the commonwealth nurse

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THE CNF VISITS ZIMBABWE

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The Commonwealth Nurses Federation (CNF), founded in 1973, is a federation of national nursing and midwifery associations in Commonwealth countries.

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from the PRESIDENT

Susie Kong
CNF President

The second half of 2011 has been a very busy time for the Commonwealth Nurses Federation. Workshops have been held in the Seychelles, Tonga, Samoa, Fiji and Zimbabwe. The CNF attended two meetings of the African Regulatory Collaborative in Durban, South Africa and Arusha, Tanzania as rapporteur and also provided technical assistance to Swaziland and Lesotho as they developed their national continuing professional development programs. The CNF was also involved in preparations for and attended the 2011 Commonwealth People's Forum and Commonwealth Heads of Government meeting in Perth, Australia.

The Commonwealth Foundation released the Civil Society Statement which was presented to the Commonwealth Heads of Government meeting in Perth Australia at the end of October 2011. The statement calls on civil society to be drivers of change in a dynamic Commonwealth. Areas covered in the Statement include: Indigenous people and communities; human rights; culture and identity; climate and environment; health; peace and security; education, technology and innovation; governance and democracy; economic development, trade and finance; and gender equity and women's rights. Members are urged to read the statement and use it as a lobbying tool to government. A full copy of the Statement can be found at:
http://www.commonwealthfoundation.com.

At the Commonwealth Heads of Government meeting, the Heads of Government considered the report of the Eminent Persons Group which was commissioned to do a review of the Commonwealth at the 2009 CHOGM in Trinidad and Tobago. The communiqué from CHOGM and the report of the Eminent Persons Group can be downloaded from the CNF website: http://www.commonwealthnurses.org. The references to health in the CHOGM communiqué can be found under item 3(g) page 6.

The CNF has been successful in being awarded two Commonwealth Professional Fellowships in 2012 as part of the Commonwealth Scholarship Commission scheme. The Fellowships are the first in a proposed regular program to develop young nurse leaders in developing countries. The two successful Fellows are Clarisse Bombi Lamnyam and Tita Pale Isa Ndognjem from Cameroon who will spend ten weeks in London increasing their skills in leadership, governance, administration, and communication which will enhance their contribution to nursing and health in their own country. The CNF congratulates Clarisse and Tita and the Cameroon Nurses Association and wishes Clarisse and Tita a successful and rewarding Fellowship program.


Clarisse Bombi Lamnyam


Tita Pale Isa Ndognjem

2012 looks to be as busy for the CNF as 2011 has been. A very exciting initiative is the Inaugural Commonwealth Nurses Conference which will be held in London 10-11 March 2012 on the eve of Commonwealth week. The theme of the Conference is: *Our health - our common wealth.* Over 80 abstracts have been received from across the Commonwealth. Make sure you plan to attend by registering at:
http://www.commonwealthnurses.org.

FOCUS ON MENTAL HEALTH

World Mental Health Day was celebrated on 10 October 2011. The WHO defines mental health as a state of wellbeing in which every individual realizes his or her own potential; can cope with the normal stresses of life; can work productively and fruitfully; and is able to make a contribution to her or his community. The WHO has released a publication titled: *10 facts on mental health.* The facts are very disturbing and you have to ask yourself why mental health is such a neglected area of care. The CNF urges members to be active in raising mental health issues in their respective countries.

http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/index.html
©World Health Organisation



FACT 1: About half of mental disorders begin before the age of 14. Around 20% of the world's children and adolescents are estimated to have mental disorders or problems, with similar types of disorders being reported across cultures. Yet, regions of the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources. Most low and middle income countries have only one child psychiatrist for every 1 to 4 million people.

FACT 2: Depression is characterised by sustained sadness and loss of interest along with psychological, behavioural and physical symptoms. It is ranked as the leading cause of disability worldwide.

FACT 3: On average about 800,000 people commit suicide every year, 86% of them in low and middle income countries. More than half of the people who kill themselves are aged between 15 and 44. The highest suicide rates are found among men in eastern European countries. Mental disorders are one of the most prominent and treatable causes of suicide.

FACT 4: War and other major disasters have a large impact on mental health and psychosocial wellbeing. Rates of mental disorder tend to double after emergencies.

FACT 5: Mental disorders are among the risk factors for communicable and non-communicable diseases. They can also contribute to unintentional and intentional injury.

FACT 6: Stigma about mental disorders and discrimination against patients and families prevent people from seeking mental health care. In South Africa, a public survey showed that most people though mental illnesses were related to either stress or a lack of willpower rather than to medical disorders. Contrary to expectations, levels of stigma were higher in urban areas and among people with higher levels of education.

FACT 7: Human rights violations of psychiatric patients are routinely reported in most countries. These include: physical restraint, seclusion and denial of basic needs and privacy. Few countries have a legal framework that adequately protects the rights of people with mental disorders.

FACT 8: There is huge inequity in the distribution of skilled human resources for mental health across the world. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are among the main barriers to providing treatment and care in low and middle income countries. Low income countries have 0.05 psychiatrists and 0.42 nurses per 100,000 people. The rate of psychiatrists in high income countries is 170 times great and for nurses is 70 times greater.

FACT 9: In order to increase the availability of mental health services there are five key barriers that need to be overcome: the absence of mental health from the public health agenda and the implications for funding; the current organisation of mental health services; lack of integration with primary care; inadequate human resources for mental health; and lack of public mental health leadership.

FACT 10: Governments, donors and groups representing mental health workers, patients and their families need to work together to increase mental health services, especially in low and middle income countries. The financial resources needed are relatively modest: US$ 2 per person per year in low income countries and US$ 3-4 in lower middle income countries.

On 10 December 1948, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights, which has become a universal standard for the promotion and protection of human rights worldwide. This year on 10 December, the international community will celebrate Human Rights Day to mark the 62nd anniversary of the adoption of the Universal Declaration. The WHO has identified key areas for the protection of the human rights of people with mental disorders as:

* Change attitudes and raise awareness,
* Improve human rights in mental health facilities,
* Empower mental health services users and families,
* Replace psychiatric institutions with community care,
* Increase investment in mental health,
* Adopt policies, laws and services that promote human rights.

For more information go to:
http://www.who.int/features/qa/43/en/index.html.

The World Health Organization (WHO) has released the 2011 Mental Health Atlas which presents data from 184 countries, covering 98% of the world's population. Worldwide, one in four people will require mental health care, yet global spending on mental health is less than US$3 per person per year and as little as US$0.25 per person per year in low-income countries.

The key messages from the WHO 2011 Mental Health Atlas are:

1. RESOURCES TO TREAT AND PREVENT MENTAL DISORDERS REMAIN INSUFFICIENT

* Globally, spending on mental health is less than two US dollars per person, per year and less than 25 cents in low income countries.
* Almost half of the world's population lives in a country where, on average, there is one psychiatrist or less to serve 200,000 people.

2. RESOURCES FOR MENTAL HEALTH ARE INEQUITABLY DISTRIBUTED

* Only 36% of people living in low income countries are covered by mental health legislation. In contrast, the corresponding rate for high income countries is 92%. Dedicated mental health legislation can help to legally reinforce the goals of policies and plans in line with international human rights and practice standards.
* Outpatient mental health facilities are 58 times more prevalent in high income compared with low income countries.
* User / consumer organisations are present in 83% of high income countries in comparison to 49% of low income countries.

3. RESOURCES FOR MENTAL HEALTH ARE INEFFICIENTLY UTILIZED

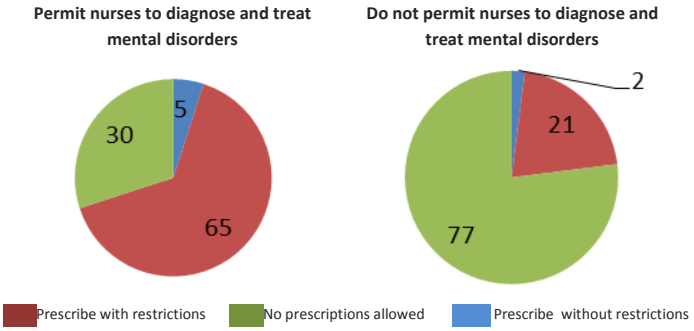
* Globally, 63% of psychiatric beds are located in mental hospitals, and 67% of mental health spending is directed towards these institutions

4. INSTITUTIONAL CARE FOR MENTAL DISORDERS MAY BE SLOWLY DECREASING WORLDWIDE

* Though resources remain concentrated in mental hospitals, a modest decrease in mental hospital beds was found from 2005 to 2011 at the global level and in almost every income and regional group.

The Mental Health Atlas is a very valuable resource. Of a potential 193 countries, 184 responded to the WHO survey which formed the basis of the findings. The introduction section deals with methodology and subsequent sections cover: governance (policy, plans and legislation); financing; mental health care delivery (primary care and institutional care); human resources (training and workforce); medicines; and information systems. The final section compares data between 2005 and 2011.

As shown in Graph 3.1.4 below (page 34 of the Atlas), of countries that *do* permit nurses to diagnose and treat mental disorders, 30% prohibit prescriptions by nurses; 65% allow prescriptions with restrictions and only 5% allow prescriptions without restrictions. In contrast, of countries that *do not* permit nurses to diagnose and treat mental disorders independently, 77% do not permit nurses to prescribe medicines for mental and behavioural disorders; twenty-one percent allow prescription with restrictions, and only 2% allow prescription without restrictions.



The data demonstrates that mental health resources within most countries remain inadequate. Moreover, resources across regions and different income levels are substantially uneven, and in many countries resources for mental health are extremely scarce. In comparing data from 2005 and 2011 there is some evidence of a small gain in mental health human resources, however these gains are largely in high and middle income countries and not in low income countries. Results reinforce the urgent need to scale up resources for mental health care within countries.

The WHO 2011 Mental Health Atlas is available online at:
http://www.who.int/mental_health/publications/mental_health_atlas_2011/en/index.html.

THE DANGERS OF UNDETECTED CHLAMYDIA INFECTION

Mrs Eseta Hope
Faculty of Applied Science National University of Samoa
Secretary Samoa Nurses Association

Major Reproductive Health and Sexually Transmitted Infection Research Project Underway in Samoa

For the first time in Samoa, a group of researchers from the National University of Samoa and the University of Otago are investigating the reproductive health outcomes associated with the high rates of sexually transmitted infections in Samoa.

Michael Walsh, a health researcher working on the project from the Centre for International Health at the University of Otago, notes that the Samoan antenatal sexually transmitted infection survey in 2000, the subsequent second generation survey undertaken between 2004 and 2005, and the more recent and ongoing antenatal screening currently undertaken by the National Health Service, has shown Samoa to have very high rates of sexually transmitted infections, particularly chlamydia, in the young reproducive age groups.

According to Mr Walsh, chlamydia if untreated can lead to a number of serious health complications in females such as pelvic inflammatory disease and possible infertility. Up to 75% of females infected with chlamydia are asymptomatic, meaning they do not actually become unwell and are likely to be unaware they have chlamydia. The infection therefore has potential to go untreated for many years and wreak havoc on the reproductive organs of an infected female. Overseas research has shown that up to 40% of those females who are asymptomatic and thus never seek treatment will go on to experience reproductive health problems including pelvic inflammatory disease, ectopic pregnancies and even infertility.

Mrs Eseta Hope is from the Faculty of Applied Science at the National University of Samoa, as well as being Secretary of the Samoa Nurses Association and a lead investigator on the project.

Mrs Hope said that many women may only find out they have or had chlamydia in the past when they visit a doctor to enquire about problems in trying to become pregnant, only to be told they are infertile. With the high rates of chlamydia in Samoa, it is important to know what the impact is on the reproductive health of the population, particularly when family lineages and genealogy are so important to Samoan identity, culture and politics.

The researchers are aiming to recruit 800, 18-29 year old females in to the project, from 51 randomly selected villages throughout Samoa. The research team is visiting each selected village where all females aged 18-29 years are brought together on the day to one central location. Those females present on the day that are eligible for the project and consent to participation, are asked to complete a short questionnaire on their sexual history and provide a blood and urine sample to test for past and current chlamydia infection. All those that are positive for infection will be treated for free and those identified with possible reproductive health issues are referred to a doctor. All but a small number of the villages that have been selected for the project have been contacted and data collection has begun.

Mrs Hope said that when dealing with such a sensitive topic such as sexual health, participant confidentiality is vital, particularly when contacting individuals for treatment when they return a positive test result. Mr Walsh advised that the project has procedures in place that will protect participant confidentiality including all blood and urine specimens sent to the laboratory being labelled with only a unique code that can only be linked back to the individual by select members of the research team. Those participants who return positive test results are contacted directly by the research team to arrange treatment for both themselves and their partners and counselling is arranged if required. The treatment for Chlamydia is a single dose of the antibiotic azithromycin and it is important that partners are also treated to prevent re-infection.

The project team would like to acknowledge other collaborators working on the project namely the National Health Service in Samoa, the Queensland University of Technology in Australia, and the Samoan Family Health Association. Vital contributions have also been provided by the Samoan Ministry of Health and the Ministry of Women, Community and Social Development. Funding for the project has been provided by the New Zealand Government Aid program (NZAid). The project team is aiming to report their findings to the funding agency and Ministry of Health in the first quarter of 2012.

FIJI NURSES LOOK TO THE FUTURE

In August 2011, the Fiji Nursing Association partnered with the CNF to present two workshops on leadership for young nurse leaders in Fiji. The workshops covered areas such as: leadership theories and models; advocacy and lobbying; strategic planning; and working with the media and were a combination of presentations, group work and self-reflection. Participants identified areas in nursing in Fiji which were of concern and developed strategies to address them. The workshops were funded by the Malaysian Nurses Association.

Workshop participants in Suva

Workshop particpants in Labasa

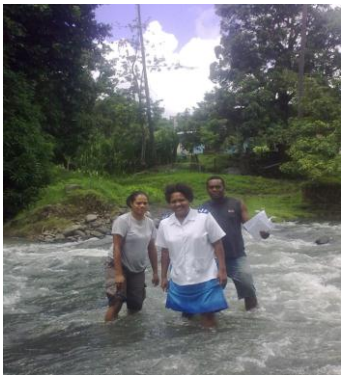
WORKING WITH THE MEDIA

Mrs Kuini Lutua is Secretary General of the Fiji Nursing Association

One of the highlights of the workshop was a presentation by Mrs Kuini Lutua, Secretary General of the Fiji Nursing Association (FNA) who explained to participants why it was so important to work with the media.

The FNA works with the media in order to:
* Inform the public about nursing issues,
* Inform members,
* Lobby for support from the public, stakeholders in health and the government,
* Justify actions and explain why,
* Encourage positive change, and
* Stand up for members and be brave.

Mrs Lutua gave some examples of how the media had been used by the FNA to successfully convey its messages to members and to members of the public. The FNA also used the media on a regular basis to promote a positive image of nurses.



The photograph shows nurses fording a swollen river in order to provide nursing care to the village on the other side.

Mrs Lutua concluded her presentation by providing participants with the dos and don'ts of working with the media.

Do give clear direct answers; be succinct, brief and concise
Do provide simple, accurate explanations
Do stay calm and relaxed
Do clarify ambiguous questions
Do know your facts
Do prepare for 'tricky' questions
Do avoid emotional or aggressive responses
Do provide interesting and genuine facts
Do adhere to deadlines
Do respond to media calls as soon as possible
Do build trusting relationships with journalists
Do send out press releases to get the ball rolling

Don't be cut off
Don't make false announcements
Don't take your frustrations out on the journalist
Don't expect journalists to see your point of view
Don't misrepresent the situation or distort the facts
Don't ignore or avoid media enquiries.

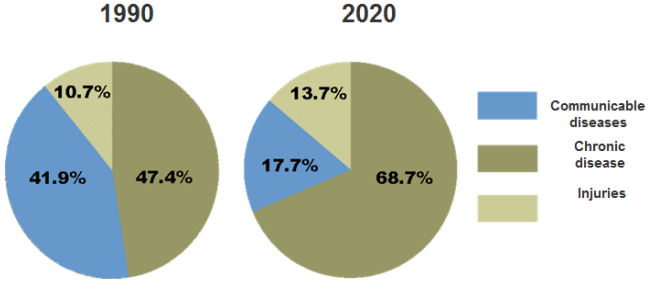
Participants concluded the workshop by identifying areas within nursing in Fiji where positive leadership could result in positive change. Working in groups, they then developed proposals including strategies and timelines which would enable them to address the issues based on what they had learned at the workshop.

CNF ACTIVITY IN THE SOUTH PACIFIC

In August 2011, the Tonga Nurses Association and the Samoa Nurses Association partnered with the CNF to present workshops on: *Preventing NCDs using a primary health care approach.* Thirty five senior nurses attended the workshop in Tonga with thirty attending in Samoa. The workshop aimed to raise awareness and develop strategies to prevent non-communicable diseases such as diabetes, cardiac disease and respiratory disease. The workshops were funded by the Commonwealth Foundation.

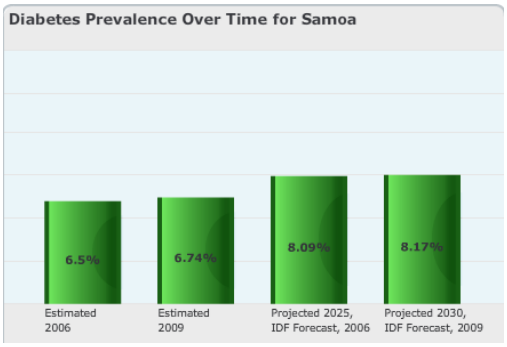
Participants learned that NCDs are largely preventable and that three risk factors cause four chronic diseases: cardiovascular disease; type 2 diabetes; many cancers; and chronic lung disease that cause over 50% of deaths worldwide. The three key risk factors for developing NCDs are tobacco use, lack of physical exercise and an unhealthy diet. Participants considered the global burden of disease as a result of NCDs and the future impact on their own countries.

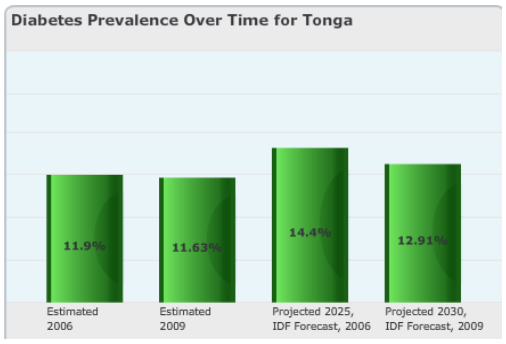
Global burden of disease



Source: Harvard School of Public Health

Diabetes was considered as one of the most debilitating NCDs. Participants learned that diabetes is a life threatening condition; that it is a common condition; that its frequency is dramatically rising all over the world; that a full and healthy life is possible with diabetes; and that in many cases, diabetes can be prevented.





Participants considered the complications associated with obesity; the causes and prevalence of obesity; the effects of lifestyle choices; and treatments available for obese persons. It was noted that, out of the top ten countries with obese populations, eight were located in the South Pacific.

Top ten countries with obese populations

Rank	Country	Percentage
1	Nauru	94.5
2	Federate States of Micronesia	91.1
3	Cook Islands	90.9
4	Tonga	90.8
5	Niue	81.7
6	Samoa	80.4
7	Palau	78.4
8	Kuwait	74.2
9	United States	74.1
10	Kiribati	73.6

The prevalence of smoking globally and regionally was highlighted and the treatments available for smoking cessation were outlined.

Rank	Country	Percentage
1	Nauru	54
2	Guinea	51.7
18	Tonga	38.3
79	Samoa	23.3
89	Fiji	20.5
91	Australia	19.5

Participants were advised that smoking increased the risk of heart disease and stroke by 2-4 times; men who smoked were 23 times more likely to develop lung cancer; and women who smoked were 13 times more likely to develop lung cancer. The risk of dying from chronic obstructive lung disease (eg emphysema) increased by 12 times for people who smoked.

Participants re-examined the Declaration of Alma-Ata from 1978 and considered the principles on which primary health care is based: accessibility, affordability, availability, and acceptability; public participation; health promotion, chronic disease prevention and management; use of appropriate skills, technology and innovation; and interdisciplinary and inter-sectoral cooperation and collaboration. Working in groups, participants developed proposals to address NCDs in their local area using a primary health care approach.

International Labour Organization

http://www.ilo.org

Tita Pale Isa Ndognjem
Clarisse Bombi Lamnyam

The ILO is the international organisation responsible for drawing up and overseeing international labour standards. It is the only 'tripartite' United Nations agency that brings together representatives of governments, employers and workers to jointly shape policies and programmes promoting decent work for all.

Some of the ILO standards or conventions are directly relevant to nurses and midwives. Is your country a signatory to these important Conventions? Check the table opposite and if your country is not a signatory, perhaps that is something your national nursing or midwifery association could take up. It is a concern that so few countries are signatories to the important Nursing Personnel Convention 149/1977.

CONVENTION 149: Nursing personnel 1977

This Convention recognises the vital role played by nursing personnel in the protection and improvement of the health and welfare of the population and notes that shortages of qualified persons and under-utilisation of existing staff are obstacles to the development of effective health services. The Convention acknowledges that the special conditions in which nursing is carried out make it desirable to supplement the general standards by standards specific to nursing personnel, designed to enable them to enjoy a status corresponding to their role in the field of health and that necessary measures are put in place to provide nursing personnel with:

a) Education and training appropriate to the exercise of their functions; and
b) Employment and working conditions, including career prospects and remuneration.

CONVENTION 111: Discrimination 1960

The Convention forbids any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation.

CONVENTION 87: Freedom of association and protection of the right to organise 1948
Employers and workers must be free to elect their representatives, organise their administration activities, and formulate their programs without interference as long as they respect the laws of the land, which should not violate the Convention.

Country	149	111	87
Antigua and Barbuda		√	√
Australia		√	√
Bahamas		√	√
Bangladesh	√	√	√
Barbados		√	√
Belize		√	√
Botswana		√	√
Brunei Darussalam			
Cameroon		√	√
Canada		√	√
Cyprus		√	√
Dominica		√	√
Fiji Islands	√	√	√
The Gambia		√	√
Ghana	√	√	√
Grenada		√	√
Guyana	√	√	√
India		√	
Jamaica	√	√	√
Kenya	√	√	
Kiribati		√	√
Lesotho		√	√
Malawi	√	√	√
Malaysia			
Maldives			
Malta	√	√	√
Mauritius		√	√
Mozambique		√	
Namibia		√	√
Nauru	No information		
New Zealand		√	
Nigeria		√	√
Pakistan		√	√
Papua New Guinea		√	√
Rwanda		√	√
St Kitts and Nevis		√	√
St Lucia		√	√
St Vincent and Grenadines		√	√
Samoa		√	√
Seychelles	√	√	√
Sierra Leone		√	√
Singapore			
Solomon Islands		√	
South Africa		√	√
Sri Lanka		√	√
Swaziland		√	√
Tonga	No information		
Trinidad and Tobago		√	√
Tuvalu			
Uganda		√	√
United Kingdom		√	√
United Republic of Tanzania	√	√	√
Vanuatu		√	√
Zambia	√	√	√
Zimbabwe		√	√

For other Conventions, go to:
http://www.ilo.org/global/standards/lang--en/index.htm

CONVENTION 98: Right to organise and collective bargaining 1951

This Convention outlines the principle of the right to organise and bargain collectively. Workers are to enjoy adequate protection against anti-union discrimination in respect of their employment. They should not be forbidden from joining unions or be forced to relinquish trade union membership.

CONVENTION 154: Collective bargaining 1981

*For the purpose of this Convention, the term **collective bargaining** extends to all negotiations which take place between an employer, a group of employers or one or more employers' organisations, on the one hand, and one or more workers' organisations, on the other, for:*

a) Determining working conditions and terms of employment; and/or
b) Regulating relations between employers and workers; and/or
c) Regulating relations between employers or their organisations and a workers' organisation or workers' organisations.

CONVENTION 155: Occupational safety and health 1981

This Convention contains requirements for establishing and maintaining a safe and healthy working environment. Nations are required to formulate, implement and periodically review national policies and services related to the identification, assessment and control of risks from health hazards in the workplace in consultation with the most representative organisations of employers and workers.

CONVENTION 100: Equal remuneration for men and women for work of equal value 1951

Rates of remuneration should ensure the application to all workers of the principle of equal remuneration for men and women workers for work of equal value.

CONVENTION 105: Abolition of forced labour 1957

Prohibits any form of forced or compulsory labour whether as a means of political coercion or education; or as a punishment for holding or expressing political views; or as a method of using labour for purposes of economic development; or as a means of labour discipline; or as a punishment for having participated in strikes; or as a means of racial, social, national or religious discrimination.

Country	98	154	155	100	105
Antigua and Barbuda	√	√	√	√	√
Australia	√		√	√	√
Bahamas	√			√	√
Bangladesh	√			√	√
Barbados	√			√	√
Belize	√	√	√	√	√
Botswana	√			√	√
Brunei Darussalam					
Cameroon	√			√	√
Canada				√	√
Cyprus	√	√	√	√	√
Dominica	√			√	√
Fiji Islands	√		√	√	√
The Gambia	√			√	√
Ghana	√			√	√
Grenada	√			√	√
Guyana	√			√	√
India				√	√
Jamaica	√			√	√
Kenya	√			√	√
Kiribati	√			√	√
Lesotho	√		√	√	√
Malawi	√			√	√
Malaysia	√			√	
Maldives					
Malta	√			√	√
Mauritius		√		√	√
Mozambique				√	√
Namibia	√			√	√
Nauru	No information				
New Zealand	√		√	√	√
Nigeria	√		√	√	√
Pakistan	√			√	√
Papua New Guinea	√			√	√
Rwanda	√			√	√
St Kitts and Nevis	√			√	√
St Lucia	√	√		√	√
St Vincent and Grenadines	√			√	√
Samoa	√			√	√
Seychelles	√		√	√	√
Sierra Leone	√			√	√
Singapore	√			√	
Solomon Islands				√	√
South Africa	√		√	√	√
Sri Lanka	√			√	√
Swaziland	√			√	√
Tonga	No information				
Trinidad and Tobago	√			√	√
Tuvalu					
Uganda	√	√		√	√
United Kingdom	√			√	√
United Republic of Tanzania	√	√		√	√
Vanuatu	√			√	√
Zambia	√			√	√
Zimbabwe				√	√

HISTORY IN THE MAKING FOR SWAZILAND AND LESOTHO

Swaziland and Lesotho were two of the successful countries who received grants from the African Regulatory Collaborative (ARC) to strengthen nursing and midwifery regulation in their countries.

The African Regulatory Collaborative is a partnership between the Centers for Disease Control and Prevention in Atlanta, Georgia; Emory University in Atlanta, Georgia; the Commonwealth Secretariat; and the East, Central and Southern Africa Health Community. The proposals from both countries were to develop national continuing professional development programs.

The Commonwealth Nurses Federation was fortunate to be in a position to provide technical assistance to both countries as they developed their national programs. A small representative group of senior nurse leaders, including representatives of the regulatory body, the national nursing association, the chief nursing officer and the educational sector, met over an intensive few days in September 2011 to develop their draft frameworks. Their frameworks were presented at a meeting of the ARC held in Arusha, Tanzania in October, 2011. Both countries hope to launch their national CPD programs early 2012.

LESOTHO TEAM

SWAZILAND TEAM

CNF FORUMS IN SWAZILAND AND LESOTHO

The CNF conducted two forums for nurse leaders in Swaziland and Lesotho in September 2011 where key nursing issues were discussed including nurses taking responsibility for their profession; regulating the profession; setting standards and competencies and scopes of practice; being advocates for the profession and for the provision of high quality care; and nurses as agents of change. The forums were made possible through funding from the Commonwealth Foundation.

The Forums also provided an opportunity for the Swaziland and Lesotho ARC teams to share the draft national frameworks for continuing professional development with a wider audience and to receive feedback about the framework.

SWAZILAND FORUM

LESOTHO FORUM

Although the national CPD frameworks for both countries covered the same key issues, there were quite a few differences in the final products as the teams worked to ensure their framework suited the way nursing was structured and practiced in each country.

Key issues covered were providing a rationale for why a national CPD program was being introduced; a definition of CPD; the principles on which the national program is based; the annual requirement and what type of activities will be considered as CPD; the documentation that will be required of nurses to demonstrate their CPD activity; accreditation of CPD activities; how compliance will be monitored and the penalties for non-compliance.

THE CNF VISITS ZIMBABWE

The CNF recently partnered with the Zimbabwe Nurses Association (ZINA) to conduct a safety workshop for thirty-six nurses and midwives.

The workshop explored issues related to a safe patient; a safe workplace; a safe profession; and a safe nurse. The key factors to ensure patient safety were identified as the availability of competent nurses; a conducive environment; adequate resources; patients actively involved in their own care and being well informed and knowledgeable.

Using prepared scenarios, workshop participants explored issues and problem solved around workplace safety. Participants strongly supported the notion that nurses have the right to work in an environment that does not threaten their health, safty or welfare and that a safe working environment contributes to patient safety.

Following a presentation on the criteria of a safe profession, participants individually assessed the nursing profession in Zimbabwe and collectively gave it a score of 64.2%.

The importance of teamwork in providing quality care was demonstrated with a number of group exercises.

Finally, partcipants undertook a number of self-reflection exercises to establish whether they considered themselves to be a safe nurse.

The nurses at the workshop recommended that ZINA advocate for:

* Adequate staffing levels and appropriate conditions of service and remuneration in all health facilities;
* Improved infrastructure for nursing education and educational opportunities to upgrade the qualifications of nursing tutors;
* Enhanced autonomy for the Zimbabwe Nursing Council so it has the capacity to ensure that nurses are competent and safe practitioners; and
* The provision of safety workshops in other provinces of Zimbabwe so the information provided can be accessible to other nurses.

After the workshop, Angela Neuhaus, CNF Honorary Treasurer, and co-facilitator of the workshop, hosted a luncheon for senior nurses in Zimbabwe at the Australian Embassy residence.

RESOURCES

Taking care of a baby at home after birth: what families need to do

Taking care of a baby at home after birth: what families need to do was published in 2011 and comes as a flipbook and contains key messages that pregnant women and their families need in order to plan care for an infant at home right after birth. It focuses on essential actions families can take to prevent newborn death and illness and to promote healthy newborn development. The book is written in clear language with practical suggestions and simple illustrations. It has a number of sections:

* Important actions for the mother to take during her pregnancy and after the birth.

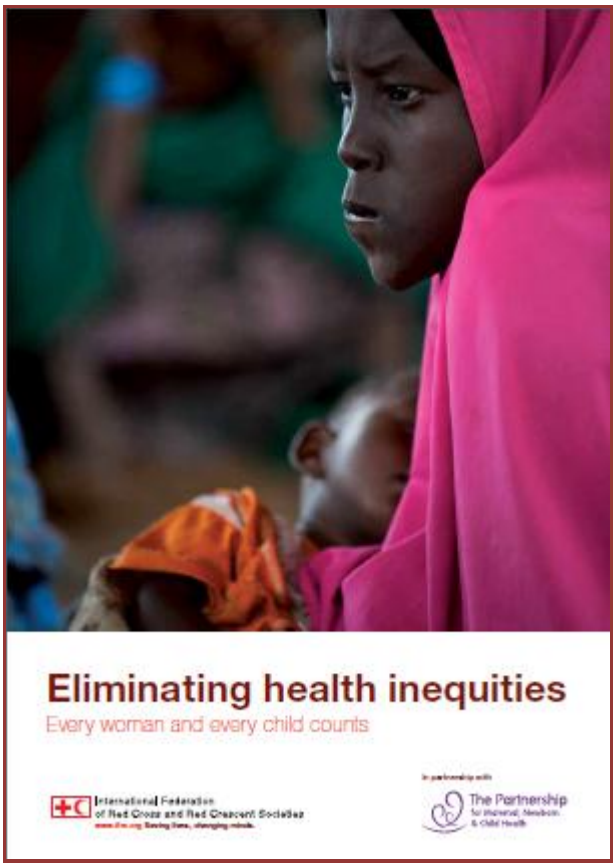
* What to do before the birth: collecting all the things needed at the birth; making plans in case of an emergency; and the special needs of mothers who are HIV positive.

* What to do for every new baby at birth: which covers dealing with common problems; how to deal with unexpected problems; breastfeeding; and what needs to be done for the baby in their first week of life. The section also provides information about babies that need special care, such as small babies or babies born to mothers who are HIV positive.

* Important actions to keep a new baby healthy, and what to do if the baby or mother shows any danger signs after the birth and how to take a new baby or its mother to get help should help should help be required.

Available from: http://www.coregroup.org/our-technical-work/working-groups/safe-motherhood-and-reproductive-health/219-taking-care-of-a-baby-at-home-after-birth-what-families-need-to-do

Eliminating health inequities: every woman and every child counts



Eliminating health inequities: every woman and every child counts is a 2011 publication from the International Red Cross and Red Crescent Societies (IFRC). Health inequities are defined as *unfair and avoidable differences in health status seen within and between countries.* Health inequities affect the most vulnerable people who have the least access, not only to health services, but also to the resources that contribute to good health.

The report suggests that women and children should be the focus of attention. Women are more likely to face health inequities because pregnancy and childbirth are life events that expose women to greater risk. Women are the gateway to improving the health of entire populations, starting with their children and members of their family. Women also bear the burden of caring for sick children and older people. The report recommends taking a human rights approach to eliminate health inequities and suggests that the standards articulated in human rights can guide policy, laws and regulations in dismantling barriers to health.

Available from:
http://www.who.int/pmnch/media/membernews/2011/20111129_healthinequities_report_eng..pdf

CNF NEWS

New CNF Board members

The CNF is pleased to welcome two new Board Members to the CNF Executive Team.

Paula Hancock is the new CNF Board member for the Europe Region.

Paula has a distinguished background in nursing education and is a member of the International Committee of the Royal College of Nursing. Paula currently works as an independent consultant in health and social care, education and training.

Lee Thomas is the new CNF Board member for the Pacific Region.

Lee is the National Secretary of the Australian Nursing Federation (ANF), the second largest union in Australia and the largest Australian nursing professional association. Lee was formerly the State Secretary of the South Australian Branch of the ANF.

Vale: Patrick Suleiman Bateganya

The CNF was shocked and saddened to learn of the recent sudden death of Patrick Suleiman Bateganya after a short illness. Patrick was a dynamic young man with a bright future and his death will be keenly felt by all nurses and midwives in Uganda.

Our thoughts and prayers are with his family, friends and colleagues at this sad time. Patrick was the Secretary of the Uganda Nurses and Midwives Union.

CNF website development program

One of the CNF projects during 2011 has been the website development program; an ongoing project to support the development of individual websites for small member associations to enable them to have an internet presence and be able to communicate more effectively within and outside their countries.

The project includes purchase of a discrete domain name for each organisation, web space for each organisation, the customisation of an individual and unique website, purchase of necessary software, and training for website maintenance so that countries can be independent.

We live in an age where increasingly, electronic communication is the medium of choice. Without access to email and the internet, organisations and individuals experience considerable disadvantage. The majority of CNF members do not have websites. Without an internet presence, these national nursing organisations are unable to effectively communicate with their members or promote themselves, their mission, their goals and their views on current issues.

To date websites have been developed for the Lesotho Nurses Association and the Sierra Leone Nurses Association and websites are underway for the Uganda Nurses and Midwives Union and the Nurses Association of the Commonwealth of the Bahamas.

http://www.lesothonursesassociation.org

http://www.sierraleonenursesassociation.org

Funding to support the development of the websites was provided by a grant from the Commonwealth Foundation.

Commonwealth Foundation

dch
the children's hospital at Westmead
Diploma in Child Health

ippc
the children's hospital at Westmead
International Postgraduate Paediatric Certificate

The Coppleson Committee for Continuing Medical Education, The University of Sydney ABN 15211513464

The International Postgraduate Paediatric Certificate for Nurses Solomon Islands

A sense of achievement was very evident at the fourth graduation of the International Postgraduate Paediatric Certificate, celebrated in Honiara, Solomon Islands, in April 2012. This brings to a total of 46 doctors and nurses who have successfully completed this program in the Solomon Islands alone.

The positive feedback from the doctors and nurses testifies to the benefits they receive as they seek the most recent paediatric knowledge to help them confidently give the best possible skilled care to the children and young people they treat. Nurses have said: "Nurses are speaking the same language as doctors". "We are the ones at the front line of primary health care; we need this program"; "I think about infants and children differently now: I measure their growth; I talk to their parents and explain problems; I think about their care when they are out of hospital". Doctors have said: "If I'd have had this lecture a week earlier, that child would not have died"; "I was able to make a diagnosis that a visiting doctor did not recognise".

This is a success story about strengthening health systems through improving human resources in health care by giving access to learning. IPPC is conducted where doctors and nurses work, while they work, without their need to travel.

What is IPPC (International Postgraduate Paediatric Certificate)?
Our vision is to give affordable managed access to an international standard in current best practice for doctors and suitably qualified nurses who care for children and young people worldwide.

IPPC is a one-year, part-time postgraduate program, awarded in conjunction with The Children's Hospital at Westmead and the University of Sydney, NSW Australia, which offers 111 lecture units from renowned experts. As collaborative in-country learning, the 111 lecture units are enriched in each country by IPPC tutors who are local paediatric experts. Tutors provide local adaptation to the lecture units, covering cultural issues, genetic variations, child protection management, local immunisation schedules and infectious disease protocols, and how best to use the available resources. Updated annually, lecture units comprise recorded lectures, learning outcomes, lecture notes and self-assessment questions. Word of mouth has been the mode of transmission of this emerging postgraduate paediatric education epidemic.

Already graduates use their new knowledge in teaching their colleagues; some graduates have even developed to become tutors. With changes in their work locations, graduates have germinated new IPPC sites and inspired their colleagues in to enjoying the energising benefits of case based teaching that connects them with current international best practice. IPPC is available already in Commonwealth countries including: Australia, the Solomon Islands, Vanuatu, India and Sierra Leone. It is about to commence in Kenya and there is emerging interest in Bangladesh. For further information see http://www.magga.org.au.

Adjunct Associate Professor Kathryn Currow Discipline of Paediatrics and Child Health, University of Sydney, NSW Australia; Executive Principal, Diploma in Child Health / International Postgraduate Paediatric Certificate; Senior CMO, Emergency Department, The Children's Hospital Westmead ; Vice President COMHAD (http://www.comhad.org); Deputy Chair Commonwealth Health Professions Alliance.