



the commonwealth nurse

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INAUGURAL COMMONWEALTH NURSES CONFERENCE

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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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Appointed Officers



Jill Iliffe
Executive Secretary



Angela Neuhaus
Honorary Treasurer

from the PRESIDENT



Susie Kong
CNF President



The Commonwealth Nurses Federation congratulates the Head of the Commonwealth, Her Majesty Queen Elizabeth II, as she celebrates her Diamond Jubilee. Her Majesty is much loved by the people of the Commonwealth and across the world for her dedication and selfless service for the past 60 years and we wish her many more years of good health. I have always admired Her Majesty from a distance and on Commonwealth Day this year, I had the great privilege of seeing her close-up, not once, but twice in one day. It was like a dream come true!

2012 is set to be a promising and busy year for CNF. Over the past few years, we have been slowly strengthening our organisation by working closely with National Nurses Associations throughout the Commonwealth and reaching out to nurses through in-country workshops, the monthly e-News and the Commonwealth Nurse. We have also helped in developing websites for some of the smaller organisations so they can be more connected with the rest of the world.

In conjunction with Commonwealth Day this year, the CNF held a very successful Inaugural Commonwealth Nurses Conference in London 10-11 March 2012. The Conference theme was: *Our health - our common wealth* and was attended by about 200 participants from 27 countries.



We were very encouraged to have the presence of His Excellency Kamalesh Sharma, Secretary General of the Commonwealth, Mr Vijay Krishnarayan, Director of the Commonwealth Foundation and Dr Danny Sriskandarajah, Director of the Royal Commonwealth Society at the Conference. Most of our Board Members were also there to support the Conference and everyone assisted in chiring sessions. We had a full programme for both days and all participants enjoyed and benefited from the sharing given by a list of distinguished speakers and other presenters. The feedback from participants was very positive, many of them said that apart from an interesting scientific programme, the food and refreshments were great, the atmosphere was very warm and friendly with lots of interactions and the whole Conference felt like a big family reunion.

Many of us who have organized conferences before would understand and appreciate the amount of hard work, and at times frustration that goes with organising a conference. I am deeply thankful to the CNF Executive Secretary, Jill Iliffe, who worked very hard to ensure we had a successful conference. My appreciation also goes to the Royal College of Nursing, United Kingdom, for generously giving us the support of their conference team.

The CNF Board met in London after the Conference and discussed strategies about how to further strengthen the CNF. As a Commonwealth organisation, our membership is limited to Commonwealth countries and some countries are very small and do not have nurses associations. The CNF Board decided that since nurses and midwives work closely together in most countries and often face similar issues and problems, it would be good to invite the midwives to join the CNF. The Board will be putting a recommendation to members to expand our membership categories and, if accepted, the CNF would consider changing our name to the Commonwealth Nurses and Midwives Federation. We look forward to hearing your views.

INAUGURAL COMMONWEALTH NURSES CONFERENCE



Trinidad and Tobago Zimbabwe



Cameroon



Ghana



East, Central and Southern Africa



Botswana



Sierra Leone



United Kingdom



Bermuda



Sri Lanka and Botswana



Zimbabwe



Kenya

LEADERSHIP IN NURSING



Dr Peter Carter
General Secretary and
Chief Executive Officer
Royal College of Nursing
United Kingdom

Leadership was the opening and closing themes of the conference. Dr Peter Carter in his opening address titled: *Leadership in nursing*, discussed the difference between leaders and managers stressing the need for nurses and midwives to be leaders first and managers second.

Leaders master the context of their mission; managers surrender to it.

MANAGERS

Doing things right

Administer, imitate, maintain
Focus on structure
Rely on control
Have short range view
Accept the status quo
Are classic good soldiers

LEADERS

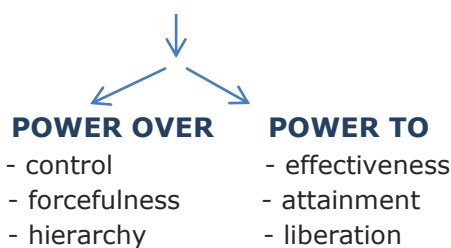
Doing the right things

Innovate, originate, develop
Focus on people
Inspire Trust
Have long range perspective
Challenge the status quo
Ask what and why

Dr Carter explained that power can be used in a number of ways both positively and negatively and that nurse and midwife leaders need to use the personal power and the power of their position wisely.

EMPOWERMENT

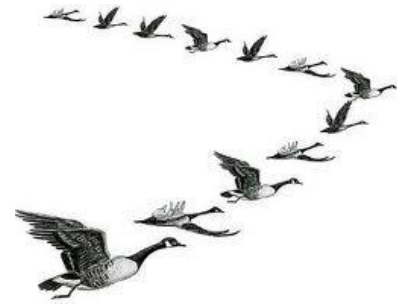
POWER



Leaders must have political awareness. They must develop the vision and establish the direction. They must manage by example and be a role model. Leaders must be visible; pay attention and listen; and communicate effectively by speaking the same language and learning who and how to influence.

Leaders need to be able to empower people; facilitate risk taking; delegate not abdicate; and network - locally, regionally, nationally and internationally.

Dr Carter said that nurse and midwife leaders could learn a great deal from the behaviour of geese. The uplift draft from each goose when flying in a 'v' formation increases flying range by 71%. The lesson for leaders is that by coordination and working together, productivity can be increased dramatically.



Dr Carter also pointed out that as the lead goose tires, the geese rotate that position. The lesson for leaders is that workload should be evenly distributed and that too much reliance should never be placed on one individual.

Dr Carter also noted that geese flying in the rear honk to provide information; to encourage; and to warn. He said that communication is critical to ensuring effective teamwork.



Another characteristic of geese is that if one goose is wounded or is unwell, two geese accompany their friend to the ground and remain until the goose has either recovered or dies.

Dr Carter said that the need for leaders to be supportive and sensitive to the needs of others, particularly in times of crisis, is paramount.



The Commonwealth Secretariat sponsored four young presenters from developing countries. Mr Maraka Monaphathi (Lesotho), Mr Senesie Margao (Sierra Leone), Miss Flora Neh (Cameroon), and Mrs Alice Tambe Agbor (Cameroon) pictured at the conference with the Secretary General of the Commonwealth His Excellency Mr Kamallesh Sharma.



Malaria is a life-threatening disease caused by parasites that are transmitted to people through the bites of infected *Anopheles* mosquitoes. According to the *World malaria report 2011*, there were about 216 million cases of malaria and an estimated 655 000 deaths in 2010. Most deaths occur among children living in Africa where a child dies every minute from malaria. Vector control is the main way to reduce malaria transmission through the use of long-lasting insecticide treated nets and through indoor residual spraying.

The Royal Commonwealth Society in partnership with Olyset held a Commonwealth wide competition for school children titled: *Me and my net*, for the best campaign ideas to prevent malaria. The winner of the competition was a 15 year old girl from India, Siya Kulkarni. Siya presented her campaign at the Inaugural Commonwealth Nurses Conference. Her innovative campaign was a mix of campaign messages, education, activities, incentives and poetry.



Following her inspiring presentation, Siya was presented with a cheque for £200 by Maura Buchanan, past President of the Royal College of Nursing, so she could purchase sixty insecticide treated nets for local distribution.



SIYA'S POEM

Once upon a rainy night
 There were two boys - Jack and Fred
 Both, in their rooms, turned off the light
 As they tucked themselves into bed



Pitter-patter went the rain
 The night was very cold and damp
 A buzzing noise, a stinging pain
 Jack woke with a start turning on the lamp
 His fingers reached out for his nose
 Which had now begun to itch
 When he saw a swarm of mosquitoes
 His eyes and face began to twitch
 He didn't sleep a wink that night
 As he tossed and turned in his bed
 He scratched and scratched the mosquito bites
 Which were quickly turning red



But Fred meanwhile had a good night's sleep
 And you may as well ask why
 For as he dreamt of stars and sheep
 He was a very clever guy
 And just before he went to bed,
 And his mum kissed him good night
 He had a plan in his head
 So the mosquitoes wouldn't bite
 Over his bed he hung a net
 And shut the windows of his room
 This definitely wouldn't let
 The insects spread their doom and gloom
 Once upon a sunny day
 After a very rainy night
 Jack with a fever in bed lay
 While Fred awoke fresh and bright



THE COMMONWEALTH: TERMINALLY ILL OR ON THE MEND



Dr Danny Sriskandarajah

Director
Royal Commonwealth Society



In March, I had the pleasure of addressing delegates to the Inaugural Commonwealth Nurses Conference in London. I have recycled the metaphor I used in my speech for the title of this article. The question seeks to establish the current health of the Commonwealth and determine just how optimistic we ought to be about its prognosis. Three years ago, the RCS undertook the largest and most comprehensive examination of the Commonwealth in an effort to answer that question. The global consultation gathered the opinions of thousands of people; members of the public and experts working both within and outside the Commonwealth. Any rose-tinted illusions we had that all was well with the Commonwealth were shattered by what we heard.

Globally, only one third of people polled could name any Commonwealth activity. Support for the Commonwealth amongst developed countries was particularly low and in countries such as Australia, the United Kingdom and Canada, only about one third of people would be sorry if their country left the Commonwealth. The Conversation revealed some uncomfortable home truths about the Commonwealth and suggested there are two problem areas in need of urgent action: principles and profile.

Apart from its history, people are no longer sure what distinguishes the Commonwealth from other associations. A re-articulation of values and principles could be one crucial step toward rectifying this. Clarification of what the Commonwealth stands for and why it is unique and important in a crowded marketplace of international actors is of the utmost importance. However, for any re-statement of Commonwealth values to be truly effective, not only must it be done in a publicly accessible way, it must be clearly distinguished from commitments made by member countries in other fora. Linked to this clarification of principles, is the question of profile. Both our polling results and subsequent findings suggest that the Commonwealth's profile is low. For publicly-funded Commonwealth institutions, this is potentially dangerous in fiscally difficult times. For the activities of Commonwealth civil society, a low profile hampers both reach and impact. At the heart of these ills still plaguing the Commonwealth is the need for strong leadership.

But at the most recent Commonwealth Heads of Government Meeting in Perth, a meeting which promised change in the form of the Eminent Persons Group bold recommendations for reforms, leaders failed to seize the opportunity provided to them, and many of the most potent reforms were relegated 'for further discussion' or deemed 'inappropriate for adoption'. It became clear to us that Commonwealth leadership and global governance must find new actors; that change will come not from world leaders or international institutions, but from 'civil society'; individuals, groups, professional associations and non-governmental organisations who increasingly demonstrate the energy, innovation and influence in the Commonwealth and across the world.

When the Commonwealth Secretariat was officially established at Marlborough House in 1965, the Commonwealth Foundation was created at the same time, designed to foster links between Commonwealth citizens and strengthen the Commonwealth's people-to-people networks. By creating this novel kind of institution, Heads of Government displayed an early recognition of the civic. It was a very progressive act at the time; predating buzzwords like 'NGOs' and 'civil society'; appreciating the importance of non-governmental actors to the success of the Commonwealth. Indeed, some Commonwealth civil society and professional organisations are older than the institution itself: the Commonwealth Parliamentary Association held its centenary in 2011; the Association of Commonwealth Universities will mark theirs in 2013.

This group of 54 nations is fundamentally different from other intergovernmental organisations. Instead of being bound by regional proximity, treaties or accords, the Commonwealth is joined by a shared commitment to democracy and development. Beyond the ties of history, language and institutions, this family of nations endures through the pursuit of common goals and aspirations. And it is the Commonwealth's expansive network of civil society organisations and professional bodies that reinforce and strengthen its intergovernmental framework. In a world of increasing complexity, of global instability and widespread unrest, true strength lies beyond classic state-state relationships. In the Commonwealth, civil society has come to embody the enormous potential of the entire institution. It is this very potential I witnessed when meeting delegates at the Commonwealth Nurses Conference last month, and it is this public potential that will help cure this ailing association. At its founding, Nehru had ambitious hopes that the Commonwealth could bring a 'touch of healing' to the world. Perhaps instead it is civil society, organisations like CNF, that first need to bring its own touch of healing to the Commonwealth if it has any hope to survive.

DOING THING DIFFERENTLY

Innovation and excellence in clinical practice



Andrea Spyropoulos
President
Royal College of Nursing UK

Andrea Spyropoulos is the President of the Royal College of Nursing in the United Kingdom. Andrea's presentation was titled: *Innovation and excellence in clinical practice*.

Andrea suggested that nursing and midwifery are the most innovative professions. Innovative practice has always been important for nurses and midwives: new ideas, learning from each other and implementing what works best are at the heart of many of the major steps forward nurses and midwives have taken on behalf of their patients. Innovative practice is a cornerstone of nursing excellence - seeing a problem or a failing in care and acting on it is what nurses and midwives do best.

Andrea shared with conference participants, the RCN UK: *Principles of nursing practice* which underpins nursing innovation and excellence.

- a. Nurses and nursing staff treat everyone in their **care with dignity and humanity** - they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.
- b. Nurses and nursing staff **take responsibility for the care** they provide and answer for their own judgments and actions - they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.
- c. Nurses and nursing staff **manage risk, are vigilant about risk**, and help to keep everyone safe in the places they receive health care.
- d. Nurses and nursing staff **provide and promote care that puts people at the centre**, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.

- e. Nurses and nursing staff are at the **heart of the communication process**: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.
- f. Nurses and nursing staff have **up-to-date knowledge and skills**, and use these with intelligence, insight and understanding in line with the needs of each individual in their care.
- g. Nurses and nursing staff **work closely with their own team and with other professionals**, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome.
- h. Nurses and nursing **staff lead by example**, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

Andrea concluded by reminding participants that innovation embodies all that is good about nursing: care that is not only about improving care but care which is cutting edge and changing lives.



TALC provides an extensive range of books, teaching materials, electronic resources and health accessories at low cost or no cost to health workers in developing countries worldwide. Their website is certainly worth a visit.

<http://www.talcuk.org>



SOUTH PACIFIC NURSES FORUM

16th South Pacific Nurses Forum

The future of nursing and midwifery: where are we heading?

Monday 19 - Thursday 22 November 2012
Leonda By The Yarra Hawthorn, Victoria, Australia

For more information go to: <http://www.spnf.org.au>

MEETING THE INFORMATION NEEDS OF NURSES AND MIDWIVES



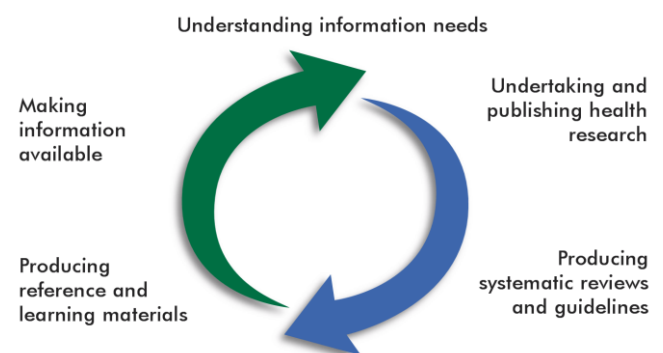
Dr Neil Pakenham-Walsh
 Coordinator Health for all by 2015 (HIFA 2015)
 Co-Director, global Healthcare Information Network

Dr Pakenham-Walsh's presentation to the conference was titled: *Meeting the information needs of nurses and midwives in low and middle income countries*. Dr Pakenham-Walsh claimed that empowering nurses and midwives is fundamental to reducing unnecessary death and suffering and achieving the health MDGs.

Dr Pakenham-Walsh said poor health care in low and middle income countries is seldom due to individual nurses and midwives. The problem is usually due to health systems failing to provide sufficient numbers of nurses and midwives or meeting the needs of existing nurses and midwives. Nurses and midwives are not the problem, they are the solution. Health systems and health management need to undergo a SEISMIC shift to meet the needs of existing nurses and midwives:

- S** skills
- E** equipment
- I** information
- S** supporting infrastructure
- M** medicines
- I** incentives (including a decent salary)
- C** communication facilities

Dr Pakenham-Walsh reminded conference participants that people are dying because of a lack of basic health care knowledge. Many of these deaths could have been avoided if individuals and health workers, including nurses and midwives, had access to appropriate and reliable health care information.



Dr Pakenham-Walsh reminded participants that to be useful, information must be relevant and reliable.

Information needs are diverse and dynamic and perceived needs are not the same as actual needs. Dr Pakenham-Walsh concluded by saying that all efforts should be directed to liberate and empower nurses and midwives to save lives and reduce suffering; that is it not acceptable that people are dying for lack of health care knowledge. Dr Pakenham-Walsh invited participants to join HIFA 2015.



Health care information for all was launched in Mombasa Kenya in 2006. It now has 7,500 members from more than 2,000 organisations in 163 countries.

HIFA2015 (Healthcare Information for All by 2015) is a global campaign and knowledge network administered by the Global Healthcare Information Network, a non-profit organisation working to improve the quality of health care in developing countries.

HIFA2015 brings together more than 5000 health workers, librarians, publishers, researchers and policymakers in 2000 organisations across 158 countries worldwide, all committed to a common goal. Together we are working for a future where people are no longer dying for lack of basic healthcare knowledge. The CNF is a member of HIFA 2015 and benefits from the information provided and the email dialogue and discussion with other members. For further information and to join HIFA2015 go to: <http://www.hifa2015.org>. Membership is free.



HESPERIAN DIGITAL COMMONS

Hesperian Health Guides are now available for free download in over 80 languages from the Hesperian website.

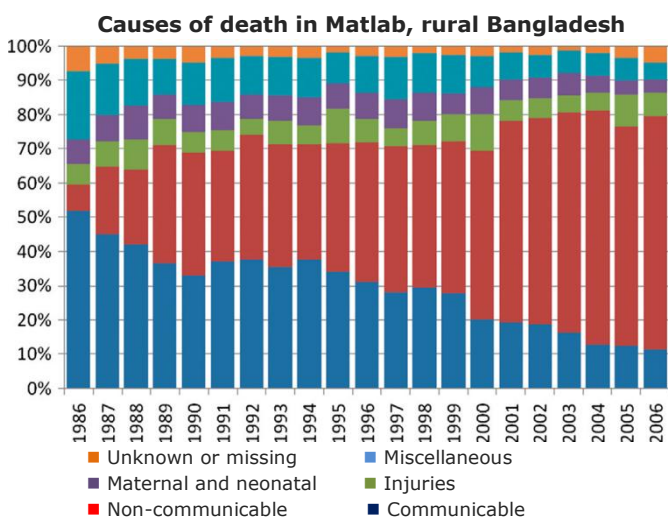
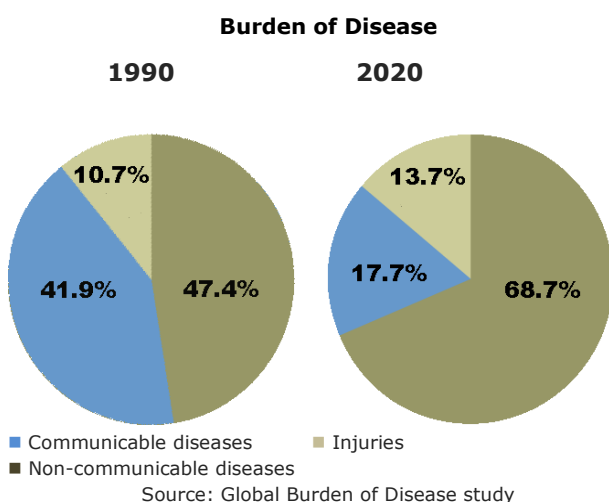
Books such as: *Where there is no doctor* and: *A book for midwives*, as well as other titles covering women's health, children, disabilities, dentistry, health education, HIV, and environmental health, are now available online. Hesperian Health Guides are easy to use, medically accurate, and richly illustrated. These wonderful resources can be downloaded from the Hesperian website: <http://hesperian.org/digital-commons/>.

THE NURSES' ROLE IN PREVENTING SUFFERING AND CONTAINING HEALTH CARE COSTS



Ms Christine Hancock
 Founder and Director
 C3 Collaborating for Health

Ms Hancock's presentation titled: *The nurses' role in preventing suffering and containing health care costs* informed participants that the incidence of non-communicable disease has been rising since 1986 while at the same time and as a result of positive health interventions, the incidence of communicable disease has decreased.

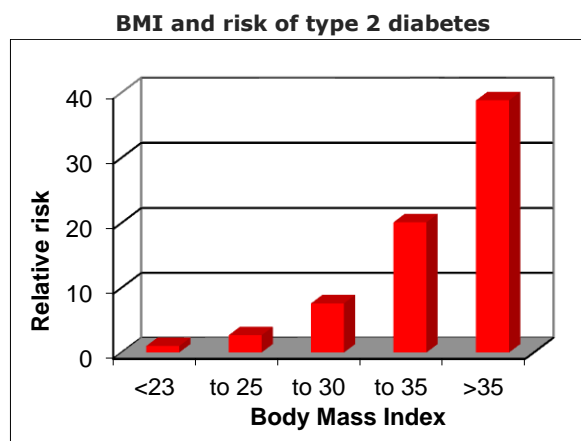


Source: Karar, Z.A. et al., 'Epidemiological transition in rural Bangladesh, 1986-2006' (2009) *Global Health Action*

Ms Hancock pointed out that **three** risk factors - tobacco use, lack of physical activity and an unhealthy diet - cause **four** chronic diseases - cardiovascular disease, type 2 diabetes, many cancers, and chronic lung disease - which cause over **50%** of deaths worldwide.

Ms Hancock emphasised that prevention works - prevention is simple, affordable and effective. Increasing physical activity reduces the risk of breast cancer, colon cancer, stroke, coronary heart disease and diabetes and has positive effects on musculoskeletal and mental health.

Adults should undertake moderate intensity physical activity (eg brisk walking) for a minimum of 30 minutes five days a week or vigorous intensity activity (eg jogging) for a minimum of 20 minutes three days a week with lower goals for older people who have physical impairments or functional limitations. Children should do at least an hour of physical activity every day.



Source: Hu, F.B. et al, 'Diet, lifestyle and the risk of type 2 diabetes mellitus in women' (2001) *New England Journal of Medicine*

In relation to diet, five servings of fruit and vegetables each day reduces the risk of cardiovascular disease by 28%; type 2 diabetes by 24%; and some gastrointestinal cancers by 20%. A study of 84,941 nurses demonstrated that the risk of developing type 2 diabetes increased as BMI increased (see figure above).

Ms Hancock noted that non-communicable disease is responsible for 60% of all deaths worldwide; 80% of chronic disease deaths occur in low and middle income countries; almost half of chronic disease deaths occur in people below the age of 70; around the world, chronic disease affects women and men equally; without action, 17 million people will die each year from non-communicable disease; and that if the major risk factors for chronic disease were eliminated, at least 80% of heart disease, stroke, and type 2 diabetes would be prevented; and 40% of cancers.

Ms Hancock concluded by reminding nurses that what Dr Haefden Mahler, WHO Director General, said in 1985 is still relevant today: *if the millions of nurses in a thousand different places articulate the same ideas and convictions ... and come together as one force ... they could act as a powerhouse for change.*

WORKING TOGETHER FOR A HEALTHY NURSING AND MIDWIFERY WORKFORCE



Ms Yvonne Chaperon
Assistant National Secretary
Australian Nursing Federation

Ms Yvonne Chaperon is Assistant National Secretary of the Australian Nursing Federation. Ms Chaperon explained to delegates that the Australian Nursing Federation (ANF) is the second largest union in Australia representing nurses and midwives and advocating on their behalf in the areas of:

- * fair salaries and working conditions;
- * safe working environments;
- * regulation, education, training, and workforce;
- * social justice, human rights, and socio-economic welfare;
- * fairness in immigration and migration policies;
- * reform in relation to health and aged care.

In undertaking its role of national union for nurses and midwives, the ANF collaborates with, and has developed strong working relationships with, a range of other organisations and key individuals, both within and outside of government, such as the chief nursing and midwifery officers; the national regulatory body for nurses and midwives; the national accreditation body for programs leading to registration as a nurse or midwife, and a wide range of specialist national professional nursing and midwifery organisations.

As the national nurses and midwives union, it is the ANF to whom the Government comes for advice on professional nursing and midwifery matters. Being a union the ANF is in the unique position of being able to advocate and legally negotiate on both professional and industrial issues. As many of these issues cannot be separated, the ANF has the benefit of being able to provide well researched arguments, and support for members, from both a professional and industrial perspective.

While the ANF has achieved much over the years, Ms Chaperon said that the chances of success are increased when there is a collaborative effort in advocating for change through reforms. However, leadership is generally required by one party in the collaborating group to organise and inspire the people being brought together, and to provide the resources needed to maintain forward movement of the group's work. The ANF regularly takes this leadership role and takes seriously their responsibility on behalf of nurses and midwives in developing a healthy workforce and healthy systems of work.

DARING, CARING AND SHARING! Keeping our Nightingale legacy alive and thriving!



Dr Deva-Marie Beck
International Co-Director
Nightingale Initiative for Global Health

The conference was very privileged to hear from Dr Deva-Marie Beck, International Co-Director of the Nightingale Initiative for Global Health. Dr Beck reminded conference participants that Florence Nightingale was revered by the whole world because she was a humanitarian and a nursing administrator; a nurse educator; and an advocate for sanitation. She was revered for her work on statistics; on health outcomes; on health policy; for her pioneering work on environmental issues; her work on hospital design; and her advocacy for cultural integrity.

Nightingale was a leader in crafting the 1st Geneva Convention in 1864 which was a key step in founding the International Red Cross, the League of Nations and ultimately, the United Nations. Nightingale was a best-selling author and a strategic communications expert who networked around the world. In 1983, Nightingale said: *Health is not only to be well but to use well every power we have.*

Founded in 2003, the goal of the Nightingale Initiative for Global Health is to keep Nightingale's legacy alive in innovative ways in order to:

- * create greater awareness about the health of all humanity,
- * empower nurses and concerned citizens to share information and resources,
- * advocate for action to solve the most vital global health problems of our time,
- * create strategic awareness of global health issues,
- * mobilise world public opinion, and
- * strengthen concern and commitment.

Dr Beck acknowledged that many countries had very special nurse leaders who were integral to developing nursing in their own country, however no one nurse leader has ever achieved the global stature of Florence Nightingale or had such an impact on the development of nursing which has endured over time. International Nurses Day is of course celebrated on Florence Nightingale's birthday, 12 May. Conference participants were encouraged to find out more by visiting:

<http://www.nightingaledeclaration.net>
<http://www.nighworld.net>

LEADERSHIP LEGACY: Caring lessons from around the world



Dr Marla Salmon

Dean of Nursing
Professor in Psychosocial and
Community Health
University of Washington DC

Dr Marla Salmon, Dean of Nursing and Professor in Psychosocial and Community Health at the University of Washington is highly regarded and much loved in international nursing circles. Through her presentation: *Leadership legacy: caring lessons from around the world*, Dr Salmon sought to explore with conference participants what constituted a positive leadership legacy; identify key characteristics of legacy leaders; and encourage participants to reflect on their own leadership legacy.

Leaving a positive leadership legacy means passing on the leadership baton, not 'owning' it; and nurturing and launching the next generation of leaders. Positive legacy leaders lead in service to and with others. They do not see 'service' as 'subservience'. They are inspired by those they serve; they are rewarded by their connection with others; and they are undaunted by adversity.

Positive legacy leaders cultivate a compelling leadership vision. They 'see' the possible in the present; they use vision as a source of unity and hope; they drive change forward toward a better future; they use history to inform, not restrict; they 'see' the strengths and aspirations of people around them; and are able to capture the power of change.

Positive legacy leaders act purposefully: they think and act strategically; they look ahead; they plan the work and work the plan; they count what counts; they know what is truly necessary; and they see compromise as a useful tool. Positive legacy leaders actively collaborate and partner. They cultivate common ground while embracing difference; understanding that difference, Dr Salmon said, helps us to see the richness of other ideas and approaches.

Dr Salmon explained that contrast helps us to see things more clearly.



Contrast helps us to see things more clearly

Dr Salmon said that positive legacy leaders steward the future. They keep the future in the forefront; actively communicate the long view; and foster deep, shared leadership with their colleagues. Positive legacy leaders actively care. They see the people in the problems; they work at staying connected; they reach out beyond self interest or convenience; they act with humanity and compassion; and understand the deep power of caring.

Positive legacy leaders act with integrity and courage. They advocate for the most vulnerable; they take risks as the price of progress; they seek and tell the truth; they assume responsibility and apologise when they are wrong; and they lead by example, even when it means sticking their neck out.

Positive legacy leaders find ways to renew and reflect through supportive communities; meaningful relationships; ongoing learning; personal meaningful spirituality; and generosity of spirit.



Positive legacy leaders know it is not always easy but they make sure they take time to smell the roses on their leadership journey.

JUBILEE TIME CAPSULE



Share your story with the Queen as she celebrates her Diamond Jubilee in 2012; 60 years as Queen and 60 years as Head of the Commonwealth. **Let us make sure that there are plenty of stories from nurses and midwives from across the Commonwealth.**

Go to: <http://www.jubileetimecapsule.org>

2012 COMMONWEALTH HEALTH MINISTERS' MEETING

Sunday 20 May 2012



Commonwealth Health Professions Alliance

Presented by Ms Jill ILIFFE
Executive Secretary Commonwealth Nurses Federation
on behalf of the Commonwealth Health Professions Alliance

Honourable Ministers of Health: I am addressing you today on behalf of the Commonwealth Health Professions Alliance and the broader Commonwealth civil society family.

The CHPA is an alliance of commonwealth accredited health organisations. Current membership includes the Commonwealth Medical Association; the Commonwealth Nurses Federation; the Commonwealth Pharmacists Association; The Commonwealth Association of Paediatric Gastroenterology and Nutrition; The Commonwealth Association for Health and Disability; the Commonwealth Dental Association; and the Commonwealth HIV and AIDS Action Group. The CHPA consider that by working together they can more efficiently and effectively represent and support health professionals in Commonwealth countries and promote high standards of care and equity in access to care for Commonwealth peoples. The CHPA also consider that by working together they can be more influential in advocating on behalf of Commonwealth health professionals in Commonwealth forums and have a positive impact on the development of health policy at a Commonwealth level. The membership of CHPA members consists of the national health professional associations in Commonwealth countries so between them, the CHPA communicates directly with the millions of health professionals delivering services in Commonwealth countries.

The economic cost and the health burden on countries of communicable and non-communicable disease is well documented. Also well documented is the fact that both communicable and non-communicable disease can be prevented with simple lifestyle behavioural change.

The theme for this Commonwealth Health Ministers' meeting is the linkages between communicable and non-communicable disease. The 2012 Commonwealth theme is: *Connecting cultures*. The Commonwealth Health Professions Alliance supports the concept so well-articulated by previous speakers that one of the key linkages between communicable and non-communicable disease is culture.

Culture has been succinctly defined by the World Commission on Culture and Development and the Intergovernmental Conference on Cultural Policies for Development as: *the whole complex of distinctive spiritual, material, intellectual and emotional features that characterise a society or a social group and includes not only the arts and letters, but also modes of life, ways of living together and the fundamental rights of the human being, their value systems, traditions and beliefs*. It is our contention and our experience that the most effective and successful health messages to prevent communicable and non-communicable disease are those that take account of, and are specifically designed around, a local community's cultural beliefs and traditions.

Globally, the HIV and AIDS epidemic taught us valuable lessons about how to convey culturally acceptable health messages if you want to change health behaviour. In Australia, for example, the early HIV and AIDS messages focused on creating fear, seeing the HIV virus as a spectre of death. These messages were largely unsuccessful. The successful messages that led to positive behavioural change were a combination of simple facts delivered in a culturally appropriate way to the groups in Australia most vulnerable to HIV infection, supported by specific health system interventions such as providing HIV testing and counselling services and non-discriminatory treatment and care.

The campaign to prevent non-communicable disease can learn a lot from campaigns to prevent communicable disease in the way that cultural considerations are integral not just to the message but also to the way the message is delivered.

A wonderful example is a small community in India where insecticide treated nets are being widely promoted to prevent malaria. Local research found that children were particularly opposed to and frightened by sleeping under nets and this influenced parental behaviour in not enforcing ITN use. A local campaign with school children encouraged them and provided the means for them to decorate their nets with colours and pictures and designs. The reported increase in ITN use was dramatic. This was a very simple and inexpensive campaign and one which is sustainable over time and which was reinforced with health information about why malaria prevention is so important.

Another successful example comes from Cross River State in Nigeria where, between 2004 and 2008, immunisation rates were increased from around 20% to over 84% and HIV seroprevalence reduced from 12% to 6.1% simply by translating health messages into local languages.

In Uganda they have had incredible success in reducing the incidence of sexually transmitted infection among young people by using drama and song with the support of popular radio and TV stars and high profile sporting personalities. One of their popular slogans was: *Let's fight the infection, not the infected.*

There are many examples across the Commonwealth of health messages which are successful because they are purposefully designed in a culturally acceptable way.

Messages about TB awareness directed to high school children in one district in India have become an integral part of the school curriculum using posters which the children develop themselves, role plays, mime and villupattu; simple tunes and simple verses to tell the story. A screening clinic is also provided on a regular basis which other family members can attend to be screened and treated for TB.

Midwives in Lesotho have designed a 'Mother-Baby' pack, a gift that is given to all mothers attending an antenatal clinic for the first time. The pack contains the essentials for a clean birth such as a new razor blade, cord ties and cloths, as well as ARV prophylaxis in case the mother does not attend the health facility for her delivery.

A successful campaign in Jamaica is targeting marginalised out of school and jobless youth from several vulnerable communities in inner city Kingston. Called '*Safe, stupid or what*' the campaign is using culturally acceptable strategies to deliver HIV and STI prevention messages. One of the key successes of the campaign is that it is delivered in the same environment where the young people 'hang out' and uses strategies that appeal to them such as dance, music and providing food and a meeting place.

Health fairs are another successful approach that have been implemented widely in the Caribbean using catchy slogans such as: *Health choices are easy choices* and: *The health of a nation is the wealth of a nation* and: *It's your health, know the facts.* Run locally by nurses, doctors, pharmacists and other health workers, tents are set up in local communities and health information and screening provided. One of the recent innovations in the Bahamas is the development by the nurses association of a 'health diary' which is given to individuals and which, beside containing very relevant and simple health messages, encourages individuals to take an interest in their health and monitor their own health status.

In Trinidad and Tobago, local health visitors have been generating interest in an individual's risk of contracting a non-communicable disease by working with them to map their family tree, highlighting those individuals in their family who have diabetes, or heart disease or cancer. This is an innovative way of demonstrating an individual's risk of developing a non-communicable disease while at the same time providing an opportunity to convey positive health messages. The family tree has been so popular it is being replicated in other districts.

In the north of Cameroon, the local health centre came up with an innovative and practical way of encouraging physical activity among local women. Participation in exercise such as jogging in shorts and trainers was not culturally appropriate however most of the local women were farmers whose farms were several kilometres from where they lived. The usual practice for these women was to pay local motor bikes to take them to their farms. The local campaign was for the women to walk to their farms instead. The campaign included linking women together so they had company while they walked and making up catchy songs to sing while they walked which told health messages. Health indicators such as weight and blood pressure were monitored and very positive health outcomes are being reported.

In Kenya, the Pharmaceutical Society of Kenya dedicate one month in each year as National Pharmacy Awareness Month and during this month they carry out various culturally sensitive public health activities in the local community targeting the prevention of communicable and non-communicable disease.

The Indian Medical Association aims to reduce the incidence of Coronary Artery Disease to less than 1% in the general population through health education in the local media translated into local languages; group discussions; screening camps for diabetes, hypertension and coronary heart disease; and providing 'after 50 coronary risk health checks' in workplaces, factories and government offices.

In the South Pacific, particularly in Tonga and Samoa, national nutrition initiatives are encouraging individuals to replace processed foods with cheaper and more readily available traditional foods. The health information delivered at the local level is also encouraging families to use the land around their home to grow their own food. I saw a very effective program in Tonga where the health intervention was to build fences around the vegetable patch to protect it from the pigs: a simple, effective and culturally responsive strategy.

The key element in all these examples which are only a small few of the many available is that they are delivered locally by people who know their target group, who know their target groups values and beliefs, and who design their health messages so that it is culturally acceptable to their target group.

The cultural approach optimises, harmonises and popularises the positive factors in the culture of a given population while minimising and eliminating the negative elements or obstructive aspects to obtain safe and responsible health behaviour.

The cultural approach will only work however if health systems and health policies are structured around a primary health care service deliver model; if resources are available for primary health care interventions; and if the necessary health personnel are available on the ground to deliver the messages.

It is also important that the management of communicable and non-communicable disease is integrated within health policy and health systems. The cultural approach works for both communicable and non-communicable disease. They are no longer separate disease clusters. People with communicable disease are living long enough to develop non-communicable disease. People with non-communicable disease are just as likely as the rest of the population to develop a communicable disease.

I started this presentation by saying that the economic cost and the health burden on countries of communicable and non-communicable disease is well documented and that also well documented is the fact that both communicable and non-communicable disease can be prevented with simple lifestyle behavioural change.

The economic cost and the health burden on health systems of countries and on their health personnel can be significantly reduced by enabling a primary health care delivery model and a cultural approach to the early detection and prevention of communicable and non-communicable disease.

CULTURE CONNECTS

Linking communicable and non-communicable disease



2012 COMMONWEALTH PARTNERS' FORUM

On Sunday 20 May following the Commonwealth Health Ministers' meeting, the Commonwealth Health Professions Alliance joined with partners – the Commonwealth Foundation and McKinsey and Company to present the Commonwealth Partners' Forum. The theme of the forum was: *Culture connects, linking communicable and non-communicable disease.*

International experts, Dr Collins Airhuhenbuwa (Professor and Head, Department of Biobehavioural Health, Pennsylvania University and author of the Penn3 model of cultural approaches to promoting healthy behaviour) and Dr Christoph Benn (Director, Resource Mobilisation and Donor Division, Global Fund) addressed over 100 delegates and shared with them their insights and expertise about how successful approaches to preventing communicable and non-communicable disease will be more successful if the message and the strategy are based on the individual's culture.



Dr Collins Airhuhenbuwa



Dr Christoph Benn

The Forum was introduced by Dr Sundaram Aralrhaj, Chairperson of the Commonwealth Health Professions Alliance and moderated by Dr Nicolaus Henke, Leader, Health Systems and Services, MckInsey and Company.

COMMONWEALTH HEALTH PROFESSIONS ALLIANCE

- Commonwealth Association for Health and Disability
- Commonwealth Association for Paediatric Gastroenterology and Nutrition
- Commonwealth Dental Association
- Commonwealth HIV and AIDS Action Group
- Commonwealth Medical Association
- Commonwealth Nurses Federation
- Commonwealth Pharmacists Association

The CHPA is an alliance of Commonwealth health professional associations who consider that by working together they can more efficiently and effectively represent and support health professionals in Commonwealth countries and promote high standards of care and equity in access to care for Commonwealth peoples (<http://www.chpa.co>).



Commonwealth Foundation



McKinsey & Company



First announcement and call for abstracts

10th European Conference of the Commonwealth Nurses' Federation

«Advancing Nursing and Midwifery through Evidence Based Practice»

Friday - Saturday 15 - 16 March 2013 • Palm Beach Hotel, Larnaca, Cyprus

The organising Committee invites abstract submissions from nurses and midwives, who are interested in sharing their skills and knowledge with a European audience.

CONFERENCE THEME

- Leadership • Evidence Based Nursing and Midwifery • Women's Health • Mental Health
- Innovations in Nursing and Midwifery Practice, Research, Education and Management
- Moving Nursing and Midwifery Forward • Practice Development Nursing and Midwifery
- Information Technology in Nursing and Midwifery
- Life Long Learning • Community Nursing and Midwifery

Abstracts should ideally fall within one of these categories, although other areas will be considered. However, presenters are reminded that papers need to include an indication of how their work addresses and adds value to nursing and midwifery.

GUIDELINES FOR PRESENTATION:

To facilitate the selection and processing of abstracts, the following information needs to be complied by the author. Please send to the conference organiser, through e-mail: cnfconference@gmail.com

- Plenary sessions will be up to 30 minutes in length and include 5 minutes for questions.
- Sessions normally run as one hour and may contain 2 to 3 papers
- Presentations sessions will be 20 minutes in length with 10 minutes for questions
- Posters should be visually stimulating and legibly presented
- Workshops are up to 2 hours in length

Please provide the following information:

1. Title (Dr / Mr / Ms)
2. Name and Surname
3. Job Title
4. Qualifications
5. Workplace
6. Mailing address
7. CYNMA, MUMN, RCN membership number
8. Telephone number
9. E-mail address
10. Short Professional biography

Provide also the following on a separate sheet:

1. Title and theme of the paper
2. Aim of the presentation
3. At least 3 intended learning outcomes
4. Prefer type of presentation (plenary, session, workshop, poster)
5. Abstract of the presentation (not more than 300 words)

Please note: All participants chosen to present must register early for the conference to be eligible to present their papers. The conference committee regrets that it is unable to meet any travel or subsistence expenses. The official conference language is English.

Closing date for abstracts: Friday 14 December 2012

