REPORT OF THE FORUM FOR THE GOVERNMENT CHIEF NURSES AND MIDWIVES, 12-13 MAY, 2010, GENEVA SWITZERLAND
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ACKNOWLEDGEMENTS

The Department of Health and Human Resources acknowledges the financial and organizational support generously provided to the WHO Forum for Government Chief Nurses and Midwives by Health Canada. In particular, the engagement and contribution of Ms Judith Skelton Green in the preparation and facilitation of the Forum is much appreciated.

The Department also thanks those presenters and organizers who assisted in the development and delivery of the Forum proceedings.

The report was prepared by Mrs Mwansa Nkowane with input from Ms Judith Skelton Green and Ms Michele Rumsey.
### ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CNO</td>
<td>Chief Nursing Officer</td>
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<tr>
<td>COP</td>
<td>communities of practice</td>
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<tr>
<td>GAGNM</td>
<td>Global Advisory Group on Nursing and Midwifery</td>
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<tr>
<td>GCC</td>
<td>Gulf Cooperation Council</td>
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<tr>
<td>CNO</td>
<td>Government Chief Nursing and Midwifery Officer</td>
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<tr>
<td>GCNMO</td>
<td>Government Chief Nursing and Midwifery Officer</td>
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<tr>
<td>GNWHOCC</td>
<td>Global Network of WHO Collaborating Centres</td>
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<tr>
<td>HCW</td>
<td>health-care worker</td>
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<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
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<td>ICN</td>
<td>International Council of Nurses</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>KRA</td>
<td>key result area</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>NM</td>
<td>nurses and/or midwives</td>
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<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>PHC</td>
<td>primary health care</td>
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<td>SBA</td>
<td>skilled birth attendant</td>
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<tr>
<td>SDNM</td>
<td>Strategic Directions: Strengthening Nursing and Midwifery Services</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WHOCC</td>
<td>WHO Collaborating Centre</td>
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<tr>
<td>AFRO</td>
<td>WHO Regional Office for Africa</td>
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<tr>
<td>EMRO</td>
<td>WHO Regional Office for the Eastern Mediterranean</td>
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<tr>
<td>SEARO</td>
<td>WHO Regional Office for South-East Asia</td>
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<tr>
<td>WPRO</td>
<td>WHO Regional Office for the Western Pacific</td>
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In recognition of the important roles of government nursing and midwifery officers and the need for networking and capacity building, the World Health Organization (WHO) convened the fourth Global Forum for Government Chief Nursing and Midwifery Officers (GCNMOs) in Geneva from 12–13 May 2010. Seventy three Government Chief Nursing and Midwifery Officers from 65 countries across six regions participated in the Forum. Participants to the Forum also included observers from WHO headquarters and regional focal point on nursing and midwifery; members of the WHO Global Advisory Group on Nursing and Midwifery (GAGNM), the Global Network of WHO Collaborating Centres (GNWHOCC), the International Council of Nurses (ICN) and other Key stakeholders (see Annex 1 List of participants). Princess Muna Al Hussein, WHO Patron for nursing and midwifery in the Eastern Mediterranean Region gave the Key note speech.

1. OBJECTIVES

The objectives of the 2010 GCNMO Forum were to bring nursing and midwifery leaders together to:

1. Engage GCNMOs in activities that will build their knowledge and skills about the workings of World Health Assembly (WHA), and the ways in which GCNMOs can confidently inform WHA policy and decisions.
2. Introduce GCNMOs to the Global Leadership Consortium, the draft roles and responsibilities of GCNMOs document and the draft Self-Assessment, and invite input.
3. Provide an update on the current status of strengthening health systems within the context of primary health care (PHC) and the fourth and fifth Millennium Development Goal (MDG5) (Maternal and Newborn Health), with focus on leadership required from GCNMOs to ensure successful implementation.
4. Identify concrete actions which GCNMOs could implement relative to PHC reform and maternal and newborn health, together with indicators they could utilize to identify progress.
2. PROGRAMME OUTLINE

In order to achieve the stated objectives, the Forum programme addressed:
Primary health care and human resources for health;
World health assembly 2010: Global Policy Decisions;
Roles and Responsibilities of Government Chief Nursing and Midwifery Officers;
GCNMOs for PHC;
PHC and nursing and midwifery contributions;
GCNMOs and MDG5;
PHC and the MDGs: Nursing and Midwifery Action;
The Future of Nursing and Midwifery: Front Line Care and;
Position Statement.

3. FORUM OUTCOMES

As a major outcome of the forum, a Position Statement on Nursing and Midwifery’s support for Health System Strengthening and contributions to the Achievement of the MDGs was generated at the conclusion of the Global Forum (see annex)
OPENING SESSION: PRIMARY HEALTH CARE AND HUMAN RESOURCES FOR HEALTH

1. WELCOME REMARKS

MANUEL DAYRIT, DIRECTOR, HUMAN RESOURCES FOR HEALTH, WHO, GENEVA

Welcomed participants on behalf of the Director General of WHO Dr Margaret Chan and the Assistant Director General of the Health Systems and services Cluster Dr Carissa Etienne and highly recognized the presence of Princess Muna Al Hussein of Jordan in the Forum as well as the Wife of the Ambassador of Jordan to Switzerland. Dr. Dayrit further recognized the importance of focusing on leadership and it is critical in the implementation of PHC, MDGs which will require enormous efforts from GCNMOs.

ROWaida Al-MAAitAH, THE CHAIR PERSON OF GAGNM

On behalf of GAGNM the Chairperson expressed appreciation at the presence of Princess Muna. She also highlighted the proceedings and recommendations of the March 2010 GANM meeting which emphasized that meeting the MDGs will require:

- increasing the capacities and improving the quality of nurse and midwife education both at pre-service and post-qualification level;
- faculty development;
- and supporting countries in maximizing/expanding the scope of practice of nurses and midwives.

JEAN YAN, COORDINATOR, HEALTH PROFESSIONS NETWORKS; NURSING AND MIDWIFERY, WHO, GENEVA

Dr Jean Yan introduced Princess Muna’s as pioneer, patron and champion for nursing and midwifery who has devoted 38 years in support of nursing and midwifery. She has also been instrumental in the creation of the Jordanian nursing Council and has served in the capacity as Advisor to the WHO Collaborating Centre on Nursing and Midwifery Development at the Jordan University of Science and Technology. She is therefore a pioneer nurse, patron and champion of nursing and midwifery globally.
2. OPENING ADDRESS

PRINCESS MUNA AL HUSSEIN

Her Royal Highness commended WHO on revitalizing PHC and its values for strengthening HSS. In spite of achievement made so far, still there are major constraints, gaps in inequities are getting wider. In developing countries the most critical problem is poverty and hunger. Up to 99% of Maternal deaths occur in developing countries. Life expectancy in these countries is low with 1/3 of the poorest people in developing countries dying of non communicable diseases. She stressed that no one country is immune to what happens in other regions. Furthermore, Princess Muna reminded the audience of the need to strengthen the health workforce especially in the 57 countries in Africa and Asia facing the crisis and that there should be greater effort on MDG4 and 5. Progress towards the attainment of the MDG4 an5 has been slow in the 10 last ten years especially the reduction of neonatal and maternal mortality rates. This requires expansion and better coverage of services. Nurses and midwives have therefore a crucial role in addressing gaps, accelerating the achievement of MDGs and respond to non communicable diseases through universal coverage and provision of quality services with support from civil society, government and professional associations. Nursing and midwifery involvement should encompass policy development, implementation and action plan. International organizations are urged to train nurses and physicians at all levels. The World Bank Report 2009 indicates that shortage of nurses and midwives reduces capacity to improve access to health services. Well trained nurses and midwives can deliver 80% services. Government chief nursing officers must be leading agents of change as ‘you are educated, credible and trusted’ nursing can be brought to the forefront of decision making. Establish global fund for nursing and midwifery. There is need to collaborate and speak with one voice and make sure:

- Competencies are defined;
- Visibility, embracing the future and moving away from traditional ways of doing things;
- An increase professional power base;
- Institute advance education;
- Core settings for midwifery and nursing include Inter Professional Collaboration (IPC) and;
- Improvement in equity for individual and families served;

The Princess finally congratulated WHO for organizing meeting to share and develop innovative was of sharing information on experiences.
3. REMARKS FROM WHO

CARISSA ETIENNE, ASSISTANT DIRECTOR-GENERAL, HEALTH SYSTEMS AND SERVICES, WHO, GENEVA

It was explained that the cluster comprises the following departments:
- Essential Health technologies;
- Essential Medicines and Pharmaceutical Policies;
- Health System Governance and Service Delivery and;
- Human Resources for Health, Health workforce;
- Health Systems Financing.

She also welcomed Princess Muna and the nursing leaders, partners and colleagues attending the meeting. Furthermore, she emphasized the fact that the whole health systems is build on nursing and midwifery and sited the Caribbean as one example. Collectively GCNMO officers present a collective force for transformation of health systems they are frontline workers, largest proportion of health workforce and thus they are the leaders of this group. The meeting was important as it allows GCNMOs to come together to support each other in light of the health challenges e.g. demographic changes such as people living longer, rapid urbanization. It is estimated that by 2035, more people will be living in cities and 2015 is fast approaching, it is even more evident progress towards MDGs is uneven between rich and poor countries.

Africa continues to have high child and maternal deaths. Maternal deaths reflects failure of health systems. Although there is some progress in malaria and HIV areas, people are still getting infected with HIV and still the many people are not on receiving treatment. Dr Carissa also emphasized that expectations of health services are the same globally and that MDGs can not be expected to be achieved with weak health systems. In brief what people want is to:
- live long healthy lives;
- have a fair deal;
- have a say in what affects their lives and that of their families;
- be treated as human beings and not just as “cases”;
- have health authorities that they can rely on;
- have medicines and technologies that work; and
- have access to good quality health care.

According to WHO there are several interrelated components of a good health system they include, good governance, medicines and technologies, information, financing human resources for health and appropriate service delivery. At the centre of this are people. She also noted that the human resource crisis continues to be an issue. Countries are not producing enough compounded with poor distribution. The nursing and midwifery cadre are at the core of this crisis and they should be involved in policy planning and implementation. In the past, service delivery has focused on curative services but it is imperative to adopt a public health to include disease prevention, health promotion and rehabilitation approaches within the context of PHC.
The ability of nurses to reach the unreached was also highlighted and that they are key to person centered care and should ensure quality continuous care offered when needed. Nurses and midwives will need appropriate skill sets for the changing roles and deal with community health care and leadership roles. This implies nurses and midwives should have a voice to represent the needs of the patients and the profession and work with various partners including civil society. Dr Carissa indicated above all this the 6 key messages:

1. Quality, accessible care;
2. Integrated community health services;
3. Training for Care;
4. Inter-professional Collaboration (working in teams);
5. Leadership; and
6. Efficiency and Health outcomes.

In conclusion she reiterated the need to scale up production, implement training based on needs (competence and community based), strive to meet people’s expectations, inter-professional collaboration in a team where each can be valued and respected. Noting that more than 80 countries will start to develop plans in the next 3 years. This offers an opportunity for WHO to support countries in making transformative and balanced plans.

Key conclusions and actions
Role of gender in developing programmes is important and must be dealt with in a systematic way in view of its impact on practice. Approaches to nursing and medical education ought to be transformative even with the existence of evidence as there is a tendency to maintain old approaches.

4. HUMAN RESOURCES FOR HEALTH AND HEALTH SYSTEMS STRENGTHENING

MANUEL DAYRIT, DIRECTOR, DEPARTMENT OF HUMAN RESOURCES FOR HEALTH, WHO

The presentation began with the introduction of three key terms Health System Strengthening (HSS), PHC and MDGs in the context of strengthening nursing and midwifery to contribute to the MDGs. He explained that HSS includes people, institutions and programmes within a certain context committed to highest possible health. While PHC is a social phenomenon of mobilizing society. It therefore embraces all forces of society mobilized to attain the highest possible health. The MDGs 4, 5, and 6 are the goals for which HSS and PHC approaches should strive for. These concepts are related as conceptual aspirations and goals and call for integrated strategies. Often in practice, integration can pose a lot of challenges but it must be discussed. WHO process three directions:

1. People centred services;
2. Greater strategic and operational integration at local level providing supermarket type of services. At the global level, promotion of integrated approaches among partners; and
3. Country ownership involving leaders and policy makers who are to mold the aspirations in ways that suit the culture and national identity.
It was also emphasized that country ownership requires that, people have strategic information, existence of a critical mass of people who are skilled and have resources. He highlighted the example on Thailand who over the past 30-40 years has been able to improve health response in the country through organized national community planning and mobilization of professions and policy makers towards people centred care. Elsavado began its improvements with small communities encouraging them to have a say in maternal care and link this to national level planning and implementation. Tanzania has achieved wider access to antiretroviral (ARVs) treatments through the participation of patients themselves, while Rwanda’s mental health action has been enhanced as a result of the genocide that took place in the 90s.

WHO is working on key areas to assist countries addressing their health system issues. For example:
- The code for international recruitment of health workers has been developed;
- Guidelines on the recruitment of health workers particularly to rural areas have been developed; and
- An initiative focusing on transformative medical and nursing education has been initiated.

It was concluded that there is need to broaden the inter-professional base for strengthening health systems and PHC. This requires leadership and adoption of approaches that address people centred care, integrated health care within the aspiration of a specific country context.
TECHNICAL SESSION: THE WORLD HEALTH ASSEMBLY 2010: GLOBAL POLICY ISSUES

1. OPTIMIZING CNO EXPERIENCE: A GUIDE TO NURSING AND MIDWIFERY DELEGATES TO THE 63RD WORLD HEALTH ASSEMBLY (WHA)

CHRIS RAKUOM: CHIEF NURSING OFFICER, MINISTRY OF HEALTH, KENYA

This presentation aimed at providing information on the WHA, share experiences and how CNMOs can have an influence during and after the Assembly in their respective countries. In his presentation Mr Rakoum explained that WHO is the directing and coordinating authority for health within the United Nations system. It provides leadership on global health matters and is involved in shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends. It is work, WHO is carried out through a governance system headed by WHO representatives at country level, Regional Directors (one in each 6 regions), the Director General at the WHO Secretariat, A Chair at the Executive Board and the President at the WHA. He explained that the WHA is an over decision making body for the WHO is made up of high level delegations/representatives of 193 member states. Certain institutions/countries/states attend as observers. For example the Vatican, the Order of Malta, and International Council of Nurses.

Through the WHA which takes place annually, an Executive Board (EB) to act on its behalf. The EB supervises financial policies and approve the WHO programme of work. The EB reports to the WHA meets twice a year and comprises 34 member countries whose representatives are technically qualified in the field of health for a period of 3 years. Furthermore, the EB gives effect to the decisions and policies of the WHA and facilitates the WHA work. Within the WHA, various activities take place and there are three Standing Committees:

- **Committee A:** Discusses technical matters and programmes of work, including programme budget and proposes resolutions on these issues to be ratified in plenary
- **Committee B:** Discusses administrative, financial and legal matters, proposes resolutions on these issues to be ratified in plenary, holds briefing meetings for delegates

Other side meetings occur during the session. These do not contribute directly to the WHA’s formal agenda. A daily journal of agenda and proceeding is available for delegates.
The Role of WHO Nursing and Midwifery Office
Provide expert information, support and guidance for delegates throughout the WHA session
Assist in organizing meetings with other delegates in order to discuss issues outside of formal WHA proceedings act as a networking link to key agencies such as the International Council of Nurses and International Confederation of Midwives

To be able to participate effectively, Mr. Rakoum encouraged CNOs to carefully read the agenda items, consider the implications they may have on the health context and the professions in your country, have a clear idea of any interventions you intend to bring forward, take into account who else could have similar views and provide support for your intervention. It was emphasized that it would be important to gather information and relevant materials for evidence-based decisions and that networking provided through attendance at the WHA was key for future collaborative efforts.

2. MAKING INTERVENTIONS AT THE WORLD HEALTH ASSEMBLY: THE WHAT, WHY, AND HOW?

TESFAMICHAEL GHEBREHIWET: CONSULTANT, NURSING AND HEALTH POLICY INTERNATIONAL COUNCIL OF NURSES

As a follow up to the presentation above Dr. Ghebrehiwet clarified that the WHA experience provides an opportunity for CNOs to provide input into the proceedings. Although not many nurses are included as delegates to the WHA, the INC does provide support to some extent for nurses to attend this gathering by lobbying through governments for the inclusion of nurses in their respective Delegations. However, most governments are constrained financially. It was explained that CNOs can make a verbal intervention during the Assembly. An intervention was defined as:

“A proposal to make a modification, add information or ask for a point of order in support a proposal or propose alternative or share information on country experience. It requires quick response and flexibility to other interventions to ensure agreed conclusion. An example of and intervention was given:

A proposed resolution (WHA62.12) on PHC, urged Member States: “to train adequate numbers of health workers, able to work in a multidisciplinary context, in order to respond effectively to people’s health needs;”

After several interventions, it was modified: “to train and retain adequate numbers of health workers, with appropriate skill mix, including primary health care nurses, midwives, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people’s health needs;”
For the 2010 interventions the basis would be the Progress Report on Nursing and midwifery on agenda of 63rd WHA. This report highlights progress in developing human resources, strengthening health systems and optimizing the contribution of nurses and midwives to health related MDGs. In the past, key interventions have related to:

- Challenges in nursing and midwifery such as need for plans to reorient nursing and midwifery to PHC, key role of nurses and midwives in health-related MDGs and WHO priority programmes,
- Concerns on the low percentage of nurses and midwives in WHO and impact on MDGs and programmes,
- Involvement of nurses and midwives in national health policy and to increase nurses and midwives in programmes and for WHO,
- Need to increase number of nursing and midwifery posts at country, regional and at headquarters of WHO and for WHO and governments
- Investing in nursing and midwifery, including building workforce capacity, ensuring appropriate skills and providing positive practice environment (PPE).

3. **WHA RESOLUTIONS--: PURPOSE, CONTENT, PROCESS**

JEAN YAN, COORDINATOR, HEALTH PROFESSIONS NETWORKS; NURSING AND MIDWIFERY

WHA is an opportunity to be part of the process to come up with a resolution. Since 2006, there has been an increase in number of nurses and midwives participating in the WHA. This is an indication that nurses and midwives are being recognized for their contribution. The 2010 WHA focus is on the achievement of MDGS. Therefore, nurses and midwives should be seen to contribute by providing their interventions.

The presenter also explained that a WHA Resolution is generated by countries. Its structure includes a section on the preamble, a section in which WHO urges Member States to take specific actions and the last aspect relates to what WHO is expected to do. For example in the previous Resolution in strengthening nursing and midwifery the main action points were that:

- Country national plans should include nursing and midwifery
- There should be involvement of nurses and midwives at all levels of decision making
- Support be provided to enhance the contribution of nursing and midwifery

This presentation concluded by indicating that the WHA resolutions are mandates compels WHO to take action. Therefore, GCNNOs should use the Resolutions as basis for their work, e.g. advocacy and lobbying for finances.
4. **KEY CONCLUSIONS**

1. Resolutions passed at the WHA provide a starting point not an end.
2. Translation of policies, strategies, and programs into action is important.
3. Strong leadership is required in driving forward reforms.
4. WHO regional and country offices and newly formed networks as key resources.
5. Personal efforts are important in shaping the nursing and midwifery agenda.
6. ICN encourages nurses all levels to participate in the WHA. A letter is sent to Member States 3 months before the Assembly to encourage nurses and midwives’ participation regardless whether they are ICN members or not.
7. The ICN luncheon during WHA serves to briefed nurses and midwives on the WHA issues of concern to the profession.
8. Recruitment of professionals at WHO is now competence based. ICN and ICM are actively engaged in the review of vacancies and alert the nursing and midwifery professionals of the existence of appropriate vacancies.
9. INC will continue to work with governments through National Associations to ensure that nurses and midwives’ participation in WHA is maintained.
1. **GLOBAL LEADERSHIP COLLABORATIVE LEADERSHIP (GLC) FOR GOVERNMENT CHIEF NURSING AND MIDWIFERY OFFICERS (GCNMOs)**

MICHELE RUMSEY: WHOCC, UNIVERSITY OF TECHNOLOGY, SYDNEY, AUSTRALIA

The Global Leadership Collaborative (GLC) is being established to address the need for a global network to develop, support and provide opportunities for networking for GCNMOs and to develop strategies for sustainable leadership amongst GCNMOs.

The foundation of this initiative is the World Health Assembly (WHA) strengthen nursing and midwifery resolutions (2001 WHA 54.12, and 2006 WHA 59.27), Islamabad Declaration 2007 and the GCNMO Forum and Regional GCNMO Alliances.

The Mission of the GLC is to develop effective partnerships between chief nursing and midwifery officers internationally and coordinate approaches to strengthen the capacity of chief nursing and midwifery officers to lead the nursing and midwifery professions in improving population health in an equitable and sustainable manner.

The membership of the GLC is open to all Government Chief Nursing and Midwifery Officers which means a nurse or midwife appointed by the government of a WHO Member State country to the role of providing official advice on nursing and/or midwifery and related issues at a national level. Where there is no national Chief Nurse or Midwife, then a nurse or midwife nominated by the Government of a WHO Member State country, or where appropriate, a nurse and/or midwife nominated by nurses of a country, will be deemed to be the Chief Nurse or Midwife.

The purpose of the Global Leadership Collaborative is to enhance nursing and midwifery effectiveness in promoting and improving population health in Member States. To do this the GLC will build the capacity of the GCNMO. This is a potentially powerful role in terms of influencing quality of health care provision and professional leadership. In particular, the role is crucial in influencing and actively leading health policy decisions.

All members decide on their own level of engagement depending on interest or need. The initial members selected from each WHO region have a virtual steering committee meeting 2-3 times a year and proposed face to face every other year at the GCNMO Forum. Working groups will be established from time to time. The Office of Nursing and Midwifery, WHO Geneva provides technical guidance and the WHO Collaborating Centre at University of Technology, Sydney is responsible for facilitating and providing administrative support to member states.
The GLC also has a knowledge gateway site for its entire membership where relevant information is shared. ([http://my.ibpinitiative.org/Community.aspx?c=ac089bf-cf3e5-4481-8a02-67efb8ea8a1](http://my.ibpinitiative.org/Community.aspx?c=ac089bf-cf3e5-4481-8a02-67efb8ea8a1)) An email needs to be sent and membership accepted to ensure only GCNMOs have access to site. Further details email whocc@uts.edu.au

An organizational structure and a plan of work have been developed. This is presented on the next page.

### An organizational structure

**Role of Government Chief Nursing and Midwifery Officers**

*Titles may differ from country to country*

- **Location of the GCNMO role within government**
- **Location of the GCNMO role within the chain through WHO**
- **Location of the GCNMO role within the chain to the professions**

**Direction General for Health**

**Minister for Health**

**WHO Regional Advisors**

**CSNM and GAGNM at WHO**

**WH & UN**

**Resolutions, Policies, Priorities, Key Documents, Declarations and Strategic Directions**

**Health sector workforce**

**Education**

**Regulation**

**Labour organisations**

**Professional Bodies**

**Resolutions, Policies, Priorities, Key Documents, Declarations and Strategic Directions**

**Global Networks**

**ICM**

**ICN**

**ILO**

**HPRAs**

**GANES**

**Responsibility** - “to achieve national public health goals through nursing and midwifery” (Salon, 2006, 30).
A Resources Package for GCNMOs which includes information on the value, roles and responsibilities and potential contributions of GCNMOs at WHA is in preparation. Its development is based on various contributors including nurse scholars. The package is still under development. The package will include a consensus statement and a diagram, one pager for advocacy, case studies, PHC compendium document and the self assessment tool. A web based forum has also been established; under the Global Alliance for Nursing and Midwifery (GANM).

2. GROUP WORK

Participants reviewed and provided feedback and suggestions on
• Global Leadership Collaborative
• Roles and responsibilities of government chief nursing and midwifery officers
• Self assessment

This activity was also an opportunity for the GCNMOs to indicate their areas of interest. The framework used to provide feedback is presented in the annex.

3. KEY CONCLUSIONS AND ACTIONS

LEILA MCWHINNEY-DEHANEY, CNO JAMAICA

Feedback from the workshops was provided. On the whole it was described as an excellent initiative with minor changes suggested to the roles and responsibilities consensus statement. It was suggested a small reference group be established to complete the Self Assessment Tool with Professor Jill White. It was agreed that all GCNMOs would be invited to the GLC membership and individuals put their names forward to form GLC working groups.

It was agreed that the roles and responsibilities consensus statement will be published by WHO headquarters. The other aspects of the package will be worked on further with Professor Jill White, the WHO CC UTS and GLC working groups.

Outlined below is a brief summary of workshop.

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<td><strong>PROS</strong></td>
<td><strong>CONS</strong></td>
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<tr>
<td>Excellent initiative</td>
<td>Limited access to internet by some CNOs</td>
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<td>Opportunity to network widely</td>
<td>English language only</td>
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<td>Great first step need to add professions next</td>
<td>Need to begin at regional level first</td>
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<tr>
<td>Great for new CNOs as it can be lonely</td>
<td>Need to specify GLC objectives</td>
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<tr>
<td>Could assist CNOs with policy development</td>
<td>Challenging to implement</td>
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<td><strong>PROS</strong></td>
<td><strong>CONS</strong></td>
</tr>
<tr>
<td>Nursing needs to involved with all of health and health areas</td>
<td>How different then is it to a Director of Nursing position?</td>
</tr>
<tr>
<td>Very helpful</td>
<td>Need commonly defined roles for standardisation then countries can add or modify</td>
</tr>
<tr>
<td>Very useful for developing own job descriptions</td>
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<tr>
<td>Can also be used as an advocacy tool</td>
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<th>3. Self Assessment</th>
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<tbody>
<tr>
<td><strong>PROS</strong></td>
<td><strong>CONS</strong></td>
</tr>
<tr>
<td>Useful for highlighting training and CEU needs</td>
<td>Too long – combine 2 &amp; 6 and 4, 5 &amp; 9</td>
</tr>
<tr>
<td>Very important</td>
<td>Leadership should have more questions</td>
</tr>
<tr>
<td>Good idea</td>
<td>Definitions should be added as an annex</td>
</tr>
<tr>
<td></td>
<td>Add generosity and integrity</td>
</tr>
<tr>
<td></td>
<td>Add collaboration and networking</td>
</tr>
<tr>
<td></td>
<td>Very subjective, suggest both self assessment and peer revision</td>
</tr>
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1. THE COMPENDIUM OF PRIMARY HEALTH CARE 38 STUDIES FROM 29 COUNTRIES ACROSS 6 WHO REGIONS.

MS JANE SAVAGE, INDEPENDENT CONSULTANT AND VISITING PROFESSOR, FLORENCE NIGHTINGALE SCHOOL OF NURSING AND MIDWIFERY, LONDON, UK

The work on revitalization of PHC was to highlight role of nurses and midwives in PHC. Under the project “Now More Than Ever: the contribution of nurses and midwives to primary health care”. Goal of project was to maintain and scale up the contribution of nurses and midwives to PHC world wide. The review of their contribution was the starting point. This lead to the compilation of a compendium of primary case studies. The focus was on country led delivery of frontline services by nurses and midwives. The lessons learnt will form the basis for shaping future work. The compilation was based on thirty eight (38) Case studies, from 29 countries from all WHO regions from a wide range of settings, contexts, cultures and levels of development. Successful projects were those that:

• Engage and empower both staff and community
• Build on existing local resources
• Clear goals and expectations
• Evidence-based interventions
• Reliable and adequate funding and resources
• Innovative thinking, especially about capacity to take on new roles

Ms Savage presented some quotes from the Compendium to emphasize certain aspects.

Sustainability

‘Services ought not to be imposed on communities, but developed in response to their identified and owned needs. Ownership of programmes by local communities was seen as fundamental to sustainability, and furthermore built self-esteem and self-belief – factors that were also considered essential indicators of good health.’

Nursing and midwifery leadership

‘One of the most significant features of the case studies is the way in which nurses and midwives at all levels of varied organizations have assumed leadership roles and taken up the challenge of leadership, sometimes with strong government and/or governance support and on other occasions with little or none.’

More information can be found at:
2. PRIMARY HEALTH CARE IN OMAN

MAJED AL-MAQBALI: CNO, SULTANATE OF OMAN

In this presentation, the role of the nursing department was outlined. The health care delivery system is divided into 11 health care regions and 61 districts. The nursing unit has participated in the Nationals Screening Programme for chronic diseases which was established in July 2006 in all PHC institutions. The structure of the nursing service unit is depicted below:

The Nursing and Midwifery Affairs also works on education, regulations, recruitment and accreditation with the Nursing and Midwifery Council. The unit has developed a strategic plan 2009-2013. The goal is to develop and support quality management systems for nursing and midwifery nationally by developing tools to calculate staffing numbers PHC services. In addition support inexperienced leaders, strengthen leadership and management and establish clear career ladders/career progression as well as by implementing flexible services responsive to local needs and by workload indicators tools to support staff deployment. Within the Strategic plan, several strategic goals have been identified. These are:

1. Develop and support quality management systems for nursing and midwifery services nationally;
2. Develop systematic and transparent strategies to support human resource planning and utilization;
3. Work in collaboration with key stakeholders to develop further the range of skills demonstrated by nurses and midwives;
4. Work in partnership with colleagues in education and training to provide, monitor and evaluate quality education and training programmes.

Future agenda
The future agenda will aim to facilitate smooth transition as care moves into the community, respond to demographic changes by planning quality services to meet the needs of the elderly population, and those people with long term conditions e.g. Diabetes. In addition, more emphasis will be placed on a greater awareness of ‘Value for money’ and budget management in the Nursing and Midwifery workforce including provision of support for safe and effective transition to new and advanced technologies for health care.
1. SUCCESS MEASURES IN PHC

MS JUDITH SHAMIAN, CEO, VICTORIA ORDER OF NURSES, CANADA

PHC is an up and down journey. It is complex tied into politics and policies and thus tied with the role of GCNMOs. Community engagement and citizen participation is key in the PHC reforms. In this presentation the role of nursing and midwifery in PHC renewal was summarized. It showed that there is plenty of evidence on the role of nurses and midwives in HPC. What is important is to measure the impact. The review attempted to answer the following question:

What is the impact of the primary and community care nurse on patient health outcomes compared with usual doctor-led care in primary care settings?

The review of literature was restricted to studies with high-level evidence. Thirty one (31) relevant studies were identified. The findings showed that nurses in primary care settings can provide effective care and achieve positive health outcomes for patients similar to that provided by doctors. The studies further showed that nurses are effective in care management and achieve good patient compliance and can function in a more diverse range of roles including chronic disease management, illness prevention and health promotion.

However, there is insufficient evidence about primary care nurses’ roles and impact on patient health outcomes.

Three priority areas were identified:
1. Synthesizing and alignment existing PHC and related knowledge to guide PHC renewal efforts at all levels of policy and practice.
2. Identifying the constraints that impinge articulating the PHC vision, health system, practitioner and preparedness for true PHC renewal at country and local levels.
3. Minimizing policy barriers underpinning the slow implementation and financing of PHC services.

The presenter concluded that the contribution of nurses and midwives is essential in moving the primary health care renewal agenda within the 4 key reform areas; universal coverage, service delivery, public policy, leadership, and including citizens’ engagement and participation (World Health Report 2008). Nurses and midwives can and do make a fundamental and critical contribution to the health of the population through PHC when policy, funding, leadership and professional structures enable them to do so. It is critical that success measure in PHC are well articulated and could include:

- Improvement in MDGs 4, 5 and 6;
- Improved access to PHC for citizens;
GCNMOs in policy development, implementation and evaluation in health system reform including PHC; and
Policy assessment.

2. KEY CONCLUSIONS

1. Advocate and convince medical colleagues on the fact that a well organizing nursing is good for patients’ positive outcomes
2. Doctor’s power base is different from that of nursing and midwifery. It is essential to utilize evidence available such as productivity indicators to convince other professions on contribution and roles of nurses and midwives in PHC and achievement of MDGs.
3. A shift to community services is needed. How can nurses be empowered in the community. What are the experiences?
4. To be effective in moving the agenda of nursing and midwifery forward four things must be considered:
   ◦ Evidence based decision making
   ◦ Listen to other partners
   ◦ Collaboration and partnership
   ◦ Integrate policies and politics

3. WHO’S INITIATIVE IN MATERNAL NEWBORN HEALTH.

MONIR ISLAM, DIRECTOR, MAKING PREGNANCY SAFER; WHO, GENEVA

WHO has developed a framework for accelerated reduction of maternal and newborn mortality in the strive to improve the quality of facility childbirths (QFC), reaching every community. Constraints to the achievement of MDGs have been well documented and these are of major concern to WHO and public health in general.

The key to accelerating quality of SBA are the following; skill development and enhancement, effective regulation, improvement of working conditions, management and retention, increasing production capacity and ensuring proper workforce distribution, management and retention policies. Having so many issues to address, WHO has prioritized what needs to be done first given the available resources. These are to:
1. address regulations;
2. develop competences;
3. generate evidence for interventions and research; and
4. scale-up partnerships.

The key is to ensure:
◦ Skilled care at facilities ensures safety, cleanliness and availability of supplies and equipments.
◦ Mixture of professionals in a facility enables life-saving emergency care to be given quickly.
◦ Improved logistics and supplies; management and supervision
Better organization of referrals and emergency transport
Provide the best opportunity to organize timely emergency obstetric and newborn care.

The encompassing objectives for this initiative are:
- Improving the quality of existing facility in short term while working on improving access for long term.
- Improving demand and access.
- Counting every pregnancy, childbirth, maternal and perinatal deaths

The presenter emphasized that putting in place supportive policies, for example - ensuring supplies, much more can be achieved as has been shown in countries where improved removal of barriers to access, motivation of health workers, improvement of existing facilities, improved monitoring and evaluation have taken place.

4. COUNTRY PROGRAMMES IN MATERNAL AND NEWBORN HEALTH

MS PELENATETE STOWERS, CNO, SAMOA

Samoa is located in the South Pacific Ocean about 30 degrees south of the equator with a population of 182,7008 (in 2004) with an estimated annual growth of 0.6% and with 59% (103,819) being below 20 years of age and 20% (36,086) being women of child bearing age (15-44 years). The health system constitutes the public, private sectors, NGOs and traditional sector. The focus of this presentation was on traditional health sector comprising TBAs and traditional healers. The Ministry of Health works with TBAs to ensure safety practices. TBAs are recognized for providing 20% of births, in the past it was as much as 60%. WHO and UNICEF introduced have introduces competencies. The new programme requires that TBAs are registered. Guidelines have been developed which includes criteria. The scope of work for the TBA encompasses:
- Early recognition and immediate referral to RN/RM or nearest health facility: at risk pregnant mothers and;
- any signs of imminent complications during pregnancy or process of labour;
- Hygiene and infection Control; and
- Maintenance of Clear and accurate recordings of births.

Overall, TBAs conduct a traditional birthing practice is non interventional, based on the belief of waiting for nature to take its course and. They also do train younger people to take over their roles.

5. CONTRIBUTIONS OF SKILLED BIRTH ATTENDANTS

MS DONNA VIVIO, TECHNICAL OFFICER, WHO BANGLADESH: IMPROVING MATERNAL AND NEWBORN HEALTH IN BANGLADESH

The presenter summarized the country profile of Bangladesh. She explained that the population: 140 million (est.) in an area of 147,570 square kilometers. The population density is approximately 948/sq km. Forty percent (40%) of people live below the poverty line. According to the available information the per-capita income
is US$ 380.33. Concerning issues of maternal and child health it was also interesting to note that the age of marriage is 15 years (2007 BDHS). There are 2,600,000 annual deliveries. Out of these 85% occur at home. Deliveries by Skilled Attendants account for only 18%. Maternal Mortality is as high as 320/100,000, neonatal mortality is at 37/1000 live birth, while infant mortality is 62/1000.

Based on the scenario above the issues of concern are:
- High birth rate: more than 2.5 million babies are born each year;
- Early marriage and pregnancy;
- High prevalence of anaemia in pregnant women and low birth weight;
- Increasing unmet need for family planning;
- Low rate of skilled birth attendance; and
- Challenges in scaling up MNH interventions concerning cost and sustainability.

The government has developed a strategy to increase births with a skilled attendant at all venues and increase facility based births. Four UN agencies (UNICEF, UNFPA, WHO, World Bank) conducted an evaluation and offered short-term and long-term recommendations. In deciding who the SBA is the government has adopted the WHO definition. The SBA is “An accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns”.

To increase the number of SBAs the government’s strategy are and not limited to;
- Increase facility based births and number and quality of midwives, provide access to SBAs at all levels including Community-based SBA.

**This cadre is defined as:**

*The accredited health worker, working at community level and trained to a proficiency in all the core midwifery skills and abilities needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in identification, and referral of complications after providing first-line management to the mother and newborn.*

**The midwife is defined as:**

*Someone who completed recognized educational programme in midwifery and is licensed by the Bangladesh Nursing Council as a midwife. The midwife works in partnership with the woman throughout the maternity experience. Meets standards and competencies of International Confederation of Midwives (ICM).*

In 2008 the government approved the Strategic Directions on the contributions of nurse midwives to meet MDGs 4 and 5. Priorities for the strategic Directions are, policy and planning, training and education, deployment and utilization to provide appropriate maternal and newborn health services and review and update the regulations to enable the practice of nurse-midwives and to safeguard the public. In conclusion the presenter highlighted some successes:
- High level commitment attained;
- SBAs institutionalized;
- Government in favour of private sector support;
- Implementation of SDM;
- Retraining of registered nurse midwives 6 month post basic programme; and
- Creation of midwifery posts in government offices for midwifery services.
Next steps
Key future programming elements with regards to midwifery were outlined as follows:
1. Deployment of midwives as close to community as possible.
2. Implementation of SDM.
3. Collaborate effectively with professional association for midwives.
4. Improve quality of nurse midwife and midwifery teachers.

6. THE FUTURE OF NURSING AND MIDWIFERY: FRONT LINE CARE

JANE SAVAGE, INDEPENDENT CONSULTANT AND VISITING PROFESSOR, FLORENCE NIGHTINGALE SCHOOL OF NURSING AND MIDWIFERY, LONDON, UK

Prime Minister Gordon Brown, launched the Commission on 10 March 2009 to look into the extent of need, involvement and response required to secure quality services. This initiative was based on the fact that nurses and midwives are responsible for so much of what we have achieved over the last 10 years in the UK. They can meet the needs of patients and their local communities.

The Commission of 20 was chaired by nurse Ann Keen, former MP and former Parliamentary Under Secretary for Health Services. The Commission included expert nurses and midwives from practice, management, education, research and policy-making.

The process of securing the much-needed evidence based recommendations the Commission carried out an extensive engagement with the public, service users, nursing and midwifery staff, other professionals and stakeholder organizations. The Commission received over 2500 submissions, representing the views of many thousands of people, and supporting evidence. International perspective of the European Union, USA and Australia were also taken into account.

The findings showed that care was not adequate delivered passionately and that nurses were not listen to. As a result of this work 19 recommendations that reflect the outcomes of the Commission’s engagement process provide a Call to Action. These recommendations cover the six key themes.

High quality, compassionate care: in the delivery and coordination of physical and psychosocial care for every service user, family and carer, throughout the care spectrum

Action areas
1. Senior nurses and midwives’ responsibility for care
2. Corporate responsibility for care
3. Protecting the title ‘nurse’
4. Regulating advanced practice
5. Regulating support workers

Health and wellbeing: through nurses role in health promotion, disease prevention and maintaining health and wellbeing
Action areas
1. Nurses and midwives’ contribution to health and wellbeing
2. A named midwife for every woman
3. Staff health and wellbeing

Caring for people with long-term conditions: especially in meeting the complex health needs of ageing

Action areas
1. Nursing people with long-term conditions
2. Flexible roles and career structures

Promoting innovation in nursing and midwifery: adopting new roles and ways in response to service users’ needs

Action areas
1. Building capacity for innovation
2. Making best use of technology

Nurses and midwives leading services: having a powerful voice at all levels of the health system as champions of care

Action areas
1. Strengthening the role of the ward sister
2. Fast-track leadership development

Careers in nursing and midwifery: offer worthwhile, appealing careers with high levels of responsibility and autonomy, plus opportunities for personal and professional development and fulfillment.

Action areas
1. Educating to care
2. Marketing nursing and midwifery
3. Integrating practice, education and research

7. KEY CONCLUSIONS AND ACTIONS

1. generally participants were positive about this report as it brings nursing at front banner to improve image and quality.
2. An important area is to look at how health systems are managed. This aspect would highlight that nurses are not in decision making positions as frequently, weakening nursing positions.
3. Solomon Island had parliamentary enquiry and came up with a strategy which includes review of nursing.
4. Such Commissions are good but require support in starting this enquiry.
5. The issue of direct entry midwives versus nurse midwives. What is importance is to discuss skills and competences
A Position Statement on Nursing and Midwifery’s support for Health System Strengthening and contributions to the Achievement of the MDGs was prepared at the conclusion of the Global Forum. This is presented in the annex.

MANUEL DAYRIT

GCNMOS should be able to influence the government. The other gap you have tried to address is strategic issues and link these to mechanisms to make them happen at country level. The interpersonal gap…..learnt more about each other and developing team spirit. Being aware of these gaps is important. From HRH perspectives, narrowing the gaps at team and department level to serve member states. Need to keep the conversation going post the forum.

Congratulated group for work done, position statement etc as an instrument at Global level to guide implementation in countries. Thanked Jean for the work done since 2004.

1. SUMMARY AND NEXT STEPS

There has been some transformation GCNOM have been fully engaged in being involved in the process of the group. Have worked together collectively to come up with actions. There is increased number of nurses working at national level from 40 in 2004 to 80 in 2008. More nurses and midwives are being co-opted to be part of the delegation and are actively involved in making interventions in WHA as well as setting up programmes at national level.
ANNEX 1: LIST OF PARTICIPANTS

GUEST OF HONOR

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ANNEX 2:

DISCUSSION TOPIC RECORDING TEMPLATE
Topic/Challenge:

Participants:

What successful practices have been implemented to address our challenge?

<table>
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<tr>
<th>Description of Successful Practice</th>
<th>Country</th>
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What concrete actions might GCNMOs undertake to promote progress in this area?

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<th>What policies, support systems, resources are required to implement actions at national level?</th>
<th>What Indicators could we use to track success?</th>
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ANNEX: FORUM STATEMENT

Government Chief Nursing and Midwifery Officer’s Position Statement on Primary Health Care

Developed at the Biannual GCNMO Forum
12-13 May 2010, Geneva

The Government Chief Nursing and Midwifery Officers are committed to advancing and strengthening Primary Health Care renewal for global health. Worldwide evidence shows that nurses and midwives are essential national and international leaders in positively impacting the health and well-being of populations. Primary health care renewal needs to continue to focus on the key reform areas outlined in the 2008 World Health Report, with the addition of strong community participation. Transformative health system strengthening within a people-centred primary health care framework will advance health equity towards the achievement of MDGs 4, 5, and 6. As the Government Chief Nursing and Midwifery Officers, we will work collectively and at the country level to support the WHA Resolution 62.12, Primary health care, including health system strengthening, and WHA Resolution 59.27 on strengthening nursing and midwifery, to scale up collaboration with key stakeholders and effectively lead and facilitate this necessary transformation.

The Government Chief Nursing and Midwifery Officers (GCNMO) recognize that:

Efforts to address Primary Health Care (PHC) renewal, although a global issue, must be owned by the member states and must be country-sensitive in design, implementation and evaluation.

Nurses and Midwives (N&Ms) form 80% of health care providers globally and they are critical and essential contributors in all aspects of PHC renewal. Nursing and midwifery worldwide have demonstrated significant leadership in making essential, unique, and innovative contributions to PHC renewal that has positively impacted the health and well-being of populations.

The 2008 Chiang Mai Declaration contains significant key value statements and evidence-informed recommendations that could advance PHC renewal.

Nurses and midwives have historically embraced and continue to endorse community-based interprofessional collaborative practice as an essential component of PHC.

There is an indisputable need to explicitly link the three synergistic priorities of health systems strengthening, progress towards the MDGs concerning women and children’s health, and continued primary health care renewal.

The fundamental role of WHO in relation to these three interlinked priorities is to provide evidence-informed guidance and support to member states in designing, implementing and evaluating their national health, governance, and N&M policy, education, and practice systems to improve the health and well-being of all citizens.
There have been critical longstanding policy barriers underpinning the slow development and financing of PHC services (e.g., information systems that allow reliable quality information gathering and benchmarking).

Although high level documents have articulated the PHC vision, at the country and more local levels there are many complex contextual factors that impede the health system, practitioner and citizenry preparedness for true PHC renewal.

There is sufficient knowledge to guide PHC renewal efforts at all levels of policy and practice.

The Government Chief Nursing and Midwifery Officers (GCNMO) therefore make the following recommendations:

**POLICY**

The PHC policy commitment and leadership within WHO and member states should be examined to ensure that capacities are in place to advance PHC renewal. This includes, but is not limited to:

- The creation of WHO N&M focal points to collaborate with GCNMOs at country levels
- WHO and partners should develop and disseminate tools and mechanisms to support PHC knowledge sharing across member states
- Resources should be mobilized to support countries and the WHO secretariat in scaling up nursing and midwifery education and practice
- Member states need to have a formal process to support community engagement and participation advance health systems strengthening within PHC renewal
- Governments should provide incentives and advance N&M to continue to work in areas of greatest health need (MDGs 4, 5, 6)

In order to advance health systems strengthening, PHC renewal and achievement of MDGs 4, 5, and 6:

- Member states should have a focal N&M Directorate at the national level
- GCNMOs should be placed within national Ministries with accompanying structural, resource, and policy accountabilities at a level of decision-making to effectively lead PHC renewal
- GCNMOs should be engaged at all levels of policy-making to drive health in all policies as part of PHC renewal
- GCNMOs should influence and create policy to shift resources towards PHC
- GCNMOs should create opportunities for N&M to be involved in all levels of decision-making, including decisions related to external funders’ resource allocation, where applicable
- GCNMOs should be responsible for levering the education, regulation and practice of N&M towards the implementation of safe and effective people-centred PHC
Scaling Up Nursing and Midwifery Services for Health system strengthening based on PHC Renewal

Education:
- Community-based PHC curricula that is competency-based should be integrated into basic and ongoing nursing and midwifery curricula
- Review competencies for entry level nursing and midwifery and accredited continuing professional development with a view to developing PHC-specific competencies in order to fulfill new and expanding PHC roles (e.g., interprofessional collaborative practice)
- Where this is not the case already, GCNMOs should be responsible for addressing the training, safety and support of community health support workers within their PHC portfolio

Scaling Up New PHC Roles and Production:
- Define the scope and competencies of nursing and midwifery PHC practice to maximize nursing and midwifery leadership roles in all areas of nursing practice
- Scale up production of an appropriate health workforce skill mix, including professional nurses and midwives, within health human resource planning to support PHC demands (e.g., extension of nurse-midwife and nurse practitioner roles, mental health)
- Increase resources to train and retrain registered community health N&M to cover hard to reach geographical areas and other underserved populations (e.g., long term care, women and children’s health) and to address individual, family and community priority issues (e.g., chronic disease)
REPORT OF THE FORUM FOR THE GOVERNMENT CHIEF NURSES AND MIDWIVES, 12-13 MAY, 2010, GENEVA SWITZERLAND