	1. Support GCNMOs as a partnership champion:
	  • know what needs to be achieved and how to achieve it
	  • understand what effective partnership means
	2. Identify opportunities for potential partners, including clients/patients, trade unions, professional organizations and educational agencies
	3. Establish partnerships based on key principles including:
	  • determine mutuality in purpose
	  • negotiate outcomes early
	  • establish measures of success
	  • identify expected roles and behaviours

The GPW serves as a guide when addressing issues pertaining to nursing and midwifery and should be aligned with national plans. GCNMOs are encouraged to utilize the current GPW document to identify national issues and implement a national plan of action for the five key areas.

STRATEGIC DIRECTIONS: STRENGTHENING NURSING AND MIDWIFERY SERVICES 2009-2015 (SDNM)

MRS SANDRA MACDONALD-RENCZ, CHIEF NURSING OFFICER, OFFICE OF HEALTH POLICY, HEALTH CANADA AND DR HEDWIG VAN ASTEN, TECHNICAL OFFICER, MAKING PREGNANCY SAFER, WHO (SDNM TASK FORCE MEMBERS)

The SDNM 2002–2008, adopted in 2002 following Resolution WHA54.12, is nearing its completion. Endorsed by a number of organizations, this first cycle SDNM identifies five key results areas (KRAs) with eight objectives, namely:
1. health planning, advocacy and political commitment;
2. management of health personnel for nursing and midwifery services;
3. practice and health system improvement;
4. education of health personnel for nursing and midwifery services;
5. stewardship and governance.

Many significant partners are involved in the SDNM initiative including the GNWHOCC, ICM, ICN, ILO, International Federation of Nurse Anesthetists, International Society for Nurses in Cancer Care, Sigma Theta Tau International, The United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and WHO.

The current review of the SDNM 2002–2008 incorporated broad consultation and will result in the development of the second cycle SDNM with a task force established to lead the process (see Annex 3, *SDNM Task Force representation and membership*).

The SDNM Task Force charter ensures the delivery of:
1. a framework to underpin the SDNM 2009–2015;
2. indicators and information on progress in achieving the SDNM objectives using the indicators and other appropriate measures;
3. a vision statement on nursing and midwifery services in 2015;
4. an updated SDNM 2009–2015 that is consistent with the framework and vision statement, and is the result of wide consultation.

The framework is being developed to coincide with both the vision statement and the new KRAs for the SDNM 2009–2015 and will be updated once the KRA objectives have been finalized.

Proposed vision statement
Nursing and midwifery (will) improve health outcomes for individuals, families and communities through the provision of competent, culturally sensitive, evidence-based care and services, in collaboration with others to strengthen health systems and enhance access to health care worldwide.

Proposed KRAs
Quality Nursing and Midwifery Services (2009–2015) are central to the implementation of the SDNM within five KRAs; each of which will be linked to an objective and indicators:
1. improved health services delivery, health system performance and health outcomes;
2. nursing and midwifery policy and professional practice;
3. education, training and career development for nursing and midwifery personnel changing service environments;

4. nursing and midwifery workforce management and leadership to meet evolving health needs and demands;
5. partnering to develop nursing and midwifery and to provide leadership for health development.

Development of indicators

Two sets of indicators have been piloted and are being collected/collated – Set 1 for the majority of WHO Member States and a more detailed Set 2 for selected countries. In developing the indicators, a review was completed of the questions from the monitoring survey as well as from global and regional workplans, and other documents.

The pilot in a number of countries will determine the availability of data and assist in clarifying definitions. The set of basic indicators will be selected and data collated for as many countries as possible by the end of 2008 as a baseline for the new SDNM 2009–2015. It will be important to have a plan for creating and facilitating the updating of the databases.

Discussion points on the SDNM 2009–2015

Information was provided in response to participant questions related to the SDNM 2009–2015. GCNMOs explored several key aspects of the process and offered advice for consideration.

What additional areas or gaps should be addressed?
- The vision should address improved access through PHC. Perhaps the vision is too long and should be shortened for better focus and easier understanding.
- The objectives do not appear evenly distributed with some being comprehensive and detailed in nature with others appearing much more specific. It is also important to include adequate references.
- Strengthening health systems relates to more than nursing and midwifery services. Perhaps in the KRAs, "health service delivery" should be revised to identify "nursing service delivery". The SDNM must articulate how the needs of nursing and midwifery can be best addressed. It needs to move beyond PHC to address all aspects of care.
- There are always political realities that require consideration and explicit attention; for example, patient safety should be addressed at the KRA level. Nurses and midwives should lead patient safety initiatives. Patient safety costs are known to decrease when nurse-sensitive indicators are available.
- It is important that results of the formal evaluation of the SDNM 2002–2008 be widely known. The global survey will show achievements from 76 countries.
- Broader consultation is important since SDNM acts as a strong mechanism for implementing the World Health Assembly resolutions. Translation of consultation documents (e.g. francophone countries) will ensure that all NM leaders can be more involved and fully engaged in the process. The survey was translated from English into French and Spanish and WHO intends to translate the SDNM documents into the six WHO languages.

How should progress be monitored?
- GCNMOs need evidence to be in the best position to impact decisions on how to invest in better health. The issue of indicators may be problematic for nursing. Since indicators are important in planning and evaluation, the comprehensiveness of the indicators needs to be determined.

○ It may be better to focus on demand or quality of services, where there is insufficient data to delineate the impact of nursing alone. It may be necessary to select fewer indicators, given that some indicators may be too costly to evaluate.

○ Adequate databases for nursing and midwifery may not be available in some countries. Having two sets of indicators will be useful, but may not solve this basic data challenge. WHO is now looking at a global survey and needs more input from GCNMOs.

○ In relation to KRAs, it is important to identify what nurses and midwives contribute in order to improve health outcomes and establish realistic indicators.

How can SDNM be implemented at the country level?

○ The SDNM and GPW are interlinked and can help build capacity in countries. The SDNM has a generic design that can be adapted to diverse country contexts and act as a foundation for planning and monitoring progress.

○ SDNM appears to plan for the ideal situation; however, many unplanned events and sustained crises can threaten our health systems (e.g. war, food shortages, etc.). GCNMOs are encouraged to bring the nursing voice to the table as much as possible in their respective countries. The SDNM describes the global level and requires country specific approaches. The document can be used as a lobbying tool.

○ The KRAs are intended as a guide for country use. Regions or countries with existing strategies can review the SDNM and consider its alignment with internal needs and activities. Some representatives stressed that progress can be made in spite of disasters (e.g. in WHO's Regional Office for the Eastern Mediterranean (EMRO), regional education standards were developed with regard to disasters as there are seven countries out of 22 experiencing emergencies. As Somalia continues to face complex challenges, scaling up of nursing and midwifery capacity is still being addressed).

○ Planning in an uncertain environment may assist in focusing on the "possible" and the activities with the most "potential" for improvement. Some activities will ultimately fit with general government plans while others will be more specific (e.g. with its strategic plan for nursing and midwifery in place and emphasis on PHC, Kenya has been able to better address community needs when facing recent upheavals).

○ The SDNM Plan is closely linked to government response and policies. The GCNMO and other NM leaders must open a dialogue with government and monitor government response.

KEY CONCLUSIONS AND ACTIONS

The SDNM Task Force representatives presented the conclusions and actions as follows.

Global Programme of Work 2008–2009

○ The GPW is viewed as comprehensive; however, additional feedback would assist in further revision and implementation. The GPW is the transition between SDNM 2002–2008 and SDNM 2009–2015.

○ The implementation of the GPW requires the involvement of the GCNMOs and WHO Regional Nursing and Midwifery Officers. It is intended that one person be nominated at regional level to ensure ongoing communication as the GPW moves forward.

○ GCNMOs were challenged to assume an active role in the implementation and communication of the GPW at national level and to examine partnerships that would assist, advise and support efforts.

Strategic Directions: Strengthening Nursing and Midwifery Services 2009–2015

○ Given that the development of the next generation SDNM 2009–2015 is still in progress, GCNMOs were invited to provide comments and specific advice on the draft document as it moves forward; specifically, advice on the proposed vision, objectives, key result areas and indicators.

○ More information will be provided to GCNMOs as the evaluation results and future strategic directions are finalized. WHO will seek the resources needed to translate the document into the six official languages.

○ GCNMOs were invited to identify their role and explore partnerships that are critical to linking the SDNM 2009–2015 with the development of national strategic plans for strengthening health systems.

3. TECHNICAL AND PLENARY SESSIONS

TECHNICAL SESSION 1: HIV/AIDS

DR EILEEN PETIT-MSHANA, MEDICAL OFFICER, SYSTEMS STRENGTHENING AND HIV/AIDS, WHO

In 2006, 2.9 million people died from AIDS, while 39.5 million people were living with HIV. In areas with generalized HIV epidemics, HIV/AIDS exacts a high toll from the health workforce due to high numbers of AIDS patients and AIDS-related morbidity and mortality. Moral exhaustion results from the lack of protection and impacts the physical and psychological health of workers.

A total of 57 countries are facing crippling health workforce shortages. This is especially the case in sub-Saharan Africa but also in Bangladesh, India and Indonesia. WHO estimates that more than four million health workers are needed with at least 2.4 million required to address the global deficit of doctors, nurses and midwives.

The WHO model attempts to address this enormous challenge by implementing an essential package of health sector interventions for HIV prevention, treatment, and care and support aimed at providing universal access by 2010. Interventions are health facility-based, community-based and delivered through outreach to most at-risk populations. National measures are needed to support service delivery.

A critical point has been reached in the case of access to antiretroviral treatment (ART). Until recently, programmes have been using available capacity and working to improve efficiency in existing operations. New capacity needs to be created to meet the projected needs for the period 2007–2010.

Other successful interventions also require scaling up. Access to prevention of mother-to-child transmission is increasing; from 11% of mothers in need in 2005 to 28% now. Outreach to intravenous drug users and harm reduction strategies are increasingly accepted. Although resources for AIDS increased rapidly to about US$ 10 billion in 2007, a resource gap of US$ 8.1 billion remains. The need to invest in health systems and supporting PHC is gaining momentum.

Increased access to HIV interventions requires new health systems capacity to address the critical areas of service delivery and human resources.

Service delivery
- Expand capacity by decentralizing and preparing tuberculosis and antenatal staff to provide chronic HIV care and ART.
- Link with integrated primary health care delivery (adolescent and adult illness, pregnancy and childbirth, and childhood illness).

Human resources
- Provide policy support for task shifting.
- Train and re-train linking pre- and in-service training and expanding production of health-care workers (HCW).
- Support HCW (treat, employ, retain).
- Support planning with evidence, e.g. workload indicators of staffing needs.

Other health system areas that require attention include financing, infrastructure, information systems, access to medicine technology, and governance and leadership.

Task shifting is being suggested as a workforce deployment approach to use HRH more efficiently and increase access to HIV and other health services. It involves moving specific and appropriate tasks from highly qualified HCW to those with less training and qualifications, and specialized to less specialized cadres of workers; both between professional groups (e.g. physicians to nurses) or within professional areas (e.g. registered/degree nurses to enrolled nurses or nursing assistants). The expanded role of nurses will require change, e.g. nurses might be asked (and should, if asked, be empowered) to prescribe treatment *(1)*.

National policies should be developed that balance the capability (i.e. competence) and motivation (i.e. monetary and non-monetary) of HCW to deliver on their professional, community, personal and leadership roles in response to HIV/AIDS. Opportunities exist for nurses and midwives in scaling up towards universal access, such as:
- nurses and midwives are the largest category of trained workers in any national health workforce;
- GCNMOs, nurse/midwife councils and associations can have great influence on practice, education, training and legislation;
- associate cadres, such as enrolled nurses, community nurses and nurse assistants, can have a great positive impact;
- Nurses/midwives can mobilize and assist in supervising PLWHA community health workers and volunteers.

It is hoped that NM will continue to support integrated service delivery and increase their capacity to support national measures required to strengthen health systems including systems for HIV. It is important that GCNMOs and other decision-makers continue to support action against the HIV epidemic.

CHIEF NURSING OFFICER RESPONSE: MRS GLORIA MUBALLE, CHIEF NURSING OFFICER, NAMIBIA

Namibia has a severe shortage of health professionals both in areas of PHC and HIV/AIDS care. Several strategies to address the gaps in health service delivery have been put in place, e.g. training current professionals in areas of HIV/AIDS treatment, care and diagnosis and recruiting non-Namibian professionals. In spite of this, the challenge of providing the much needed services to all remains.

Given the shortage of nurses and midwives, task shifting has been introduced. In the Namibia context:

> *Task shifting is the name given to a process of delegation of certain clinical tasks from one cadre of health professional to another as well as to lay providers (task delegated to less specialized cadres).*

Table 3.1 describes the four categories of task shifting and provides examples in the HIV context in Namibia.

TABLE 3.1 TASK SHIFTING IN THE HIV CONTEXT IN NAMIBIA	
Categories of task shifting	**Examples of task shifting related to HIV**
Type I: from doctor to non-physicians/clinicians (clinical officers/medical assistants)	Type I task shifting does not occur in Namibia because the non-physician cadre does not exist.
Type II: from doctor to registered nurse	Type II task shifting is dominant with registered nurses charged with the responsibility for: • managing some ART side effects and less opportunistic infections • determining patient eligibility for ART • providing ART prophylaxis to newborn babies • monitoring and supporting adherence to ART • prescribing and dispensing Nevirapine to pregnant mothers.
Type III: from registered nurses to enrolled nurses	Types II and III task shifting are further implemented in hospital settings, where tasks are shifted from the doctors to the registered nurses, and registered nurses shift tasks to enrolled nurses and further down to the nursing auxiliary.
Type IV: from enrolled nurses to nursing assistants, and down to community counsellors, corps, etc.	Type IV task shifting is from the enrolled nurse to nursing assistant and further down to community counsellors, corps. Community counsellors and corps comprise lay providers trained and certified by civil society organizations, and their tasks are limited to HIV counselling and testing.

Note: A cadre called ward aides is also in place in hospitals and they do all the non-nursing tasks in the wards – this cadre is, however, not found nationally.

Nursing and midwifery education has changed to ensure that nurses graduating from the University of Namibia as registered nurses are prepared for task shifting:
- the curriculum for student nurses at the University of Namibia currently includes specific training in assessment, diagnosis and treatment, and prescribing medications to patients;
- by the end of 2008, it is envisaged that the student nurse curriculum will include HIV treatment, including the initiation of ART prescription and referral of patients for care;
- the Integrated Management of Childhood Illnesses approach has already been incorporated into the curriculum;
- plans are underway to include the Integrated Management of Adult Illnesses approach into the curriculum;
- training in Prevention of Mother to Child Transmission of HIV is being conducted nationally by the International Training and Education Centre on HIV (I-TECH) in partnership with the Ministry of Health and Social Services.

Although progress is being made, challenges still exist with the prevailing human resource deficit and the need to scale up the provision of ART. Namibia needs to take advantage of this new drive by improving and strengthening the management and support systems, improving training, and creating attractive service conditions for staff. Support can be gained from networking with other countries and learning about best practices.

Plenary discussion
Participants' comments focused on task shifting and on the implications of this human resource strategy.
- How did nurses gain authority to prescribe medications? In Nambia, legislation governs the scope of practice that enables nurses to prescribe drugs. I-TEC is providing training for nurses in collaboration with the Ministry of Health and includes a one-year diploma.

○ Safe practice needs to be ensured, especially task shifting from regulated to non-regulated health workers. Training health workers is most important, given the client and services implications. With increased public awareness about task shifting and assurance that workers are properly qualified, patient satisfaction in Namibia is now acceptable.
○ Task shifting can be vertical and horizontal, i.e. physician to nurse and nurse to physician depending on the human resource situation. Although countries have practiced task shifting for many years, WHO now has guidelines available.
○ Namibia focuses on known success factors, such as patient safety and adequate training, to ensure protection of health workers.

Recommendation

GCNMOs are encouraged to review and consider WHO's global recommendations and guidelines on task shifting mentioned above in relation to their particular country context.

TECHNICAL SESSION 2: PANDEMIC FLU

PANDEMIC FLU: DR CARMEM PESSOA-DA-SILVA, MEDICAL OFFICER, BIORISK REDUCTION FOR DANGEROUS PATHOGENS, WHO

WHO *"assists Member States to endorse quality promotion of health care which is safe for patients, health care workers, others in the health care setting and the environment."* Technical support is provided to help prevent spread of infections associated with health care through evidence-based measures and to ensure infection control preparedness and response to public health emergencies.

The infection control strategy for pandemic influenza identifies the development of prevention and control guidelines for epidemic- and pandemic-prone acute respiratory diseases, including health care facilities and community care (Table 3.2).

TABLE 3.2 CONTROL STRATEGY FOR PANDEMIC FLU – HEALTH CARE AND COMMUNITY CARE	
Strategy for health care	**Strategy for community care**
Programme for health care facility emergency preparedness and response to epidemics and pandemics	Development of easy guidance materials for caregivers and community health workers
Acute respiratory diseases package on infection control practices in health care facilities	Dissemination of materials through WHO Global Nursing and Midwifery Network

Since the input of nurses who are closest to the community is critical, the strategy is being developed in consultation with the WHO Nursing and Midwifery Office and the process is ongoing. Table 3.3 provides an overview of the general assumptions and measures.

TABLE 3.3 OVERVIEW OF ASSUMPTIONS AND MEASURES FOR COMMUNITY HEALTH CARE

Assumptions established for community health care:
- many individuals will fall sick
- the burden of patients will pose challenges
- patients are main sources of pathogens for subsequent transmission
- safe practices should reduce transmission associated with care, improve HCW capacity, avoid unnecessary disruption of health care system and mitigate the impact of pandemic flu and other diseases.

General measures at home for acute respiratory diseases are applicable now and can act as a measure to prevent spread:
- separate placement of ill individuals whenever possible and keeping at least 1 m distance
- cough etiquette for all
- hand hygiene
- ventilation, and
- cleaning of the environment.

Community measures during pandemic emphasize the need to follow public health recommendations in place at the time. In a symptomatic household individuals should:
- limit contact with ill persons
- avoid direct contact with body fluid, and
- enhance hygiene and clean the environment.

For those providing care for the sick at home:
- if close contact care must be provided to the ill person:
  - make it as short as possible
  - the ill person should cover cough/sneezing when close to others
  - for protection, the community HCW should wear a medical mask or the next best available protection
  - to protect members of the household providing care, instructions need to be adapted to the level of resources and ability to comply
  - materials used to cover the mouth/nose should be discarded or cleaned appropriately, and followed by hand hygiene
  - persons at increased risk of severe disease should not care for the ill person or be in close contact with the ill person.

If the ill person needs to seek medical care during a pandemic:
- notify the health-care provider of diagnosis and receive instructions on where to seek care when/where to enter the health care facility, and the infection control precautions that are to be followed
- try to stand or sit as far away from others as possible ($\geq$ 1 m), when in transit and when in the health care facility.
- always perform respiratory hygiene/cough etiquette
- open vehicle windows
- avoid public transportation, if possible.

CHIEF NURSE OFFICER RESPONSE: DR HUAPING LIU, CHIEF NURSING OFFICER, SCHOOL OF NURSING, CHINA

China is a large country with a huge population. Nurses account for 33% of health professionals and now have a new nursing regulation. Although the number of nurses has increased, there is still a shortage. The GCNMO relies on the Nurses Association to provide development support (e.g. develop ethics for nurses).

The issue of infection spread is critical, given the large and dense population. As a result of the difficulties experienced during the Sudden Acute Respiratory Syndrome (SARS) epidemic, the country is now better prepared. It has developed preparedness plans, guidelines and training programmes at the policy and professional levels and support is available to families.

Plenary discussion
Questions were raised and general comments received.
- Pandemic flu is a concern, especially for overcrowded populations, such as the prison population. Although infection control is difficult, the best approach is to work with prison officials to create reasonable conditions that meet minimal standards of hygiene.
- Children and school populations are also a challenge. There are studies that have shown that children can be taught about hygiene and, in fact, can educate their parents. Respiratory and gastric infections can be reduced by introducing preventive measures in children.

○ Staff protection is critical. With task shifting to lay persons, there must be adequate training to avoid transmission of infections.

Recommendation
GCNMOs can assist in disseminating educational materials on pandemic flu and encouraging their use *(2)*.

TECHNICAL SESSION 3: CLIMATE CHANGE AND HEALTH

CLIMATE CHANGE AND HEALTH: DR MARIA NEIRA, DIRECTOR, DEPARTMENT OF PROTECTION OF HUMAN ENVIRONMENTS, WHO

> *"With impoverished populations in the developing world the first and hardest hit, climate change is very likely to increase the number of preventable deaths. The gaps in health outcomes we are trying so hard to address right now may grow even greater. This is unacceptable"*
> *Dr Margaret Chan, Director-General WHO, December 2007*

WHO has been working on the relationship of climate change and health for the last 20 years, but now it is an even higher priority. In fact, the WHO World Health Day 2008 report is on climate change.

Evidence proves that climate change is affecting human health. Climate scientists continue to provide ever-stronger evidence that the world has warmed; rainfall patterns are changing; and floods, droughts and storms are becoming more extreme. Human actions are largely responsible.

Climate change will affect, in profoundly adverse ways, some of the most fundamental determinants of health: food, air, water. Climate change impacts health both directly, for example, through heatwaves, floods and storms, but also indirectly, through effects on infectious disease, on water availability, and on agricultural production. None of these impacts are inevitable – they are affected by factors such as socioeconomic development and, most importantly, by the actions of public health systems. Although some of the health effects of climate change will be beneficial, most will be adverse (Table 3.4).

TABLE 3.4 HEALTH EFFECTS OF CLIMATE CHANGE	
• Temperature-related illness and death	• Vector-borne and rodent-borne diseases
• Extreme weather-related health effects	• Effects of food and water shortages
• Air pollution-related health effects	• Effects of population displacement
• Water and foodborne diseases	

We are not climate scientists, but we do have experience in what climate extremes mean for health: the clearest example is from the western European heatwave of 2003 where it is now estimated that it caused over 14 000 additional deaths in France during a two-week period. Across central and western Europe, it is estimated that there were more than 70 000 additional deaths in 2003 than other years.

The number of extreme weather events, such as floods, storms and droughts, has risen rapidly according to the emergency database of the Centre for Research on the Epidemiology of Disasters in Belgium. Floods, droughts and storms will cause deaths and injuries, infections (e.g. leptospirosis, hepatitis, diarrhoeal, respiratory, vector-borne), exposure to toxic substances, mental health effects, destruction of health services, and increasing demand on already burdened health services.

Diseases that are sensitive to climate include malaria and diarrhoea and risk conditions such as undernutrition. We must also be concerned about the health and social impacts of population movement and displacement, which are indirect effects of climate change. Persistent drought, flooding and rises in sea level will force people to immigrate. Displaced populations – whether internally displaced or refugees – have poorer health. Such poor health is characterized by the spread of infectious diseases and increased risk for violence and injuries due to competition for scarce water supplies.

> *"In short, climate change can affect problems that are already huge, largely concentrated in the developing world, and difficult to combat."*
> *Dr Margaret Chan, Director-General WHO, 7 April 2008*

Climate change can reduce food production, and increase water scarcity and infectious disease transmission. Indirect health effects are the biggest killers. Already, each year undernutrition (the single largest contributor to the global burden of disease) kills 3.5 million, diarrhoea kills 1.8 million and malaria kills almost one million. Unfortunately, the poorest populations are least responsible, but the most vulnerable. Together, these three conditions kill many millions each year, especially children in developing countries.

It is estimated that, in 1995, 1.5 billion people lived in water stressed locations. Latest projections reveal that Africa will be severely affected by 2020 where the number of Africans affected by water stress will increase from 75 to 250 million. It is not difficult to imagine that climate change will definitely worsen water, sanitation and hygiene concerns.

The WHO programme attempts to move from evidence to action. The UN Secretary-General has established a coordination group that includes the continuous participation of WHO through the Executive Board (EB) Report and Resolution (January 2008) to the World Health Assembly in May 2008; World Health Day 2008; and the WHO workplan submitted to the EB in January 2009.
The WHO programme has six objectives:
1. Raising awareness: putting health at the heart of climate change;
2. Strengthening public health systems: coping with additional threats posed by climate change:
   - better management of environmental health determinants – provision of safe water and sanitation, control of air pollution;
   - improved surveillance and response, such as warning systems for heatwaves, and compliance with International Health Regulations to monitor and prevent the spread of disease;
   - strengthened primary health care, and health action in crises, including improved planning and provision for emergency response;

3. Health in climate change mitigation: improving health as greenhouse gas emissions are reduced:
   ○ the main barrier to reducing greenhouse gas emissions is that it is argued to be expensive; however, there are significant "co-benefits" to health from action on climate change;
   ○ there is an opportunity to reduce the 800 000 annual deaths from urban air pollution; the loss of 1.9 million lives and 19 million years of healthy life from physical inactivity; and the 1.2 million deaths and over 50 million injuries from road-traffic accidents;
4. Leading by example: improving sustainability within the health sector:
   ○ the health sector is one of the largest employers and consumers of resources, and health professionals occupy unique positions of responsibility and public trust;
   ○ WHO action (e.g. World Health Day – working toward climate neutrality);
   ○ action by health agencies, organizations and professional groups.
5. Research and assessment: evidence-based risk assessments;
6. Monitoring and evaluation: effectiveness of interventions.

Key activities are identified under the WHO Global Nursing Capacity Building in Environmental Health:[1]
   ○ Preliminary Regional Planning Meeting in Doha, Qatar (EMRO), March 2008;
   ○ Global Planning Workshop preceding this meeting where a partnership was launched and plan developed, 13–14 May 2008;
   ○ provision of training of trainers on environmental health in nursing following the mercury elimination in health care conference, December 2008, New Delhi, India;
   ○ nursing practice, education, research and policy advocacy:
     • tools to assess and monitor health impact from environmental exposures;
     • education on treatment and referral for health effects;
     • curricula and training materials for basic and continuing nursing education (adaptation of Children's Health and Environment (CEH) modules);
     • advocacy on policy to prevent and control environmental hazards.

CHIEF NURSING OFFICER RESPONSE: DR CAROL ROMANO, DEPUTY CHIEF INFORMATION OFFICER, NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND; ASSISTANT SURGEON GENERAL, USA

It is recognized that climate change has increased natural disasters, transmission of tropical diseases and gastroenteritis pathogens (food and waterborne infections). In responding to the health impact of climate change, nursing roles may include: emergency response and preparedness, infection control, food and water safety, and advocacy for vulnerable populations.

In the United States, a National Response Framework now outlines pre-incident, incident and post-incident activities. The full spectrum of management action is described for mass casualty events/situations – preparedness, prevention, response, recovery and mitigation. Action must be applied and modified to the specific context over time (e.g. natural disaster, flu infections, flu pandemic), and address both the immediate and sustained impact. In a mass care event, guiding principles shape the response:

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[1] Contact: Susan Wilburn wilburns@who.int

1. keep health care system functioning: deliver acceptable quality to **preserve maximum number of lives**;
2. comprehensive, **community-based planning** coordinated at regional level;
3. **legal framework** for providing care;
4. protect **individual rights**:
5. clear **communication with public**, before, during and after event.

We all need to work together if our mission is to protect, promote and advance the health and safety of our nations. New partnerships are needed when facing disasters and mass events; partnerships between:
- the consumer and health-care professional;
- the provider and interdisciplinary team;
- the health care system and the informatics community;
- the public and private sectors;
- health and education and community organizations.

Communication and role delineation is important. Nurses have always been proponents of holistic care and coordinators of the interdisciplinary health teams. In preparedness and response, the nurse's role encompasses:
- early surveillance:
  - identification of the signs and symptoms on admission to the emergency department, doctor, office, clinic, or on the call-in line;
- frontline response at the site of a disaster and the hospital;
- administration of mass prophylaxis and immunization;
- training/teaching people not in the health care field on the essentials of survival and caring for others;
- anticipation of the medical consequences and identification of first intervention;
- supervision and provision of triage and care during emergencies.

Pandemics are different from other types of emergencies in that there will be no clear beginning or end. There will be multiple waves with many locations being affected simultaneously. Resources cannot be shifted geographically as in other emergencies. Every country will be affected, but countries with better plans will be less vulnerable to terrorism and other threats during a pandemic. Public Health Functions and Services *(3)* describe four key areas to develop:
- assessment:
  - monitor health status and identify problems;
  - diagnose and investigate health problems;
- policy development:
  - inform, educate, empower people about health issues;
  - mobilize partners to solve problems;
  - develop policies and plans to support individual and community health efforts;
- assurance:
  - enforce laws and regulations that protect health and ensure safety;
  - link people to services; assure provision of care when unavailable;
  - assure competent public health and personal health care workforce;
  - evaluate effectiveness, accessibility and quality of services;
- research for new insights and solutions.

Recommendation
GCNMOs are referred to WHO's report Protecting health from climate change: Report for World Health Day 2008 for more information and a broad range of resources to assist planning efforts during pandemic or emergencies (see Annex 2 *Forum background material and recommended references*).

TECHNICAL SESSION 4: MAKING PREGNANCY SAFER

MAKING PREGNANCY SAFER: MRS HEDWIG VAN ASTEN, TECHNICAL OFFICER, MIDWIFERY, MAKING PREGNANCY SAFER, WHO

The Making Pregnancy Safer programme is supported by 110 staff/staff representatives, more than 60% of whom are working at country level, 20% at regional level and less than 20% at headquarters. The thrust of the work is on technical and norms support, partnership and monitoring, and evaluation. The overall aim is to contribute to MDG 4, 5 and 6 with emphasis in priority countries. In order to achieve improvement, the work relies heavily on collaboration. So as to meet maternal needs adequately, attention is given to a wide range of areas including skilled birth attendants (SBA), emergency obstetric care, HIV (preventing mother-to-child transmission), malaria in pregnancy and adolescent services. In addition, audit, monitoring, coverage and quality improvement activities are carried out.

The WHO Maternal and Child Health Department has many documents outlining a symptomatic approach: newborn approaches (coverage, performance, capacity building, guidance, tools and technical support) and technical support for individuals, families and communities, which are not limited to the medical model. Recent work on maternal and newborn health in emergencies describes the SBA's role in preparedness, response and recovery, and improves aspects of the minimum initial service package and rapid assessment tools. Contributions have been made to inter-agency field manuals and training of individuals participating in emergency preparedness.

Efforts targeted at scaling up existing programmes explore options in the short-, medium- and long-term and attempt to find specific and incremental responses to country-specific situations. Country profiles, available on CD for 72 countries, show inequities and can assist with advocacy, priority setting and programme planning to identify appropriate targets. A toolkit for strengthening midwifery is being launched in 2008 which includes:
- strengthening midwifery – health check;
- legislation and regulation of midwifery;
- developing standards to improve service;
- competencies for practice;
- curriculum development;
- programmes for preparing midwifery teachers, supervision, monitoring and assessment of continued practice;
- developing capacity, strategy and adaptation.

Recommendation

GCNMOs could be involved in Making Pregnancy Safer in all aspects: technical, strategy and monitoring assistance; appropriate, available and accessible services; and leadership. A wide range of reference material is available from WHO.

TECHNICAL SESSION 4: REPRODUCTIVE HEALTH

REPRODUCTIVE HEALTH: DR MARGARET USHER-PATEL, SCIENTIST, COMMUNITY OF PRACTICE PARTNERS OF THE IMPLEMENTING BEST PRACTICES (IBP) INITIATIVE SECRETARIAT, WHO

The WHO Global Reproductive Health Strategy has been ratified by 192 countries. Reproductive health has been included in the MDGs given its burden of disease and the potential impact of family planning on health by reducing maternal deaths and childhood deaths.

> *All countries should strive to make accessible through the primary health-care systems, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015.*
> *International Conference on Population and Development Programme of Action, 1994*

To this end, at the 2005 World Summit, a commitment was made towards:

> *(g) Achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, …*

The four cornerstones of evidence-based guidance promoted in reproductive health are:
1. medical eligibility criteria for contraceptive use
2. selected practice recommendations for contraceptive use
3. decision-making tool for family planning clients and providers
4. handbook for family planning providers.

The context surrounding maternal and perinatal health is challenging: 120 million couples with an unmet need for family planning; 80 milion women with unintended or unwanted pregnancies; 45 million pregnancies ending in abortion; 500 000+ women dying annually in pregnancy and childbirth; approximately 210 million left with disabilities after childbirth; and 2.7 million stillborn infants.

Investments in the prevention and control of sexually transmitted infections will reduce the global health burden, prevent HIV infection and serious complications for women, prevent adverse pregnancy outcomes and poor newborn health, and contribute to MDGs 4, 5 and 6. However, many constraints impact progress: ignorance and lack of information; stigma, prejudice and lack of appreciation of disease burden and asymptomatic nature of sexually transmitted diseases (STIs), lack of the best configuration and effectiveness of integrated STI care and the limited array of partners involved.

In order to make a difference, attention must be given to unsafe abortion and post-abortion care, adolescent sexual and reproductive health, and gender issues and reproductive rights. Table 3.5 outlines the rationale for targeted work within reproductive health.

TABLE 3.5 RATIONALE FOR TARGETED WORK WITHIN REPRODUCTIVE HEALTH		
Unsafe abortion and post- abortion care	**Adolescent sexual and reproductive health**	**Gender issues and reproductive rights**

• About one in five pregnancies worldwide end in abortion
• Approximately 42 million abortions occur annually
• 47% are unsafe abortions
• Worldwide, approximately five million women are hospitalized for abortion-related complications
• Complications due to unsafe procedures account for 13% of all maternal deaths
• Approximately 220 000 children lose their mothers every year from abortion-related deaths
• Additional consequences are loss of productivity, economic burden on public health systems, stigma and long-term health problems
	• 1.2 billion adolescents in the world and rising
	• 86% of adolescents live in developing countries
	• 14.3 million births (10%) are to adolescent girls (15–19 years)
	• 2.5 million unsafe abortions performed annually on adolescents; 26% of all unsafe abortions
	• 50% of sexually active adolescents have their first sexual encounter against their will
	• 40% of all new infections of HIV are in adolescents (2006)
	• Approximately 13 million youths are living with HIV
		• Assess laws, policies, practices
		  - rights-based approach to maternal and newborn health
		  - assist countries to improve the legal, policy and regulatory environment for sexual and reproductive health
		• Coordinate multinational research aimed at abandonment of female genital mutilation and vaginal practices
		• Continue analyses of data from multi-country study on violence against women
		• Mainstream gender and reproductive rights issues
		• Develop guidance for health sector on response to violence against women
		• Contribute to understanding of relationship between human rights and sexuality, and sexual health

WHO technical cooperation is available to:
- assist with identification of sexual and reproductive health needs;
- build capacity for research (national, regional and global) and support the dissemination and implementation of research results;
- support the introduction, adaptation and implementation of evidence-based technical materials, and proven effective managerial and performance improvement tools;
- provide support to planning, implementation, monitoring and evaluation of programmes aimed at improving access to good quality sexual and reproductive health care;
- support countries to identify and scale practices to make programmes work;
- build partnerships to harmonize approaches and reduce duplication of effort.

Recommendation
GCNMOs could contribute to improving sexual and reproductive health by getting involved with:
- child and maternal health
- family planning
- prevention and control of sexually transmitted diseases and reproductive tract infections
- prevention of gender-based violence
- prevention of unsafe abortions
- promotion of adolescent reproductive health
- provision of essential medicines and commodities.

TECHNICAL SESSION 6: HUMAN RESOURCES FOR HEALTH (HRH)

HUMAN RESOURCES FOR HEALTH: MRS BETH MAGNE WATTS, ADVOCACY AND COMMUNICATIONS OFFICER, GLOBAL HEALTH WORKFORCE ALLIANCE (GHWA)

Health workers are the cornerstone and drivers of the health system and yet the world is facing a serious shortage of health workers – a shortage that is identified as one of the most critical constraints to the achievement of health and development goals. The figures tell the story:

- according to the WHO, there is a shortfall of over 4.3 million health workers globally;
- sub-Saharan Africa has 11% of the world's population with 25% of the global burden of disease, but only 3% of the world's health workers;
- on average, one in four doctors and one nurse in 20 trained in Africa is working in developed countries;
- in sub-Saharan Africa and some Asian countries, the monthly wage for a public sector physician can be less than US$ 100; in developed countries it can exceed some US$ 14 000 per month;
- in terms of the size of the crisis, according to *The World Health Report 2006 – working together for health*, 57 countries were identified as having "critical" shortages of health workers with 36 of these in sub-Saharan Africa.

This is more than just a crisis affecting health and medical communities. This crisis is impairing the provision of essential, life-saving interventions, such as childhood immunization, safe pregnancy and delivery services for mothers, and access to treatment for HIV/AIDS, malaria and tuberculosis. Health workers are also critical to our preparedness and response to the global security threats posed by pandemics and the consequences of global climate change.

There is no doubt that without prompt action, the shortage will worsen, demand for care will continue to grow and health systems will be weakened even further. It is a crisis characterized by widespread global shortages, inappropriate distribution of personnel within and between countries, migration of local health workers and poor working conditions.

But how did this happen? Some of the drivers leading us to the current crisis situation have been identified as populations living longer, increasing high disease burden in low-income countries, and a long history of neglect and economic collapse in sub-Saharan Africa. This crisis has now captured international attention and commitment to action is beginning to bear fruit.

GHWA is a global partnership officially launched in May 2006 that is hosted and administered by WHO as a priority programme. The Alliance provides a common platform for action that is dedicated to identifying and implementing solutions to the health workforce crisis. Its vision is, "access for all to a skilled, motivated and supported health worker as part of a functioning health system".

The Secretariat has a small core group of professionals driving and coordinating the implementation of the GHWA Strategic Plan, which reports directly to the Board for programmatic results and to WHO for administration of personnel and financial matters. The Board is made up of key high-level partners, including representatives from professional associations, such as ICN.

One GHWA key activity for the first two years of operation has been the setting up of task forces and working groups, established as needed to address specifically defined areas of work, such as migration and retention, education and training, financing and universal access to HIV prevention, treatment, care and support.

Strategically, GHWA's approach is twofold: accelerating action in countries and addressing global constraints that impede country action. The activities of the Alliance can be split into five categories:

1. **Accelerating country action** through country action teams and regional networks. GHWA assists countries with their efforts to develop and implement their plans to scale up the health workforce and advocates for multi-sector country action teams from the fields of health, finance, education, civil society and the private sector. Progress to date includes:
   - guidance for countries through provision of tools and guidelines that enable countries to plan and manage health workforce issues – including the Action Framework;
   - Working Group on Tools and Guidelines – led by WHO's HRH Department – which developed an HRH Action Framework;
   - focused learning in pathfinder countries in phase I that include Angola, Benin, Cameroon, Ethiopia, Haiti, Sudan, Viet Nam and Zambia. Another 18 countries have already been identified for phase II;
   - The Alliance has helped mobilize regional networks in Africa and Asia, and has provided them with the capacity and tools to work with countries.

2. **Strengthening synergy between partners** by convening stakeholders to work together and reduce fragmentation, participating in actions and maintaining close collaboration with groups. Progress to date includes:
   - participating in actions, such as the Global Alliance for Vaccines and Immunization's Health Systems Strengthening Task Force and the WHO/HIV Department's "Treat, Train, Retain" workplan;
   - closely collaborating with the Joint United Nations Programme on HIV/AIDS, the Stop TB Partnership, The Partnership for Maternal, Newborn & Child Health, The Global Fund to Fight AIDS, Tuberculous and Malaria, etc.;
   - convening meetings and discussions between key partners, including the United Kingdom and the United States, which have led to enhanced support and action on HRH issues.

3. **Knowledge brokering** by serving as an information hub, watchdog and monitoring body, and using and disseminating existing evidence while commissioning new research (e.g. a number of publications that ICN have been working on: incentives guidelines, positive practice environment campaign). Progress to date includes:
   - sharing/disseminating through GHWA's web site, list services, forums, a newsletter and regional briefings;
   - working with Regional HRH Observatories in WHO's regional offices – the Regional Office for Africa (AFRO), Regional Office for the Americas (AMRO)/ Pan American Health Organization (PAHO), EMRO, Regional Office for Europe (EURO), Regional Office for South-East Asia (SEARO) and the Regional Office for Western Pacific (WPRO).

4. **Advocacy** that is central to GHWA's work and one of the unique "added values" of the Alliance. GHWA raises and maintains awareness and political visibility. Progress to date includes:
   - The Alliance's work has publicized HRH issues, keeping the issue high on the agendas of decision-makers, health partnerships and initiatives, and development partners by active participation in high-level events, through the media and focus meetings with key stakeholders;

- ○ Health Workforce Advocacy Initiative – civil society network – keeping HRH visible and high on the political agenda;
- ○ Other working groups/task forces, which will contain a strong advocacy element.

5. Addressing global challenges by engaging in global problem-solving on resource mobilization, macroeconomics and fiscal space, migration, research, harmonization and alignment. Such activity is largely accomplished through the setting up of international task forces. Progress to date:

- ○ Working Group on Scaling-up Education and Training co-chaired by Nigel Crisp and Bience Gawanas;
- ○ Working Group on Migration drafting an International Code of Practice, co-chaired with Mary Robinson, former President of Ireland;
- ○ Task Force on HRH Financing addressing macroeconomic constraints to HRH in close collaboration with the World Bank;
- ○ Task Force on Universal Access to HIV Treatment;
- ○ private sector engagement.

GHWA convened the first-ever Global Forum on Human Resources for Health in March 2008. Over 1500 participants came together in Kampala, Uganda, to share experiences of what is and what is not working in the response to the health workforce crisis, and to build networks, consensus and capacity. The Forum culminated in the endorsement of the Kampala Declaration and Agenda for Global Action – a roadmap to guide work on human resources for health over the next decade. It builds on global commitments already made by high-level policy-makers and outlines five key elements:

- ○ building coherent national and global leadership for health workforce solutions;
- ○ ensuring capacity for an informed response based on evidence and joint learning;
- ○ scaling up health worker education and training with needs-based skill mixes;
- ○ retaining an effective, responsive and equitably distributed health workforce;
- ○ managing the pressures of the international health workforce market and its impact on migration;
- ○ securing additional and more productive investment in the health workforce.

GHWA will monitor the implementation of both the Declaration and Agenda and re-convene in 2010 to report and evaluate progress.
Moving forward, GHWA will continue to advocate for health workers to be trained, supported and retained in sufficient numbers to ensure accelerated progress towards the MDGs. Through collaborative actions of its broad membership base, the Alliance will support the development of evidence-based, comprehensive and coherent country-level approaches and the significant scaling up of country, regional and global actions necessary to ensure universal access to health workers for all. A number of specific action areas will be:

- ○ keeping HRH high on the global agenda – at the moment, there is a window of opportunity, but it will not last forever;
- ○ "connecting" our partners at all levels and facilitating, encouraging and enabling each to play their roles;
- ○ knowledge brokering with GHWA as a central point for knowledge and evidence on HRH issues, providing a much needed way to consolidate existing efforts, put together a common agenda for knowledge-building, and disseminate all knowledge to interested parties;

- accelerating actions in the 57 countries in crisis;
- monitoring the implementation of the Kampala Declaration and Agenda for Global Action.

Recommendation
GCNMOs could contribute to planning and implementing HRH strategies at the country level, which will improve access and strengthen nursing and midwifery, and the general heath workforce.

CHIEF NURSING OFFICER RESPONSE: MR FAYÇAL ALAOUI, CHIEF NURSING OFFICER, MINISTRY OF HEALTH, TUNISIA

Tunisia, a member of EMRO, is a country with a population of over 10 million. Quality of life is improving and is reflected in demographic and epidemiological changes. The public sector provides 66% of outpatient consultations and 90% of hospitalizations within the basic health structures and university hospital centres.

Nurses and midwives constitute 50% of HRH with a density of 2.87/1000 population. The nursing education infrastructure consists of public schools and private institutions offering nursing programmes. In September 2005, WHO assisted with the formulation of a national development strategy for the nursing profession with the objective of increasing the level of education of nurses, and revising the role and position of nursing within the health system. The justification for the reform was threefold:

- better respond to population needs resulting from demographic changes (e.g. ageing) and epidemiological changes (e.g. decreasing infectious diseases and increasing prevalence of chronic and degenerative diseases);
- maximize the growth of health expenditures by adopting new approaches to service delivery;
- re-validate the nursing role by strengthening prevention, integrating the community aspect and adopting a less invasive and more humanistic approach to care.

The strategy is being implemented through a nursing education partnership involving the Prime Minister, the Ministry of Public Health, the Ministry of Higher Education, EMRO and the University of Saint Joseph (Lebanon). In particular, reform elements include:

- elevation of nursing education to university level;
- establishment of five higher institutes of nursing education;
- bridging programmes to provide Master's degrees in nursing science;
- strengthening the capacity of nurses to play a more important role in the management and leadership of the health system.

Initiated in 2006, the reform is making progress, yet it still faces major challenges in meeting the human resource requirements, adopting innovative training approaches, and determining the licensure/classification structure of nurses with different education levels (e.g. diploma to Master's).

KEY CONCLUSIONS AND ACTIONS

- GCNMOs are encouraged to review and consider the global recommendations and guidelines on task shifting *(4)* in relation to their country context.
- GCNMOs can assist in disseminating educational materials on pandemic flu and encouraging their use *(5)*.
- GCNMOs are referred to a recent WHO report for more information on protecting health from climate change *(6)* and a broad range of resources to assist planning efforts during pandemic or emergencies (see Annex 2, *Forum background material and recommended references*).
- GCNMOs could be involved in Making Pregnancy Safer in all aspects: technical, strategy and monitoring assistance; appropriate, available and accessible services; and leadership. A wide range of reference material is available from WHO.
- GCNMOs could contribute to improving sexual and reproductive health by getting involved with (i) child and maternal health; (ii) family planning; (iii) prevention and control of sexually transmitted diseases, and reproductive tract infections; (iv) prevention of gender-based violence; (v) prevention of unsafe abortions; (vi) promotion of adolescent reproductive health; and (vii) provision of essential medicines and commodities. Reference material is available from WHO.
- GCNMOs could contribute to planning and implementing HRH strategies at the country level that will improve access, and strengthen nursing and midwifery, and the general heath workforce.

4. PRIMARY HEALTH CARE

MODERATOR: MR PAUL MARTIN, CHIEF NURSING OFFICER, SCOTLAND

The principles of primary health care cut across the Forum's agenda and issues being explored at the third GCNMO meeting. A key message being heard is that PHC is the centre for health care services. A key challenge, however, is to work from a common understanding of PHC to more easily describe the involvement and impact of nursing.

During the 30th anniversary celebration of PHC at Almaty (formerly Alma-Ata), nurses and GCNMOs have an opportunity to market the nursing contribution to PHC. The question then becomes: "If we have the opportunity to showcase nursing contribution to PHC in the 2008 Almaty conference, what should be on the agenda, how do you expect to contribute, and what key messages should be coming from the event?"

DR JOHN MARTIN, ADVISER TO THE DIRECTOR-GENERAL, WHO

The GCNMO meeting is extremely timely as 193 Member States are currently reflecting on what PHC should endorse. There continues to be confusion between *primary health care* and *primary care*. There is also widespread discontent.
- Governments are under pressure to view health as a social justice issue wherein access to appropriate care close to home is expected for all needs, not just targeted diseases.
- In some countries, health systems do not have the capacity to meet health needs and governments are losing control.
- Countries experience health inequalities and service inequalities among populations, in particular between rich and poor.
- The international financing system is in disarray and countries are lagging behind in social commitments.
- Lower income countries desperately need money generated at the global level, but some have lost some control in targeting dollars properly within their health system.
- Donors can be frustrated when countries do not deliver the impact and results expected from the investments.
- In parts of the world, financial and political crises threaten the achievement of results in countries with commitments made to MDGs.
- Financing health care is seen as a significant barrier to access; in fact, it is estimated that over 100 million people are driven into poverty due to health care financing policies.

Countries need to make a strong and clear statement on problems and potential solutions in PHC to improve the health of the world. PHC-based systems are not a technocratic approach, but a commitment to put in place a system and health workers able to reach out to the community and use the health system as part of social mobilization. There is need to recognize a major role for communities in health and to work on the broad determinants of health.

WHO is listening with a view to building an understanding among Member States for radical response to address current challenges and gain adequate political commitment. Regional consultation has begun and will eventually culminate in the 2008 Almaty conference. It is hoped that all 193 Member States will sign off renewed PHC by May 2009 in order to radically improve the health of their populations. The success of PHC relies heavily on such political will.

DR WIPADA KUNAVIKTIKUL, DEAN AND DIRECTOR, WHOCC FOR NURSING AND MIDWIFERY DEVELOPMENT, FACULTY OF NURSING, CHIANG MAI UNIVERSITY, THAILAND

The Chiang Mai Declaration on Nursing and Midwifery for Primary Health Care was created at the international conference on "New Frontiers in Primary Health Care: Role of Nursing and Other Professions", which was organized by the Faculty of Nursing and took place at Chiang Mai University from 4–6 February 2008. This Declaration describes the vital role of nursing and midwifery in the achievement of PHC and the MDGs and makes recommendations for action.

The conference was supported by various partners and was attended by over 750 participants from 34 countries. More than 40 speakers were involved with 260 presenters from different parts of the world. The development of the Declaration evolved through a six step iterative process resulting in sharing a final copy with all delegates for distribution and briefing of respective government agencies.

The Chiang Mai Declaration (February 2008) can now successfully move towards action. It has been integrated into major global events this year; the Global Forum in Kampala (March 2008), the World Health Assembly (May 2008) and, hopefully, the World Health Report 2008.

DR DEVA-MARIE BECK, INTERNATIONAL CO-DIRECTOR, NIGHTINGALE INITIATIVE FOR GLOBAL HEALTH, CANADA

The Nightingale Initiative for Global Health is interested in taking issues of health and nursing to the global level. In order to celebrate the 60th anniversary of WHO (1948–2008) and the 30th anniversary of the Declaration of Alma-Ata on Primary Health Care (1978–2008), Nightingale partnered with the WHO Health Professions Network and Office of Nursing and Midwifery in a project to recall rare and historic photographs from WHO's archives (1950–1990).

The video presentation celebrates the role of health professions in PHC and feature nurses and midwives. The selected photographs from 56 countries representing all nations and the six WHO regions showcase the involvement of NM across the years and around the world. Nurses and/or midwives contribute to PHC with knowledge, competence, experience, critical thinking, leadership, trust, commitment and quality care. Such quality care is exemplified:
- for mothers and children, in reproductive health, health promotion, proper nutrition, safe water, basic sanitation, rehabilitation and prevention;
- in the control of locally endemic problems with appropriate treatment of common diseases and illnesses, immunization and provision of essential drugs;

- by working with health-care teams for education and capacity building, research, monitoring, evaluation, impact assessment and evidence for action;
- through practical, scientifically sound and culturally acceptable methods, and universally accessible care for individuals and families involving the full participation of the community;
- by fostering self-reliance and self-determination integral to a nation's health system and overall human development at a cost communities and nations can afford to maintain, and located close to clients in the communities, hospitals, clinics, schools and homes;
- by positioning nurses and midwives as central and critical to PHC then, now and into the future.

Nurses and midwives need to be strengthened, supported and sustained to make primary health care and improved health outcomes a reality for all peoples so they can keep on caring.

The video will be showcased in Kazakhstan. Several revisions have been completed and the review is in the final stages. This visual statement has a number of possibilities to strengthen nursing and midwifery.

HEALTH SYSTEMS DEVELOPMENT TOOLKIT FOR COMMUNITY NURSING PRACTICE: MR PAUL MARTIN, CHIEF NURSING OFFICER, SCOTLAND

Global challenges compel our health systems to examine service models and adopt approaches to best meet health care needs. Health care is shifting from hospital to community; workforce shortages exist; and scope of practice needs to increase. The system must move from "technical" care to health maintenance and health improvement and to more self-care and community involvement. Community-oriented models vary across extended general practices, managed care enterprises, reformed polyclinics, district health systems, community development agencies, and franchised outreach.

In response, Scotland introduced the family health nurse (FHN) as a generalist model delivering clinical care across generations and embracing health promotion and community health initiatives. Key findings from the evaluation of the FHN demonstrate that there is a positive attitude to the FHN role and it is valued as first point of contact. Although a risk exists of creating a dependency, the model is effective with families with multiple needs and health issues are identified that are otherwise missed. Service users are very positive about the holistic approach and accessibility. However, achieving full potential requires transformation of the current model to embrace a family-focused approach, which is embedded in the needs of the community.

Scotland is now implementing accessible integrated care that builds on the lessons from the family health nurse model. The generic model has a single point of entry and is supported by a multidisciplinary team that includes community health nurses. Nursing adopts the public health approach to meet the health needs of communities. In working with families and carers, early interventions prevent hospital admissions, services are coordinated and self-care is supported.

A capability framework will identify worker abilities against which services and educators can plan the workforce to meet identified needs. It is important to know how nurses contribute and how to maximize their potential. There is an opportunity to position nurses as key players within a community-based and multidisciplinary approach.

A project is underway that builds on the family health nurse model and the Scottish experience and will result in a health systems development toolkit for community nursing practice. After examining the literature and practice evidence, a framework of flexible models will be developed, a vision created and a "community of practice" established for dialogue and information sharing. It is recognized that health inequalities are relative to each country context and different solutions may be indicated that respect both capacity and capability. Although most countries currently involved are in Europe, the project could move to the global scene and serve as a resource for other countries.

Discussion points

WHO needs to clarify primary health care versus primary care and nurses need to participate in the dialogue. Consideration could be given to creating a task force that examines the role of nurses in leading PHC. In Africa, one lesson learned from past PHC is that nurse-led programmes have a better chance of success and continuation after initial funding disappears.

PHC is a strategy implemented towards the achievement of the MDGs. How can nurses speed up delivery of that goal? In order to deliver results, health workers must step out of their traditional role and reach out through collaboration and partnership.

At the African conference on PHC, 29 participating ministers expressed frustration about PHC. The discussion concluded that there are good examples of PHC models still continuing. A declaration endorsing the 1978 PHC resulted from the meeting, but the need was expressed to address current conditions, e.g. cancers, diabetes and the achievement of MDG 5. The principles of social justice must be applied and governments require much more support to deal with the challenges. The strong political level endorsement offers an opportunity to rebuild PHC with the full engagement of public and private partners.

We must not forget that people are driven into poverty due to health cost presenting a threat to PHC. Health sector reform appears to focus on revenue rather than social justice and equity. Most basic packages offered are not adequate with most patients required to pay for services outside the basic package.

PHC works differently in different country contexts. There are also challenges to creating and retaining a healthy and happy health workforce that continues to deliver services.

The issue of financing is an example of how health workers can influence policies. Nurses must examine the evidence indicating that PHC, if properly organized, is cost effective. The nursing community should get together and come up with an agenda and key messages to advocate at the 2008 Almaty conference.

KEY CONCLUSIONS AND ACTIONS

The participants agreed that social justice and equity was becoming increasingly politicized. It is important to explore the issues related to understanding PHC, applying the lessons learned, and linking policy to action. Nurses and midwives are key to improving health and strengthening health systems, but are not the only solution. More work is required to position the role of nurses and midwives effectively within the PHC movement of the future.

5. PLAN FOR ACTION

BUILDING PARTNERSHIPS FOR NURSING AND MIDWIFERY

MODERATOR: DR JUDITH SHAMIAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VICTORIAN ORDER OF NURSES, CANADA

Building partnerships for nursing and midwifery is a critical component of strengthening health systems. Dr Shamian described the important role of the GCNMO in giving a visible face to nursing, providing advice and access to senior levels of government, participating in agenda setting, retaining authority in areas of policy and acting as a unifying voice for diverse interests and roles.

Although there are many faces to partnership, it is indisputably about the process of "building" understanding and relationships in areas of common interest. Within their role, GCNMOs can identify external and internal partnership opportunities for nursing and midwifery at both the local and national levels. Potential partners can be identified within public service, education, government and the profession itself.

Partnerships are often complex and require skill and patience to cultivate. It begins with taking time to understand the issues and define the goals and interests of the partners. So as to have the best chance of success, the expectations in decision-making power, shared responsibility and accountability must be clearly outlined at the beginning.

The GCNMO addresses policy issues involving partnership in areas such as regulation, public policy deliberation, policy engagement, public awareness, and knowledge development and research. Continuing to build partnerships will contribute to strengthening health services and systems.

WHO-AFRO: MR CHRIS RAKUOM, CHIEF NURSING OFFICER, MINISTRY OF HEALTH, KENYA

Kenya's experience in successful partnerships was shared in two areas.

1. Setting up a nursing and midwifery workforce database
   The partnership to develop the workforce database involved the United States Emory University and the Centers for Disease Control and Prevention as experts/developers, and the Nursing Council of Kenya and the Government of Kenya as contributors/end users. This partnership evolved in phases and was directed through a memorandum of understanding with respective roles clearly outlined for each phase. Issues were jointly resolved, such as the need for continuity and sustainability of the database.

Feedback on progress has been shared with nurses and they are motivated to continue to provide the data that will assist in determining shortage, monitoring distribution and managing skills mix. Extension of the initiative is now being considered for other health workers.

2. **Emergency recruitment of nurses to address shortages**

   Partners worked together to address the shared need for emergency recruitment of nurses, given the public sector's inability to meet the demand: Clinton Foundation (Danish Programme), Global Fund to Fight AIDS, Tuberculosis and Malaria, the Capacity Project, WHO, UNICEF, UNFPA and the Government of Kenya. The goal of increased recruitment of nurses for HIV has focused on two districts and nurses are often deployed to where the need is urgent. During the period 2004–2007, the Ministry reported recruitment of 3424 nurses as well as 1370 other health workers.

WHO-EMRO: MRS ASSIA ESSMAN AHMMED, NURSING FOCAL POINT, WHO SUB-OFFICE, SOMALIA

Somalia is experiencing a complex emergency situation due to the past 15 years of civil war and conflict. Nursing reflects the isolation and neglect within an underdeveloped health system that is poorly resourced and imbalanced.
In 2002, a situational assessment was completed by WHO-EMRO through the Regional Adviser for Nursing and Allied Health Personnel to identify gaps. Table 5.1 summarizes the findings that emerged.

TABLE 5.1 SUMMARY OF FINDINGS OF WHO-EMRO SITUATIONAL ASSESSMENT OF NURSING IN SOMALIA		
Human resources	Education	Practice
Critical shortage of qualified individuals	Absence of student accommodation	Lack of health professional regulations
Lack of accurate information – numbers and nature	Absence of national standard curriculum development	Proliferation of disease- specific vertical programmes
Lack of clarity and role definition	Lack of faculty and learning materials	Deficient clinical training sites at hospital and community level
Low morale of staff due to low salaries	Isolation from regional and international experience	Inadequate supplies for provision of care

WHO is now leading an action plan that is focusing on education and training, and involves specific partner contributions from UNESCO, the United Nations High Commissioner for Refugees (UNHCR) and UNICEF (Table 5.2).

TABLE 5.2 ACTION PLAN ON EDUCATION AND TRAINING, BY PARTNER CONTRIBUTION	
Partner	Partnership contribution
WHO	Supporting most country services: reopening of the nursing schools, development of the nursing and midwifery curriculum, building the capacity of nursing and midwifery tutors, training of clinical preceptors, logistics
UNESCO	Supported a workshop on teaching methodology for health science teachers
UNHCR	Supported building two blocks of student accommodation
UNICEF	Supported provision of chairs and tables

Since 2002, measurable achievements have been reported. WHO is focusing on building the capacity of health authorities, nurses, midwives and allied health personnel through:
- fellowships, training and workshops to update knowledge and skills;
- revision and updating of the nursing and midwifery curriculum;
- funding three nursing schools in the country;
- funding training on Intranet Access to Research Initiative (HINARI) with 10 institutes registered;
- Very Small Aperture Terminal (VSAT) system for distance;
- provision of teaching materials and libraries;
- training of 65 clinical preceptors;
- education of 152 nursing graduates.

The partnership is making a difference in re-building our nursing and midwifery workforce.

WHO-EURO: MR SERGIO DAVID GOMES, CHIEF NURSING OFFICER, PORTUGAL

In Portugal, the CNO views its key partners as (i) all Ministry of Health services; (ii) the Portuguese Council of Nurses; and (iii) other nursing associations and colleges. A window of opportunity now exists for strategic nursing contributions in targeted areas of reform.

The CNO Executive Commission is a strategic and advisory body created to support the CNO in defining strategies to facilitate the implementation of priority nursing measures. Priorities for action in nursing encompass training, accessibility, practice and staffing guidelines, home nursing, service management and integration, safety and effectiveness, visibility and marketing, and information systems.

Through partnership, and taking into account the WHO GPW 2008–2009, a national strategic plan for nursing is being defined that considers a wide range of issues including:
- the value and proximity of nursing care;
- new contexts in school training;
- nurse involvement in the primary health care system, especially the Continuous Health Care Network;
- incorporation of nursing interventions into the national health programmes;
- planning of nursing care as a "Reference Nurse";
- the needs in nursing human resources (general and specialized nurses);
- using the Patients' Classification System to determine care hours;
- good nursing practices centred on clinical skills and research;
- national performance indicators for nurses;
- priority areas for investigation and research;
- development and organization of human resources.

WHO-SEARO: MS DURGA SHARMA, CHIEF NURSING OFFICER, NEPAL

Since the Nepal Nursing Council was formed in 1997, the nursing system has increased its capacity in nursing and midwifery, and experienced growth within institutional and home-based service delivery. The current focus is on improving hospital-based care, revising the education curriculum, offering incentives to skilled birth attendants and continuing training in nursing leadership.

Collaboration has been established with the Family Health Division and Institution of Medicine. These developments have had a positive impact as demonstrated by:
- reduced fatality and improved recovery rate;
- reduced maternal mortality rate from 539 to 281 and newborn mortality rate from 39 to 33 in 2006;
- increasing home delivery by SBA;
- increased efficiency and effectiveness of service delivery and management.

Recommendations for future action to strengthen nursing and midwifery, and the health system are to:
- initiate midwifery education in the country;
- increase capacity of the nurses and midwives focusing on leadership training;
- re-establish a Nursing Division in the Health Department;
- continue networking at regional and international levels;
- launch the global agenda to make the nursing and midwifery profession effective.

WHO-WPRO: MS PAULINE TAN, CHIEF NURSING OFFICER, SINGAPORE

In Singapore, there is a dual system of health care delivery. The Government manages the public system while private hospitals and general practitioners provide the private system. The health care delivery system encompasses primary health care provision at private medical practitioners' clinics and outpatient polyclinics, and secondary and tertiary specialist care in the private and public hospitals.

The system's current challenges are to improve human resources, develop nursing capacity, enhance standards, and strengthen coordination and continuity of care. Nurses are involved more in polyclinics and other specialized care.

Strategic leadership in the country is provided under the leadership of the Ministry of Health and through collaboration with the public sector health care system and health-care professionals. A Strategic Nursing Partnership is in place that involves:
- private-public sector partnership: services, standards of care, benchmarking, patient safety, quality improvement;
- service-education partnership: training standards, comprehensive training, capacity building;
- hospital-community partnership: continuity of care, coordination of care, consistent standards.

In practice, the CNO meets with a wide range of partners on a regular basis to review problems and challenges, and develop common strategies for a comprehensive patient-centred health care system. Partners are involved in agenda setting, implementation and evaluation.

CONCLUDING REMARKS: DR JUDITH SHAMIAN, MODERATOR

The presentations highlight the partnership dynamics: dialogue and feedback; action in times of crisis; involvement of external and internal organizations; the power of evidence; and focus on outcomes. There are many faces to partnership and one partnership approach does not fit all situations.

DEVELOPMENT OF GLOBAL NETWORK FOR GOVERNMENT CHIEF NURSES AND MIDWIVES

MODERATOR: MS AUDREY SCOTT, CHAIRPERSON, REGIONAL NURSING BODY, CARIBBEAN COMMUNITY (CARICOM); CHIEF NURSING OFFICER, ST. VINCENT AND THE GRENADINES

The Regional Nursing Body of the Caribbean has been in existence for close to 50 years with a formal structure established in 1972. Constituencies represented are 16 CARICOM states, four associate states and five institutions (Caribbean Development Bank (CDB), Caribbean Law Institute / Caribbean Law Institute Centre (CLI/CLIC), Organisation of Eastern Caribbean States (OECS), University of Guyana (UG), University of the West Indies (UWI)) and PAHO. Constituents collaborate and function as a non-statutory autonomous body that is advisory to governments.

Its purpose is to deal with problems that cannot be solved by individual countries while its formal objective is stated as:

> "To set and maintain standards of Nursing Education and Nursing Practice in unit territories through regional co-operation. The ultimate goal is the provision of a sufficient quantity of adequately prepared nursing personnel to meet the health care needs of the countries of the Region."

Achievements and current activities of this group are further evidence of the power and impact of partnership:
- developed a "Manage Migration Strategy";
- developed a regional action plan for nursing and midwifery;
- conducted a survey of nursing schools;
- developed a regional examination for nurse registration;
- lobbied for the CNO post in some countries;
- developed regional standards for practice and education as well as audit tools.

Current activities:
- reviewing standards of practice and education;
- developing proposal for the accreditation of nursing education;
- reviewing the Registered Nurse Curriculum to BSc.

Through partnership, much has been achieved.

MR MARC JONES, CHIEF NURSING OFFICER, NEW ZEALAND

The Forum listened with interest to a proposal for the development of a Global GCNMO Network. Mr Jones articulated the potential impact that a group of nurses can have if they work together to influence change. As a global resource, he suggested that the proposed GCNMO network would act as:
- a support network
- an expert resource
- an international lobby
- a "safe" reference group
- a group to connect with other professionals.

A future GCNMO network could build on the three meetings held to date and the experience of established regional networks (e.g. WPRO-South Pacific Nursing and Midwifery Officers Alliance, WHOCC) and other emerging networks. Some basic elements already exist while others issues need to be addressed.

The global GCNMO group is growing in size and communication between meetings is often difficult. The group's diverse skills and talents could be applied to the work that needs to be done. At the same time, there could be international consistency and translation of declarations to regional- and country-specific contexts.

The proposed GCNMO network could involve the further development of regional networks with consistent terms of reference and some regional flexibility. WHOCCs are central to the work of GCNMOs given their role as the research-practice-policy nexus for quality patient care and should be linked to any future regional network.

"Regional networks, connecting globally" can share and plan for better care. Mr Jones indicated that he would be interested in working with several other GCNMOs to explore the Global GCNMO Network concept, determine its scope, and design a working model for future consideration and implementation.

MS FATEMA ABDEL WAHED, CHIEF NURSING OFFICER, BAHRAIN

Gulf countries are part of WHO-EMRO and share many similarities. The Gulf Nursing Technical Committee (NTC) was formed in 1992 and functions in collaboration with the Gulf Cooperation Council (GCC). Each GCC country has two representatives – nursing services and nursing education. The NTC goals are to:
- study the status of nursing in GCC countries;
- determine the challenges and barriers facing the nursing profession in education, training and service delivery;
- draw up regional strategic plans to resolve challenges;
- exchange information and expertise among GCC nursing leaders in nursing regulation, practice and education;
- maintain standardization of nursing education and training;
- determine classification and levels of nursing workforce;
- draw up plans to expand GCC national nursing workforce.

The NTC is responsible for providing strategic and policy advice to the GCC Health Minister Council on strengthening nursing within the region. Since 1993, four regional strategic plans have been developed, promoted by the Committee and implemented by member countries. The strategic framework has six key elements: leadership development, human resources, nursing education, quality of nursing services, regulation and research, and evidence-based practice. Past achievements and future directions are based on the identification of regional challenges and priorities (Table 5.3).

TABLE 5.3 EMRO STRATEGIC FRAMEWORK, ACHIEVEMENTS AND FUTURE DIRECTIONS	
Achievements	**Future directions**

• Establishing a nursing directorate and administration in the Ministry of Health
• Establishing nursing licence and regulation
• Upgrading the entry level for nursing education to high school certificate in all GCC countries
• Standardization of:
  - basic nursing education curriculum
  - classification of nursing workforce (title and levels)
  - elements of nursing workforce data bank at country level
• Publishing:
  - GCC Nursing Code of Conduct
  - guidelines and standards (standards of nursing education, academic accreditation, patient safety framework for nursing law, etc.)
• Maintaining GCC Best Nurse Award programme
• Maintaining regional nursing seminars
• Establishing Nursing Specialization Council for GCC States
	• Improve nursing cadre, salaries and incentives
	• Increase BSN bridging programmes and have BSN as entry level into practice
	• Increase nursing specialization programmes
	• Establish nursing council within each GCC country
	• Implement massive plans to attract more nationals into the profession
	• Conduct regional nursing research

DR MARGARET USHER-PATEL, SCIENTIST, COMMUNITY OF PRACTICE PARTNERS OF THE IMPLEMENTING BEST PRACTICES (IBP) INITIATIVE, WHO

If the vision is to create a global network of GCNMOs and build on the momentum created at meetings, the concept of "communities of practice" (COP) could be used to support collaborative learning and knowledge sharing. In order to inform the policy dialogue and exercise power in partnership, there is need to keep networking, continue the dialogue, share resources/knowledge/experience, support each other and grow as a community. The COP concept refers to a process of social learning that occurs when people who have a common interest in some subject or problem collaborate over an extended period to share ideas, find solutions and build innovations.

To assist COP, WHO has developed a virtual system (IBP Knowledge Gateway) supported by the partners of the Implementing Best Practices (IBP) Initiative in Reproductive Health. This Internet-based technology functions easily through e-mail and can be accessed from anywhere, even rural areas. It can connect individuals to global and specific communities of practice unlocking a world of information (e.g. libraries, discussion forums, events calendars, announcements, administrative support and a helpline, linkages with experts, international agencies, collaborating centres, institutions and centres of excellence).

In 2008, the IBP Gateway reached 180 countries. In fact, the Global Alliance for Nursing and Midwifery Communities of Practice was launched in 2008 *(7)*.

The idea is to connect people and discuss issues. If GCNMOs decide to use the IBP Knowledge Gateway to connect globally to share knowledge and resources, individuals would join the COP and receive and respond to the e-mails. Each individual can decide how often to receive e-mails, including attachments that are sent and held virtually so as not to overload individual e-mail systems.

In order to make this work for the GCNMOs, the group must make a commitment and have a core planning group. The group must examine the COP system and develop a strategy that offers opportunities to continue and contribute to the policy dialogue without creating system overload. It is a shared responsibility with the focus on sharing experiences and resource materials, as well as advice and support.

Discussion points on the Global GCNMO Network

A network could help strengthen the nursing profession's voice in national and international dialogues. One member expressed the value of the COP system in terms of improving technical support, receiving documents and engaging in discussion on specific issues. It was noted that the need to connect had been stated in the past; however, there had been a lack of adequate follow up to these discussions.

The group was asked about their interest in both the Global GCNMO Network and establishing a COP using the IBP Knowledge Gateway. Although some believed it would be an excellent way to communicate and connect to the external world, others expressed concern about the demands and expertise required for ongoing management of the proposed COP. Participants were reassured that it would be a shared responsibility to structure and maintain the network.

Key conclusions and actions

1. There was general support for a Working Group to further explore the concept of a Global GCNMO Network and the most effective approach.
2. New Zealand (Mr Mark Jones, CNO) volunteered to further explore the concept of a Global GCNMO Network in collaboration with several other individuals (yet to be identified; Bahrain, Bermuda).

ROLES AND FUNCTIONS OF GCNMOS

PROFESSOR JILL WHITE, DEAN, FACULTY OF NURSING, UNIVERSITY OF SYDNEY, AUSTRALIA

It is important to have a clear understanding of the roles and functions of GCNMOs and the relationships between their work and the work of WHO. Professor White explored this relationship while working for six weeks in 2007 at WHO through the Nurse Scholar Programme.

The role of the GCNMO is understandably complex as the system struggles to face diverse health and system challenges. As political interest in health and education grows, there are new opportunities for GCNMOs to influence and impact on services and policy. This role can be examined by exploring the context of health care change, the rationale for the role of the GCNMO, and models of GCNMO operation and competencies.

Context of health care change

An environmental scan identifies many elements that shape the context for health care change: developing countries, health-care professionals, health care delivery, changing workplace, educational issues and political issues. Protection of the public in accessing quality and safe health services can be facilitated through regulation and adequate human resources. In nursing, increased patient mortality and "failure to rescue" is associated with levels of staffing, education and experience. The system has also realized that staff satisfaction and retention is important.

WHO is often involved in the development and endorsement of global declarations that impact nursing and midwifery:

1. *2006 World Health Assembly Resolution on Strengthening Nursing and Midwifery (WHA59.27);*

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2. *Working together for health: The World Health Report 2006, and Policy Briefs, 2006;*
3. *Nursing and Midwifery Services: Strategic Directions 2002–2008, WHO, 2002;*
4. *Islamabad Declaration on Strengthening Nursing and Midwifery, 4–6 March 2007;*
5. *Chiang Mai Declaration: Nursing and Midwifery for Primary Health Care, February 2008;*
6. *Strategic Directions Nursing and Midwifery 2009–2015 and the Global Programme of Work 2008–2009.*

The diagram below depicts the inter-relationship that the CGNMO has with many groups that contribute to the achievement of improved health service delivery.

In order to have effective health care delivery, the system needs appropriate: (i) programmes for health status improvement; (ii) processes for health systems and services improvement; and (iii) policy for health policy improvement and leadership development. While WHO is more involved in programmes and processes, the GCNMO plays a major role in policy and implementing such declarations at the national level.
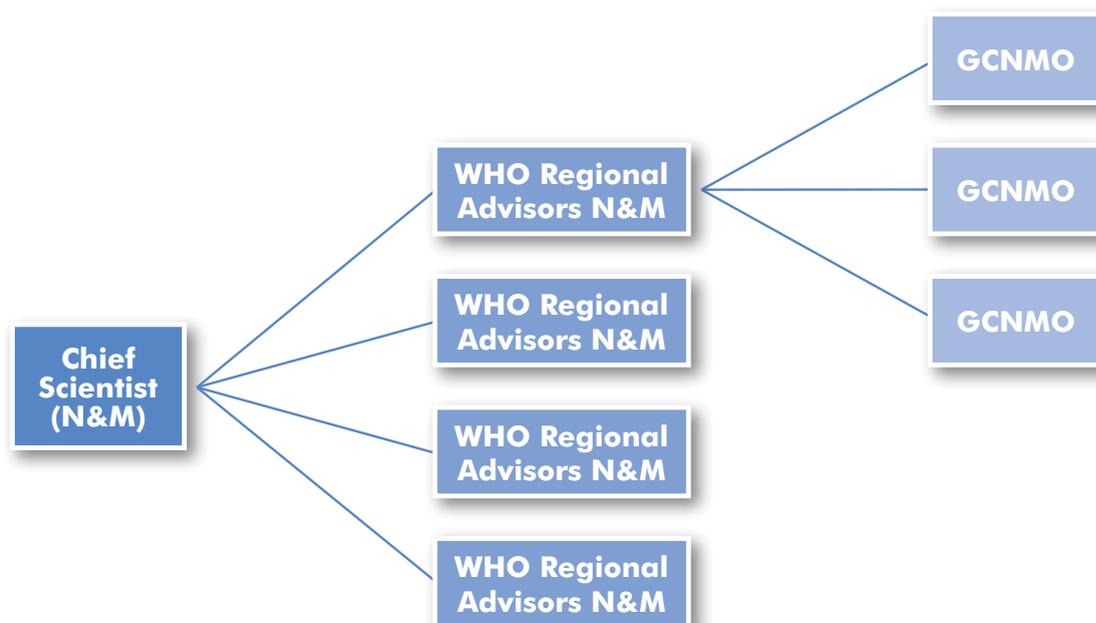
Rationale for the role of the GCNMO
The questions are often asked why nurses and midwives should be included at the decision-making table and why the GCNMO is needed at all. Findings from the review would suggest that the GCNMO is the government link to the profession. Table 5.4 outlines the rationale for involvement in programmes, processes and policy.

TABLE 5.4 RATIONALE FOR THE ROLE OF THE GCNMO	
GCNMO role	Description of rationale
Programmes (management, staffing, monitoring)	Programmes require preparatory education, models of care, staffing with specialist education and oriented staff. Outcomes need data accurately recorded, collected and analyzed. All these aspects require coordination and commitment from professional groups through the GCNMO.
Processes (health systems and services planning, management, monitoring)	The GCNMO has an integral role in all workforce development aspects for the largest component of the health workforce: recruitment, migration, retention, safe workplace, education standards and numbers, scope of practice, skill-mix, models of care, especially primary health care. The GCNMO is able to contribute evidence-supported wisdom.
Policy (understanding, implementation, influence)	The GCNMO is the government and policy link to the professions: • professional organizations (continuing professional education, credentialing); • regulatory authorities (scope of practice, code of conduct, discipline, registration of local health professionals; • accreditation authorities (standard of programmes): • educational institutions (numbers, recruitment and standard of new graduate, specialty education, research); • directors of nursing and midwifery practice (staffing, skill mix, safety and quality, workplace environment, retention, career structure, models of care); • Other health professionals (collaboration and inter-professional learning and practice). Establishes an effective mechanism for nursing and midwifery contribution to government health policy and decision-making in order to meet the health needs of the country. This need is greater in the face of constrained human, financial and other resources, and the burden of chronic and emerging diseases.

Models of GCNMO operation

The models of GCNMO operation relate to the ability to influence policy with four being described by Shamian (2006) *(8)* as:
- the "Dispersal Model" (no longer have GCNMO and roles dispersed, usually no longer central to decision-making);
- the "Advisory Model" (federated systems where operational management at state or regional level and central position advisory BUT engaged in national policy decision-making);
- the "Executive Model" (national ministries with GCNMO having line authority over nurses and nursing within their jurisdiction, need high-level reporting relationships *(9)*);
- the "Program Model" (manage specific programmes, content expert/manager, cross sector linkages but not across the discipline as a whole).

Whether the models are advisory or executive in nature the essential features for operating effectively are authority, access, recognition of the position and adequate support.

Competencies

The suggested competencies for GCNMOs have been drawn from several key literature references *(10,11,12,13,14)*. The primary domains are "public service" and "health leadership" for which a description is provided in Table 5.5.

TABLE 5.5 DESCRIPTION OF THE PRIMARY DOMAINS OF THE GCNMO ROLE	
Public service **the ends = public good**	**Health leadership** **the means = nursing and midwifery**
• Public policy development and implementation • Understanding the political process and being politically savvy • Convening meetings and networking • Collaborating across disciplines and sectors • Building and maintaining partnerships • Being a disciplinary spokesperson	• Transformation capacities: strategic approach based on analytical thinking, researching, information seeking, finance, innovation • Execution capacities: collaboration, communication, technical management of information, performance measurement, project management, initiative and organizational awareness • People capacities: team leadership, human resources management, interpersonal understanding, self-confidence and professionalism

Source: (16) (from National Centre for Health Leadership).

Beyond the service and leadership skills, the GCNMO must develop other critical abilities to be effective: understanding public policy, understanding the political process and understanding the use of data to make compelling cases for change.

Understanding public policy (adapted by J. Shamian & ONP from Tanlov, 1999)
The policy cycle involves an eight-step process of "getting to the policy agenda":
- values and beliefs
- problem or issue emerges
- knowledge development and research
- public awareness
- political engagement
- interest group activation
- public policy deliberation and adoption
- regulation, experience and revision.

Understanding the political process (15,16)
Four stages of political development are identified: stage 1 (buy-in), stage 2 (self-interest), stage 3 (political sophistication), and stage 4 (leading the way). Each stage is characterized by five elements: (i) nature of the action; (ii) language; (iii) coalition-building; (iv) nurses as policy-shapers; and (v) building relationships.

Understanding the use of data to make a compelling case for change
Using data to make a compelling case for change demands that GCNMOs demonstrate information systems management, research literacy, financial literacy, ability to be articulate with multiple audiences, and self-confidence and professionalism.

In conclusion, Professor White indicated that although growing evidence associates appropriate nursing and midwifery services with significant health improvements, the influence of nurses and midwives on health policies and programmes is described as inconsistent and, at times, nearly absent.

The importance of the GCNMO role relates to the fact that, in most countries, nurses are "health care" and "the glue" that hold the health system together (i.e. 60–70% globally and up to 85% in some countries). The GCNMO is the link to the policy table and policy is the bridge to change.

Discussion points

It was felt that the presentation on the GCNMO role provided a realistic context and can contribute to the discussion on how GCNMOs can support each other in their respective roles. This conversation could start through the COP and by exploring the development of a Global GCNMO Network.

The African region has a need to develop training and support GCNMOs. Tenure is often brief and, without adequate training, performance and effectiveness are affected. Regional or global COP may be more feasible and could prevent the feeling of isolation.

In future, participants would like to spend more time discussing and developing their role. In the meantime, there may be regional opportunities. This information can assist in responding to questions about why GCNMOs should be at the policy table. However, to have a lasting impact, resources, research and evidence are needed. Countries must share research and practices. Information is available on the Internet, but more relevant information on country experiences would be valuable. The regional COP is the starting point, but it is also important to link with the WHOCC.

GCNMO key conclusions and actions
- There is a need for increased training and support of GCNMOs.
- More time must be allocated at a future meeting to discuss and develop the role of the GCNMO.
- GCNMOs must share research and practices.

ORIENTATION TO THE 2008 WORLD HEALTH ASSEMBLY

Mr Norbert Dreesch reviewed the rules and functioning of the World Health Assembly and responded to questions on the process to better prepare delegates for their participation.

Rules and procedure
1. Convened by the WHO Director-General once a year based on Executive Board (EB) decision or, in exceptional cases, at the request of a majority of Member States or at the request of the EB.
2. Invitations cover Member States and all nongovernmental/intergovernmental agencies in official relations.
3. The Agenda of the WHA is prepared by the EB at its January session preceding the Assembly.
4. The Assembly elects its officers from its members (i.e. a President and Vice-Presidents for a duration of one year and Chairs of Committees A and B).

Agenda item discussions and resolutions (from official documents)
a) The annual report of the Director-General on the work of the Organization.
b) All items that the Health Assembly has, in a previous session, ordered to be included.
c) Any items pertaining to the budget for the next financial period and to reports on the accounts for the preceding year or period.

d) Any item proposed by a Member or by an Associate Member.

e) Subject to such preliminary consultation as may be necessary between the Director-General and the Secretary-General of the United Nations, any item proposed by the United Nations.

f) Any item proposed by any other organization of the United Nations system with which the Organization has entered into effective relations.

The General Committee reviews the proposed items after the opening of the Assembly and submits them to the Plenary meeting for adoption.

There are two committees with their respective chairs and secretariat support discussing Agenda items and proposing resolutions for adoption by the Plenary meetings of members.

a) Committee A – to deal predominantly with technical programme matters.

b) Committee B – to deal predominantly with administrative, financial, budget and legal matters.

Summary of WHA meeting process

○ Opening of the Assembly and election of officers (President, Vice-Presidents, Committee A and Committee B chairs and other officers).

○ Working sessions in Committees A and B discussing and deciding on Agenda items proposed.

○ Resolutions on Agenda items developed by Member States.

○ Resolutions are submitted to the Plenary sessions for adoption.

Government Chief Nursing Officers' involvement

GCNMOs were advised to seek out the WHA agenda and background information provided to the delegations. It was noted that the progress report on nursing is one of the agenda items. If a country decides to make an intervention, the GCNMO can advise their delegations on relevant issues and actions related to strengthening nursing and midwifery using the progress report and Forum conclusions as a guide.

FORUM STATEMENT

Participants recognized that the scope of matters considered at the Forum was a true reflection of the breadth and complexity of issues they face as GCNMOs. To acknowledge and conclude the discussion, a Forum Statement was developed.

Acknowledging the critical contribution of nursing and midwifery to health systems and the health of the people and the communities they serve;

Reaffirming, in the face of global HRH shortage and acknowledging that some countries are in crisis, the ongoing and urgent need to scale up nursing and midwifery capacity to contribute to the achievement of the MDGs through the primary health care approach; and

Recognizing the intensive planning and action undertaken by the WHO and GCNMOs, and the recommended directions contained within the Strategic Directions for Nursing and Midwifery (2009–2015), and the Global Programme of Work for Nursing and Midwifery (2008–2009);

The delegates and participants of 2008 GCNMO Forum agree:
1. *to accelerate collaborative efforts and build partnerships, at all levels, to move the recommended strategies and plans to action that will deliver results for improved global health;*
2. *such efforts by nursing and midwifery requires the highest level of political commitment and policy leadership through an inter-sectoral approach and the active participation and leadership of GCNMOs;*
3. *each Member State should support the position of a CNMO within its national government, and the associated resources that are required to support these initiatives.*

The Forum will convene in two years' time (2010) to consider and evaluate the impact of the agreed programme of work.

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ANNEX 1: LIST OF PARTICIPANTS

Temporary Advisers

Mrs Fatema Abdel Wahed, Head of Nursing, Ministry of Health, Manama, BAHRAIN
(E-mail: Ahmed1@health.gov.bh)

Ms Alejandra Acuna, Presidenta del Consejo Nacional des enfermedades, Ministerio de Salud, San José, COSTA RICA
(E-mail: acunaenator@gmail.com)

Mrs Assia Essman Ahmmed, Nursing Focal Point, WHO Sub-office, Hargeysa, SOMALIA
(E-mail: fayemih@nbo.emro.who.int)

Mrs Ghada Al Aylé, Project Coordinator, Mother and Child Department, Ministry of Public Health, Beirut, LEBANON
(E-mail: nndp@terra.net.lb)

Mr Majed Al Mokkabal, Director of Nursing & Midwifery Affairs, Ministry of Health, Muscat, OMAN
(E-mail: majid.almaqbali@gmail.com)

Mr Facial Alaoui, Head of Nursing Continuing Education, Ministry of Public Health, Tunis, TUNISIA
(E-mail: alaoui45@yahoo.fr)

Dr Youssef Al-Shouaibi, Director General for Nursing, Ministry of Public Health and Population, Sana'a, YEMEN
(E-mail: yousef5_2@hotmail.com)

Ms Barbara Ashwood, Chairperson, Bermuda Nursing Council, Ministry of Health, Paget, BERMUDA
(E-mail: not available)

Dr Sheila Bandazi, Deputy Director of Nursing Services, Ministry of Health of Malawi, Lilongwe 3, MALAWI
(E-mail: bandazi411@yahoo.co.uk)

Mrs Christine Beasley, Chief Nursing Officer, Department of Health, London SW1 2NS, UNITED KINGDOM
(E-mail: christine.beasley@dh.gsi.gov.uk)

Ms Maria del Carmen Becona, Chief Nursing Officer, Ministry of Health, URUGUAY
(E-mail: not available)

Mrs Yusupova Bermet, Chief Nursing Officer, Ministry of Health, Bishkek 720033, KYRGYZSTAN
(E-mail: RahmatovaD@euro.who.int)

Ms Alicia Cabrera, Membro Equipo Tecnico del Departamento de Evaluación de Calidad de Servicios del Ministerio de Pública, Profesora Titular de la Facultad de Enfermeria de Universidad de la Republic Montevideo, URUGUAY
(E-mail: alicab@adinet.com.uy)

Ms Brenda Canitz, Assistant Executive Director, Office of Nursing Policy, Health Canada, Ottawa, ON K1A 0K9, CANADA
(E-mail: brenda_canitz@hc-sc.gc.ca)

Ms Cynthia Mery-Le-Bone Chasokela, Chief Nursing Officer, Director of Nursing Services, Ministry of Health & Child Welfare, Harare, ZIMBABWE
(E-mail: cmzchasokela@yahoo.com)

Ms Beta Cholewka, Acting Director, Office for Nurses and Midwives, Ministry of Health, 00-952 Warsaw, POLAND
(E-mail: b.cholewka@mz.gov.pl)

Mrs Kanjana Chunthai, Director, Bureau of Nursing, Department of Medical Services, Ministry of Public Health, Royal Thai Government, Nonthabury 11000, THAILAND
(E-mail: chunkanjana@hotmail.com)

Ms Isobel Costa Mendes, Director, WHO Collaborating Centre for Nursing Research and Development, University of Sao Paulo, College of Nursing at Ribeirão Preto, Sao Paolo CEP 14040-902, BRAZIL
(E-mail: coopintl@eerp.usp.br)

Ms Audrey Gittens-Scott, Chief Nursing Officer, Regional Nursing Body and the Ministry of Health, Ministry of Health and the Environment, Kingstown, SAINT VINCENT AND THE GRENADINES
(E-mail: mohesvg@vincysurf.com)

Mrs Azam Givari, General Director of Nursing Department, Ministry of Health & Medical Education, Tehran, ISLAMIC REPUBLIC OF IRAN
(E-mail: a_givari@yahoo.com)

Mr Sergio David Gomes, Chief Nursing Officer, Public Health Line Directorate-General of Health, 1049-005 Lisbon, PORTUGAL
(E-mail: sergiogomes@dgs.pt)

Mrs Hanan Halwani, Field Nursing Officer, Health Department UNRWA, C/O Dr Guido Sabatinelli, United Nations Relief and Works Agency, Amman, JORDAN
(E-mail: H.halwani@unrwa.org)

Mrs Ana Maria Heredia, Inter-Institutional Commission on Nursing, Ministerio de Salud, 1408 Buenos Aires, ARGENTINA
(E-mail: aheredia@cas.austral.edu.ar)

Mrs Marcel Johnson, Acting Director of Nursing, Ministry of Health and Social Development, Nassau, New Providence, BAHAMAS
(E-mail: marceljohnson@bahamas.gov.bs)

Mr Mark Jones, Chief Advisor (Nursing), Clinical Services Directorate, Ministry of Health, Wellington, NEW ZEALAND
(E-mail: mark_jones@moh.govt.nz)

Ms Roxanne Kipps-Jackson, Midwifery Officer, C/O Department of Health, Hamilton, BERMUDA
(E-mail: rkippsjackson@gov.bm)

Dr Lubica Kontrova, Chief Nursing and Midwifery Officer, Ministry of Health of the Slovak Republic, 837 52 Bratislava 37, SLOVAKIA
(E-mail: lubica.kontrova@health.gov.sk)

Dr Wipada Kunaviktikul, Director, WHO Collaborating Centre for Nursing and Midwifery Development, Faculty of Nursing, Chiang Mai University, Chiang Mai 50200, THAILAND
(E-mail: wipada@mail.nurse.cmu.ac.th)

Ms Gaylia Landry, Chief Nursing Officer, Department of Health, Hamilton HM EX, BERMUDA
(E-mail: gelandry@gov.bm)

Ms Chrissoula Lemonidou, National Focal Point for Nursing, Professor of Nursing, Nursing Faculty, University of Athens, 11527 Athens, GREECE
(E-mail: clemonid@cc.uoa.gr)

Ms Huaping Liu, Chief Nursing Officer, School of Nursing, Peking Union Medical College, Beijing, CHINA
(E-mail: huapingliu2@126.com)

Ms Sandra Macdonald-Rencz, Executive Director, Office of Nursing Policy, Health Canada, Ottawa, ON K1A 0KA, CANADA
(E-mail: sandra_macdonald-rencz@hc-sc.ge.ca)

Dr Amal Mansour, Chief, Mother and Child Department, Ministry of Public Health, Tehran, ISLAMIC REPUBLIC OF IRAN
(E-mail: nndp@terra.net.lb)

Mr Paul Martin, Chief Nursing Officer, The Scottish Office Department of Health, Directorate of Nursing, Edinburgh EH1 3DG, UNITED KINGDOM
(E-mail: paul.martin@scotland.gsi.gov.uk)

Mr Grzegorz Mazurczak, Senior Specialist, Office for Nurses and Midwives, Ministry of Health, 00-952 Warsaw, POLAND
(E-mail: g.mazurczak@mz.gov.pl)

Ms Nancy McKay, President, Management Dimensions Inc., Bathurst, NB E2A 3S2, CANADA
(E-mail: nemckay@nb.aibn.com)

Dr Leila McWhinney-Dehaney, Acting Chief Nursing Officer, Ministry of Health and Environment, Kingston, JAMAICA
(E-mail: dehaney@MOHE.gov.jm)

Mrs Stavroulla Michael, First Nursing Officer, Ministry of Health, Nicosia 1448, CYPRUS
(E-mail: nursingservices@moh.gov.cy)

Mrs Janet Michael, Director General, Nursing and Midwifery, Ministry of Health, Government of Southern Sudan (GOSS), Juba Region, SUDAN
(E-mail: janetmicheal50@yahoo.com)

Ms Suzanne Michaud, Senior Nursing Consultant, Office of Nursing Policy, Health Canada, Ottawa, ON K1A 0K9, CANADA
(E-mail: suzanne_michaud@hc-sc.gc.ca)

Ms Mantsebo Moji, Chief Nursing Officer, Ministry of Health and Social Welfare, Maseru, LESOTHO
(E-mail: mphoma547@gmail.com; cno@lesotho.gov.ls)

Ms Hariette Molijn, Chief Nursing Officer, Ministry of Health, Mbabane, SWAZILAND
(E-mail: vogez@sr.net)

Mr Gustav Moyo, Chief Nursing Officer, Ministry of Health, Dar-es-Salaam, UNITED REPUBLIC OF TANZANIA
(E-mail: gusmoyo@yahoo.com)

Mr Clavery Mpandana, Chief Nursing Officer, Ministry of Health, Dar-es-Salaam, UNITED REPUBLIC OF TANZANIA
(E-mail: claverympandana@yahoo.co.uk)

Mrs Gloria N.N. Muballe, Chief Nursing Officer, Ministry of Health and Social Services, Windhoek, NAMIBIA
(E-mail: gnnmuballe@yahoo.com)

Mrs Dorica Sakaka Mwewa, Chief Policy Analyst, Nursing Services, Ministry of Health Headquarters, Lusaka, ZAMBIA
(E-mail: doricamwewa@yahoo.com)

Ms Yoko Nomura, Director, Nursing Division, Health Policy Bureau, Ministry of Health, Labour and Welfare, Tokyo 1008916, JAPAN
(E-mail: nomura-yoko@mhlw.go.jp)

Ms Sheila O'Malley, Chief Nursing Officer, Department of Health and Children, Dublin 2, IRELAND
(E-mail: Sheila_O'Malley@health.gov.ie)

Mrs May Osae-Addae, Chief Nursing Officer, Director of Nursing Services, Ministry of Health, Accra, GHANA
(E-mail: Mayaddae@yahoo.com)

Dr Marjaana Pelkonen, Docent, Senior Officer, Health Promotion and Disease Prevention, Health Department, Ministry of Social Affairs and Health, 00170 Helsinki, FINLAND
(E-mail: marjaana.pelkonen@stm.fi)

Mr Chris Rahuom, Chief Nursing Officer, Ministry of Health, Nairobi, KENYA
(E-mail: cprakuom@yahoo.com)

Dr Carol Romano, Assistant Surgeon General, Acting Chief of Staff, Office of the Surgeon General, Chief Nursing Officer, Rockville, MD 20857, UNITED STATES OF AMERICA
(E-mail: cromano@cc.nih.gov)

Ms Aminath Saeed Firag, Director of Nursing, Indira Gandhi Memorial Hospital, Male, MALDIVES
(E-mail: saeed_aminath@hotmail.com)

Ms Alice Salamanca, Secretary, National League of Philippine Government Nurses Inc. (NLPGN Inc), Manila, THE PHILIPPINES
(E-mail: bessieborja@hotmail.com)

Ms Rigbe Samuel, Head of Nursing Services and Quality Assurance Unit, Ministry of Health, Asmara, ERITREA
(E-mail: rigbe_11@yahoo.com)

Dr Judith Shamian, President & CEO, Victorian Order of Nurses, Ottawa, ON K2P 1B4, CANADA
(E-mail: Judith_Shamian@von.ca)

Ms Durga Sharma, Nursing Chief, Ministry of Health & Population, Government of Nepal, Kathmandu, NEPAL
(E-mail: d_durgas@yahoo.com)

Dr Sara Botros Shokai, Nursing Focal Point, Federal Ministry of Health, Khartoum, SUDAN
(E-mail: Sara_shokai@yahoo.co.uk)

Ms Pauline Tan, Chief Nursing Officer, Manpower Standard and Development Division, Ministry of Health, Singapore 169854, SINGAPORE
(E-mail: Pauline_Tan@moh.gov.sg)

Dr Lis Wagner, Institute of Clinical Research, Research Unit of Nursing, 5000 Odense C, DENMARK
(E-mail: lwagner@health.sdu.dk)

Mrs Adeline Welin, Principal Tutor, Vanuatu Center for Nursing Education, Ministry of Health, Port Vila, VANUATU
(E-mail: awelin@vanuatu.gov.vu)

Professor Jill White, Dean, Faculty of Nursing, Midwifery and Health, University of Technology, Lindfield, NSW 2070, AUSTRALIA
(E-mail: jill.white@uts.edu.au)

Dr Hoda Zaki, Director of Nursing, Ministry of Health and Population, Ministry of Health, Cairo, EGYPT (E-mail: hoda@hcssmideast.org)

Observer

Ms Maureen Shawn Kennedy, News Director, American Journal of Nursing, Lippincott/Wolters Kluwer Health publishers, New York, NY 10001, UNITED STATES OF AMERICA
(E-mail: Shawn.Kennedy@wolterskluwer.com)

World Health Organization

Headquarters

Dr Manuel Millar Dayrit, Director, Department of Human Resources for Health (E-mail: dayritm@who.int)

Mr Norbert E. Dreesch, Budget/Programme Planning Officer, (E-mail: dreeschn@who.int)

Miss Noela Joy Fitzgerald, Conference Coordinator (E-mail: fitzgeraldn@who.int)

Ms Virgie B. Largado-Ferri, Secretary, Health Professions Networks (E-mail: largadov@who.int)

Mrs Beth Magne-Watts, Communications Officer (E-mail: magnewattsb@who.int)

Dr John David Martin, Adviser to the Director-General (E-mail: martinj@who.int)

Dr Maria Purificacion Neira, Director (E-mail: neiram@who.int)

Mrs Annette Mwansa Nkowane, Technical Officer (E-mail: nkowanemwansa@who.int)

Ms Ana Paula Oliveira, Technical Officer (E-mail: oliveiraa@who.int)

Dr Carmen Lucia Pessoa da Silva, Medical Officer (E-mail: pessoasilvacl@who.int)

Dr Eileen Josephine Petit-Mshana, Medical Officer (E-mail: petitmshanae@who.int)

Ms Margaret Kay Usher-Patel, Scientist (E-mail: usherpatelm@who.int)

Miss Hedwig Dorothea Maria Van Asten, Technical Officer (E-mail: vanastenh@who.int)

Mrs Susan Wilburn, Technical Officer (E-mail: wilburns@who.int)

Dr Jean Yan, Chief Nurse Scientist (E-mail: yanj@who.int)

Regional Offices

AFRO

Mrs Loma Margaret Phiri, Regional Adviser, Human Resources for Nursing/Midwifery (HRN), Division of Health Systems and Services Development (DSD)
(E-mail: phirim@afro.who.int)

EMRO

Dr Fariba al Darazi, Regional Adviser, Nursing and Allied Personnel
(E-mail: aldarazif@emro.who.int)

ANNEX 2: FORUM BACKGROUND MATERIAL AND RECOMMENDED REFERENCES

Background material was circulated to participants at the Forum and additional reference information was recommended by Forum speakers.

1. Circulated background documents

(i)   Agenda
(ii)   Objectives
(iii)   List of participants
(iv)   *Resolution WHA 59.23. Rapid scaling up of health workforce production* (http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_R23-en.pdf, accessed 10 December 2008).
(v)   *Resolution WHA 59.27. Strengthening nursing and midwifery* (http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_R27-en.pdf, accessed 10 December 2008).
(vi)   *Islamabad Declaration on Strengthening Nursing and Midwifery, March 2007* (http://www.who.int/hrh/nursing_midwifery/Islamabad_declaration.pdf, accessed 10 December 2008).
(vii)   *Chiang Mai Declaration Nursing and Midwifery for Primary Health Care, February 2008* (http://www.who.int/hrh/nursing_midwifery/chiang_mai_declaration.pdf, accessed 10 December 2008).
(viii) *Report of the Forum for Government Chief Nurses and Midwives, Geneva, 17-18 May 2006* (http://www.who.int/hrh/nursing_midwifery/CNO-report.pdf, accessed 10 December 2008).
(ix)   *Health Workers for All and All for Health Workers: Kampala Declaration and Agenda for Global Action, Kampala, 2—7 March 2008* (http://www.who.int/workforcealliance/forum/2_declaration_final.pdf, accessed 10 December 2008).

2. Additional reference information

National strategy for pandemic influenza implementation plan one year summary. Washington DC, Homeland Security Council, July 2007 (http://www.whitehouse.gov/homeland/pandemic-influenza-oneyear.html, accessed 10 December 2008).

Altered standards of care in mass casualty events: bioterrorism and other public health emergencies. Rockville MD, Agency for Healthcare Resesrach and Quality, April 2005 (AHRQ Publication No. 05-0043), (http://www.ahrq.gov/research/altstand/, accessed 10 December 2008).

Mass medical care with scarce resources: a community planning guide. Rockville MD, Agency for Healthcare Research and Quality, February 2007 (AHRQ Publication No. 07-000), (http://www.ahrq.gov/research/mce/, accessed 10 December 2008).

National nurse emergency preparedness initiative: on-line training resources for nurses, Washington DC, Homeland Security, 2008 (http://www.nnepi.org, accessed 10 December 2008).

Patient safety and quality: an evidence-based handbook for nurses. Rockville, MD, Agency for Healthcare Research and Quality, April 2008 (AHRQ Publication No. 08-0043), (http://www.ahrq.gov/qual/nurseshdbk, accessed 10 December 2008).

ANNEX 3: SDNM TASK FORCE REPRESENTATION AND MEMBERSHIP

The SDNM membership representation includes:

- WHO
  - 2 Officers of nursing and midwifery
  - 2 Regional Nursing and Midwifery Advisers
  - 2 GAGNM members
  - 1 CNO/CMO group members (adding 1 or 2)
  - 2 Focal points for nursing and midwifery in WHO
  - 2 WHO Collaborating Centres (others working on specific tasks)
  - 2 Stakeholders groups
- Representatives from ICN, ICM, ILO, UNFPA, the Global Network of WHO Collaborating Centres for Nursing and Midwifery, Sigma Theta Tau International, International Society for Nurses in Cancer Care, International Federation of Nurse Anesthetists
- University of Toronto (Global Monitoring Survey)

Drafting Group of the SDNM 2009–2015

- Dr Sandra Land, Former Regional Nursing and Midwifery Adviser, as facilitator

The SDNM members are:

Professor Ennam Abou Youssef	Global Advisory Group on Nursing and Midwifery
Dr Rowaida Al-Maaitah	Global Advisory Group on Nursing and Midwifery
Professor Sanchia Aranda	International Society for Nurses in Cancer Care
Dr Sandra Black	Department of HIV/AIDS, WHO
Dr Vincent Fauveau	UNFPA
Professor Valerie Fleming	Global Network of WHO Collaborating Centres
Ms Kathleen Fritsch	Regional Adviser in Nursing, WPRO
Dr Kathy Herschderfer	International Confederation of Midwives
Dr Laetitia J. King	Stakeholder, Member of the Drafting Group of the SDNM 2002–2008
Dr Hester Klopper	Sigma Theta Tau International Honor Society of Nursing
Dr Wipada Kunaviktikul	WHO Collaborating Centre for Nursing
Miss Sandra MacDonald- Renez	Chief Nursing Officer
Dr Linda O'Brien-Pallas	Principal Investigator Monitoring Survey
Dr Judith Oulton	International Council of Nurses
Mrs Margaret Phiri	Regional Adviser for Nursing and Midwifery, AFRO
Mr Pascal Rod	International Federation of Nurse Anesthetists
Dr Hedwig Van Asten	Making Pregnancy Safer Department, WHO
Mrs Peggy Vidot	Nursing and Midwifery Stakeholder
Professor Jill White	Stakeholder; WHOCC
Ms Christiane Wiskow	International Labour Organization
Dr Jean Yan	Chief Scientist for Nursing and Midwifery, WHO
Dr Sandra Land	Office of Nursing and Midwifery, WHO

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