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2nd COMMONWEALTH NURSES CONFERENCE
nurses and midwives: *agents of change*

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Appointed Officers

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Executive Secretary

Angela Neuhaus
Honorary Treasurer

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

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from the PRESIDENT

Ramziah Binti Ahmad
CNMF President

I feel very proud to have been elected unopposed as President of the Commonwealth Nurses and Midwives Federation (CNMF), especially as I am the first President of the CNMF to be elected from Malaysia. I am humbled by the trust that has been extended to me from CNMF members and I will work hard as CNMF President to represent all CNMF members and to build on the legacy I have inherited.

I would like to pay tribute to Miss Susie Kong who was CNF President for nine years and who has passed on to me a very vibrant and well respected organisation which is making a significant contribution to nursing and midwifery across the Commonwealth.

I come to the Presidency of the CNMF at a very historic time. At the 21st CNMF Biennial Meeting held in London on 7 March 2014, the Commonwealth Nurses Federation changed its name to the Commonwealth Nurses and Midwives Federation. The change of name is a reflection that in some Commonwealth countries, midwifery is a separate, although closely related, profession to nursing. In other Commonwealth countries, a nursing qualification is a pre-requisite to undertaking a midwifery qualification. In relation to the name change, the CNMF Board emphasised the inclusion of midwives in the title did not constitute an endorsement of midwifery as a separate profession to nursing. Each country has the right to be self-determining in relation to this issue. The circumstances for one country may be very different to the circumstances for another country.

Another significant change for the CNMF was an expansion of membership categories to allow midwifery organisations to join the CNMF as full members and the creation of affiliate, associate, and individual membership categories which will open the CNMF to international, regional, and national specialist nursing and other health related associations. One of the underpinning values of the CNMF is inclusiveness, and it is this philosophy of inclusiveness, as well as the many requests received by the CNMF for membership of the organisation, that motivated the change of name and the expansion of membership categories.

CNMF members also endorsed the inclusion of a values clause within the CNMF constitution. The values on which the work of the CNMF is based are:

- to be committed and contribute to the objectives of the CNMF,
- to be an effective and efficient organisation,
- to be responsible in the use of internal and external resources,
- to be inclusive and involve members in decision making,
- to be cooperative and work as a team with members,
- to be consistent, congruent and ethical in decision making and behaviours,
- to respect the human rights of members and other people,
- to avoid discrimination of members or other people,
- to be protective of the privacy and confidentiality needs of members and other people,
- to be tolerant and accepting of members and other people,
- to be open, forthright and have integrity in dealing with members and other people,
- to be flexible, innovative, and determined in order to achieve CNMF objectives,
- to be compliant with relevant legislation and regulation.

The new constitution is available on the CNMF website: http://www.commonwealthnurses.org.

During my term of office I would like to visit each CNMF region and as many members as I can. My first visit is to a national nursing organisation which has just re-joined the CNMF and I would like to welcome Brunei Darussalam back into the CNMF family. I am very excited to be able to visit our newest national nursing association member as the CNMF President and discover from them how the CNMF can support the growth of the national nursing association and nursing in their country.

This edition of The Commonwealth Nurse highlights the 21st Biennial Meeting which was held in London on 7 March. The CNMF is grateful to the Royal College of Nursing, their Chief Executive Officer, Dr Peter Carter; their President, Mrs Andrea Spyropoulos; and the RCN Council for providing the venue for the Biennial and other support services. The RCN generously provides office space and support services for the CNMF on an ongoing basis which is greatly appreciated. The 21st Biennial Meeting was attended by representatives from eighteen CNMF member countries. Further details of the decisions taken can be found later in this edition of The Commonwealth Nurse.

COMPETENCE TO PRACTICE
Professor Mary Chiarella

Professor Chiarella outlined her presentation to participants saying she wanted to cover professionalism and professional regulation for nurses and midwives; the elements of professional regulation; the question of continuing competence; and the interface between regulation and workforce.

Professor Chiarella explained that a profession is an occupation whose core element is work based on the mastery of a complex body of knowledge and skills. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.

Professional regulation, Professor Chiarella said, is where a profession regulates itself. The profession decides, among other things:

- who should enter the profession,
- what attributes those who enter might have (aged of entry, physical and mental wellbeing, fitness to practice, educational qualifications, language proficiency, criminal record checks etc),
- how they might properly conduct themselves as members of that profession, and
- what criteria would need to be breached in order for them to be excluded from the profession.

The four elements of profession regulation are registration (registration standards, endorsements); codes and guidelines (codes of conduct and ethics, competency standards, professional guidelines); accreditation (curriculum standards, course guidelines, site reviews and inspections); and complaints and notifications (performance, impairment, professional misconduct).

Nursing and midwifery course accreditation, Professor Chiarella noted, has customarily been undertaken by jurisdictional registration bodies. The WHO however makes the point that: *the legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government* (WHO 2005 p.4). Accreditation bodies are increasingly being set up that are completely separate from the registration body. The accreditation body sets the standards for courses and programs leading to entry to the professions and for post-registration or specialist programs where appropriate. These standards are developed and agreed by the education providers and key professional stakeholders and in this way, can clearly be seen to be an arm of professional self-regulation.

Continuing professional development (CPD) is another aspect of self-regulation and is becoming a mandatory requirement for renewal of practising license in many countries. CPD is a means of ensuring that health professionals keep up to date with current knowledge and trends in health care. CPD provides for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered.

However it is difficult to determine how CPD can assure competence. For example, is there any link between a person who attends a lot of lectures and a person who is competent? Clearly there are people who do complete their requisite CPD but still are found to be unsafe to practise.

Assessment of Competence

Sufficient CPD **Competent** **No problem**	**Insufficient or no CPD** **Competent** **No problem: they will get picked up but they are not dangerous.**
Sufficient CPD **Not competent** **Problem: will not get picked up as meets renewal requirements but is not safe**	**Insufficient or no CPD** **Not competent** **Potential problem but should be picked up because of lack of CPD.**

Just because a health practitioner performs competently during one assessment of competence, does not mean they will perform competently the next time they undertake the same skill. I might bake a perfect cake today and burn one tomorrow. I might drive my car well today but have an accident tomorrow.

Competency Awareness Matrix

AWARE they are competent ✓	**AWARE they are incompetent** ✓
UNAWARE they are competent ?	**UNAWARE they are incompetent** X

Professor Chiarella said that perhaps the important aspect of CPD is not necessarily the assurance of competence, but rather a heightened sense of self-awareness of risk and the ability to reflect on competence. Reviewing our practice against competency standards or relying on CPD cannot guarantee that we will always be competent. But then nothing can. It is perhaps more important that we are aware of our limitations and strengths and are able to measure these against the requirements of a given situation and that we are **aware** of our level of competence or incompetence in any given situation.

In relation to the interface between regulation and the workforce, Professor Chiarella said that while governments should take an interest in the provision of health services and are aware such services are not possible without an adequate workforce, too much government interference (eg: the most workers at the lowest cost) can cause conflict with regulators. One of the difficulties in regulation is that regulators have the protection of the public as a primary concern. This may require setting standards that a government in search of a workforce might think are too high or too exclusionary. Conversely, when professional regulation legislation makes specific provision for government oversight and right of veto, this may make a mockery of the advice of educators or the concerns of regulators.

Professor Chiarella concluded her presentation by saying that professional regulation is more than the registration of health professionals. It consists of four key elements: registration; codes and guidelines; accreditation; and complaints and notifications; that together are designed to protect the public from unsafe practitioners. Professional regulation is however a key element of professionalism as it is one of the ways in which the public bestows its trust and confidence in nurses and midwives as health professionals.


Ghana delegates


Trinidad and Tobago delegates

Jamaica delegates


Bahamas delegates


Namibia delegates

MENTAL HEALTH LEGISLATION IN COMMONWEALTH COUNTRIES: Time for a Review

Dr Soumitra Pathare
Indian Centre for Mental Health Law and Policy

Dr Pathare said the 'gold standard' for mental health legislation is the United Nations Convention on the Rights of Persons with Disability (CRPD) which came into force in 2006. To date 166 countries have ratified the convention (62% of Commonwealth countries).

Approximately 10% of the world's population, 650 million people, live with disabilities (the 'world's largest minority'), Dr Pathare said. Twenty per cent of the world's children and adolescents, regardless of culture, are estimated to have mental ill health.

Mental ill health is the third highest cause of disease burden in the world, predicted to be the leading disease burden by 2030. One third of the anticipated spend on NCDs over the next 20 years is on mental ill health which is a common co-morbidity of NCDs, infectious diseases and poverty.

Prior to the CRPD, existing international human rights instruments failed to adequately promote and protect the rights of persons with disabilities. A Convention was needed which specifically focused on protecting and promoting the rights of persons with disabilities. The CRPD sets out a full range of, civil, cultural, economic, political, and social rights that governments are required to put into effect.

Despite the affirmation in the Universal Declaration of Human Rights, all over the world, persons with mental disorder are subject to inhuman and degrading treatment because of stigma associated with mental disorders. Violations of basic human rights and freedoms and denial of civil, political, economic, social and cultural rights to those suffering from mental disorders is a common occurrence across the world, both within institutions and in the community, including physical restraint, seclusion and denial of basic needs.

The CRPD introduced a paradigm shift: from seeing people with mental health disorders as objects of charity to subjects with rights; from seeing them as a burden on society to active members of society; and from paternalism to respect for human rights.

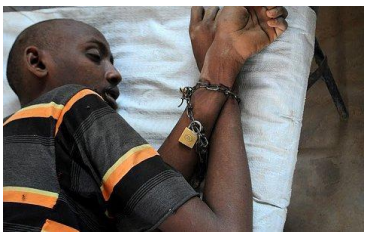
In 2013, the Commonwealth Health Professions Alliance with funding from the Commonwealth Foundation, undertook a research project to assess mental health legislation in Commonwealth countries against the CRPD. The 53 Commonwealth countries were contacted for copies of their mental health legislation. There was no dedicated legislation in four countries and legislation was unable to be obtained for another four countries leaving 45 countries whose legislation was analysed. Only dedicated mental health legislation was analysed; other legislation which might impact on persons with mental health issues such as employment, property, employment etc was not examined.

The research was conducted by the Indian Centre for Mental Health Law and Policy. The key findings were that mental health legislation in Commonwealth countries failed the standard of the UN Convention on Rights of Persons with Disability. Mental health legislation in 20 per cent of Commonwealth member states was enacted prior to 1960 before modern medical treatments became available and before many of the international human rights instruments came into force.

Mental health legislation in only 11 per cent of Commonwealth member states specifically include provisions that state mental health care should be provided on an equal basis with physical health care.

	Low (n_1=7)	Low-middle (n_2=18)	Upper-middle (n_3=10)	High (n_4=10)	Total (N=45)
Yes	0	2 (11%)	1 (10%)	2 (20%)	5 (11%)
No	7 (100%)	16 (89%)	9 (90%)	8 (80%)	40 (89%)

Provisions for protection from cruel, inhuman and degrading treatment are included in the legislation in only 23 (51 per cent) countries.



The informed consent of persons with mental disorders for participating in clinical and experimental research is specifically mandated in mental health legislation in only five (11 per cent) countries.

	Low (n_1=7)	Low-middle (n_2=18)	Upper-middle (n_3=10)	High (n_4=10)	Total (N=45)
Yes	0	2 (11%)	2 (20%)	1 (10%)	5 (11%)
No	7 (100%)	16 (89%)	8 (80%)	9 (90%)	40 (89%)

The legislation in only four countries (9 per cent) promote voluntary admission as the preferred alternative to involuntary admission.

The legislation in only 14 countries (31 per cent) provides for review of treatment given during an involuntary admission.

Article 12 of the CRPD requires countries to move to a regime of supported decision making. Only four Commonwealth countries (9 per cent) have supported decision making provisions in their legislation.

Laws in only two (4 per cent) countries restrict involuntary admission of minors with mental health problems, and laws in only three (7 per cent) countries ban any irreversible treatments on children with mental health problems.

Only 11 Commonwealth countries (24 per cent) had provision in their legislation to promote community care and deinstitutionalisation, rehabilitation and a psychosocial approach.

Provisions in and the language of mental health laws in many instances add to negative perceptions and further stigmatisation of persons with mental disorders.

The word "*Lunatic*" is used in the mental health laws of 12 countries; the term "*Insane*" is used in the mental health laws in 11 countries; the term "*Idiot*" is used in the mental health laws in 10 countries; two mental health laws use the term "*Imbecile*"; and two mental health laws use the term "*Mentally defective*". Overall 21 (47 per cent) laws use 1 of the above terms.

Dr Pathare said the conclusions were both devastating and clear. Mental health legislation in many Commonwealth member states is outdated and does not fulfil member states' international human rights obligations toward persons with mental disorders. Mental health legislation in many Commonwealth member states is not compliant with the Convention on Rights of Persons with Disabilities.

Mental health legislation in many countries is based on an outdated understanding of mental disorders; ignores advances in the care and treatment of mental disorders and denies the capacity of persons with mental disorders to manage their lives with the result that, instead of protecting the rights of persons with mental disorders, is likely to lead to violation of rights.

Most mental health laws pay little attention to protecting the rights of vulnerable groups with mental health problems such as minors, women, and minorities and the special needs of such vulnerable groups.

Many mental health laws in Commonwealth countries do not address the issue of (a lack of) access to mental health care, in particular, making care and treatment easily available; provided in a manner which enhances the capacities of individuals and protects and promotes their rights; and enables them to live and participate in their communities.

There is little participation of persons with mental disorders and their families and care-givers in the development and implementation of legislation.

The subsequent report of the research, titled: *Mental Health: a legislative framework to empower, protect and care,* made several recommendations (available from http://www.chpa.co):

1. Commonwealth member states should urgently undertake reform of mental health legislation.
2. Member states should ensure that the legislation meets their obligations under international human rights treaties, in particular the Convention on Rights of Persons with Disabilities.
3. The Commonwealth should consider providing financial and technical support to low and middle income member states to undertake mental health law reform.
4. Commonwealth member states need to thoroughly review all legislation to comprehensively address all civil, political, economic, social and cultural rights of persons with mental disorders.
5. Commonwealth member states should introduce provisions to promote supported decision making in mental health legislation.
6. Commonwealth member states must involve persons with mental disorders and care-givers, apart from other stakeholders, in the mental health law reform process.

This is no way to care for people with mental disorders. People with mental disability have been neglected for too long. There is much that can be done and the work needs to start now.

21st CNF BIENNIAL MEETING IN PICTURES

21st CNF BIENNIAL MEETING

The 21st CNF Biennial Meeting was held in London at the premises of the Royal College of Nursing UK on Friday 7 March 2014. CNF members from Australia, Bahamas, Barbados, Botswana, Cyprus, Ghana, Jamaica, India, Malaysia, Malta, Namibia, Sierra Leone, Singapore, South Africa, Trinidad and Tobago, and the United Kingdom attended the Biennial Meeting.

This was a historic meeting as the membership voted to change the name of the CNF to the Commonwealth Nurses and Midwives Federation (CNMF).

Other constitutional changes were an increase in membership categories to include national midwives associations into full membership; clarification of the membership categories of affiliate and associate member; and the introduction of an individual member category. The Biennial Meeting also agreed to include a values clause in the CNMF constitution.

The CNF Strategic Plan was endorsed by the membership as well as a revised structure of membership fees to reflect the revised membership categories.

Regional groupings of members discussed CNF priorities and activities for their region in the period 2014-2016. Priorities for members were universal across the Commonwealth: raising the standard of pre-service education; availability of continuing professional development and specialist postgraduate education; regulatory support for advanced practice; shortages of nurses and midwives particularly in Africa and Asia; and the creation, without consultation, of various different health cadres undertaking nursing and midwifery roles and were the subject of lively debate.

FAREWELL SUSIE KONG

The 22nd CNF Biennial Meeting also brought to an end the nine year term of Miss Susie Kong as President of the CNF. Under Miss Kong's stewardship, the CNF had grown in membership and profile to become an influential Commonwealth organisation.

Susie Kong with Jill Iliffe

In her farewell speech, Miss Kong reflected on the achievements of the CNF over the past nine years, despite the challenges of limited funding and limited paid personnel. Miss Kong paid tribute to CNF Board Members for their commitment to and hard work for CNF and to the loyalty of members. Ms Kong thanked the Royal College of Nursing for their continued support especially for hosting the CNF Board meeting and the CNF Biennial meeting. Ms Kong commented that it would be very difficult for the CNF to function effectively without the ongoing support and commitment of the Royal College of Nursing.

Retiring Board Members included: Dr Marion Howard (Atlantic Region); Mrs Alice Asare-Allotey (West Africa Region); and Mr Donald Epaalat (East, Central and Southern Africa Region).

Ms Ramziah Binti Ahmad from Malaysia was elected the new President of the CNMF with Professor Kathleen McCourt from the United Kingdom being elected Vice President. New Board Members included: Ms Rosemarie Josey (Atlantic Region); Ms Hossinatu Mary Kanu (West Africa); and Mr Paul Magesa Mashauri (East, Central and Southern Africa).

Ms Ramziah Binti Ahmad

Professor Kathleen McCourt

EXECUTIVE SECRETARY REPORT
21st CNF BIENNIAL MEETING

Jill ILIFFE

Ms Iliffe briefly highlighted with a power point presentation the key activities of the CNF over the past two years under the headings: governance, administration, finances, communication, liaison, membership and programs.

Governance: Ms Iliffe advised that elections had been held for President and Vice President and as there was only one nomination for each position, both nominees were declared elected. Elections had also been held for Board Member for the CNF Atlantic Region, CNF East, Central and Southern Africa Region, and CNF West Africa Region. The Board Member position for the CNF Asia Region is now vacant as the incumbent is now the CNF President. The CNF Board will appoint someone to fill the position for the remainder of the term. Ms Iliffe referred to the constitutional changes in relation to change of name and expansion of membership categories to be voted on at this Biennial Meeting and said both were essential for a sustainable future for the CNF.

Administration: Ms Iliffe said that all administrative processes for the CNF were running smoothly. All CNF files are now kept digitally so they were readily accessible and the CNF had a comprehensive, searchable data base. Ms Iliffe said she hoped to be able to digitise all paper based CNF files over the coming year.

Finances: Ms Iliffe reported that the CNF was in a stable financial position. Revenue was derived from membership fees, grants, and consultancy work. Revenue from the consultancy work for the African Regulatory Collaborative was an important source of revenue for the CNF allowing accumulation of reserves which has not been possible in the past. Ms Iliffe also reported that in November 2013, the CNF was registered as a limited private company with Companies House in the UK. Registration was essential for the CNF to be able to apply for grants.

Communication: Ms Iliffe reported that the three main mediums for communication were the CNF website, the monthly e-News, and the bi-annual journal, The Commonwealth Nurse. The e-News was sponsored by the RCN Publishing Company and had a distribution of 1,600. The Commonwealth Nurse now has its own website and is produced digitally. This generates considerable printing and postage charges.

http://www.commonwealthnurses.org

Liaison: The CNF keeps in regular contact with the Commonwealth Secretariat and the Commonwealth Foundation; the Commonwealth Health Professions Alliance; the Royal Commonwealth Society; C3 Collaborating for Health; the Burdett Trust; ICN and ICM; Health Information for All; and other international organisations.

Membership: Ms Iliffe reported that membership is stable however there are some Commonwealth countries who are still not members of the CNF and that renewals of membership are slow and require continual follow-up. Ms Iliffe said she hoped the new membership categories for the CNF would be endorsed, as the aim of the Board is for membership fees to be sufficient to pay the salary of the Executive Secretary.

Programs: Ms Iliffe outlined some of the programs the CNF had been able to provide over the past two years including six leadership programs; six programs on nurse and patient safety; two programs on NCDs; six programs on regulation and standards; and seven maternal health updates. Ms Iliffe said she was pleased to report that the CNF had been successful in a grant application to the Commonwealth Foundation to work with two Commonwealth countries to review and reform their mental health legislation.

In concluding her report, Ms Iliffe paid tribute to the leadership and support of Ms Susie Kong as outgoing President and commented that the growth of the CNF would not have been possible without her.

Patient and Nurse Safety Sri Lanka


Leadership Bahamas


Regulation and Standards Botswana


Maternal Health Update Sierra Leone


Regulation and Standards Swaziland


Maternal Health Update Sierra Leone


Maternal Health Update Zimbabwe


Maternal Health Update Zimbabwe

THE COMMONWEALTH NURSES FEDERATION
STRATEGIC PLAN 2014-2016

The purpose of the CNF is to contribute to the improved health of citizens of the Commonwealth by fostering access to nursing education, influencing health policy, developing nursing networks and strengthening nursing leadership.

PROGRAMS

The CNF will provide a wide range of programs and activities in consultation with and in partnership with members.

1. Programs will be developed in response to identified needs and emerging issues.
2. Programs conducted by the CNF will be determined in consultation with members and the CNF Board.
3. Board members will be actively involved in delivering CNF programs.
4. All programs will be evaluated and a report made publicly available on the CNF website.
5. Programs will be provided across all regions of the CNF.

MEMBERSHIP

The CNF will provide a high quality service to members providing information, regular communication, and supporting capacity building and leadership development.

1. Current membership will be actively maintained and new membership sought.
2. Members will be provided with regular communication on issues of interest to them.
3. Input from members will be sought when preparing CNF responses to issues of interest or concern.
4. The membership data base will be kept current.
5. A proposal for expanding membership categories will be developed and submitted to the CNF Biennial Meeting in 2014.

COMMUNICATION

The CNF will have a dynamic communication strategy which will effectively and attractively promote its purpose and activities to members and other stakeholders.

1. The CNF e-News will be published monthly and sponsorship maintained.
2. The *Commonwealth Nurse* will be published bi-annually; member contributions actively sought; and advertisements and sponsorship sought to offset costs.
3. The *Commonwealth Nurse* will be published online from its own website to increase access and reduce paper, printing and postage costs.
4. The CNF website will be updated regularly.
5. Opportunities will be sought to have CNF activities publicised in other communication media and published in other relevant journals.

LIAISON

The CNF will maintain active links with relevant stakeholders within the Commonwealth and the wider international community in order to fulfil its purpose.

1. Close links with the Commonwealth Foundation and the Commonwealth Secretariat will be maintained and opportunities pursued to partner with these organisations particularly in relation to Commonwealth Ministers' meetings.
2. Active participation in the Commonwealth Health Professions Alliance will be maintained in order to influence policy at Commonwealth level.
3. Opportunities will be actively sought to partner with other organisations in activities which support the objectives of the CNF.
4. Close links will be maintained with the International Council of Nurses and the International Confederation of Midwives.
5. Formal links will be established and maintained with other relevant organisations.

GOVERNANCE

The CNF will be a well governed, responsive, responsible and transparent organisation.

1. The President, Vice President and Board members will be actively engaged with all aspects of the organisation.
2. Democratic elections will be held in a timely manner and in accordance with the CNF Constitution.
3. Reports will be provided quarterly by the Executive Secretary to the President, Vice President and Board members covering all key strategic areas.
4. The Constitution of the organisation will be reviewed in consultation with members prior to each CNF Biennial Meeting.
5. The Annual Report including annual financial audit of the organisation will be circulated to members and other stakeholders and made available on the CNF website.

ADMINISTRATION

The CNF will maintain effective and efficient administrative processes with specific consideration to reducing costs and environmental impact.

1. All files of the CNF will be held in a secure electronic format.
2. A permanent archival site will be sought to securely archive old paper format files.
3. A single comprehensive, current, and secure data base will service communication with members and other stakeholders.
4. All complaints received will be responded to in a timely manner and a report provided to the Board.
5. A project will be developed and funding sought to develop a history of the CNF.

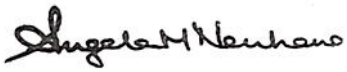
FINANCES

The CNF will have a financial growth strategy, a diversified financial base and operate within open and transparent financial systems.

1. An annual budget will be approved by the Board.
2. Membership subscriptions will be invoiced annually and payment of membership subscriptions will be actively pursued by the Executive Secretary and by Board members on request.
3. Opportunities will be actively sought to apply for grants, consultancies and sponsorships; and where feasible, work provided on behalf of other organisations will be on a cost recovery basis.
4. End of year financial statements will be prepared which include a comprehensive breakdown of income and expenditure.
5. The financial accounts of the CNF will be subject to an annual audit which will be publicly available to members, be uploaded to the CNF website, and form part of the CNF Annual Report.

HONORARY TREASURER'S REPORT
21st CNF BIENNIAL MEETING

Angela NEUHAUS



NOTES TO THE CNF ACCOUNTS

INCOME

Grant Income: Commonwealth Foundation
Access to an annual grant which included core funding for Commonwealth accredited civil society organisations ceased at the end of the 2012-2013 financial year. The CNF was successful in obtaining £10,000 in transition funding which will mainly be used for the Board strategic planning on Tuesday 11 March 2014. The CNF has applied for a Commonwealth Foundation Responsive Grant for 2014-2015 to conduct a project around mental health legislation and the project has been shortlisted for funding.

Grant income: Other
In 2011-2012 this consisted of £35,000 for the Burdett Trust Maternal Health Updates project; £5,000 from the Commonwealth Secretariat to fund the attendance of a number of speakers from developing countries to the Inaugural Commonwealth Nurses Conference; and £3,535 from the Commonwealth Foundation for Commonwealth Health Professions Alliance to host the Commonwealth Partners' Forum 2012 in conjunction with the Commonwealth Health Ministers' meeting. The amount from the Commonwealth Foundation for this activity in 2012-2013 the amount was funding from the Commonwealth Foundation toward the Commonwealth Partners' Forum 2013 held in conjunction with the Commonwealth Health Ministers' meeting.

Reimbursement
In 2011-2012 reimbursement was from the Ramphal Commission and the Commonwealth Secretariat for airfares to attend various meetings. It also consisted of reimbursement from CHPA members for various expenses in relation to the Commonwealth Partners' Forum and the CHPA website. In 2012-2013 reimbursement related to airfares to attend various Commonwealth Secretariat meetings and also a repayment of an overcharge by the travel agent.

Sponsorship
In 2011-2012 sponsorship related to the CNF e-News by the RCN Publishing Company. In 2012-2013 in addition it included sponsorship from Ontario Shores Mental Health Services for three participants to attend the Mental Health Nursing Forum.

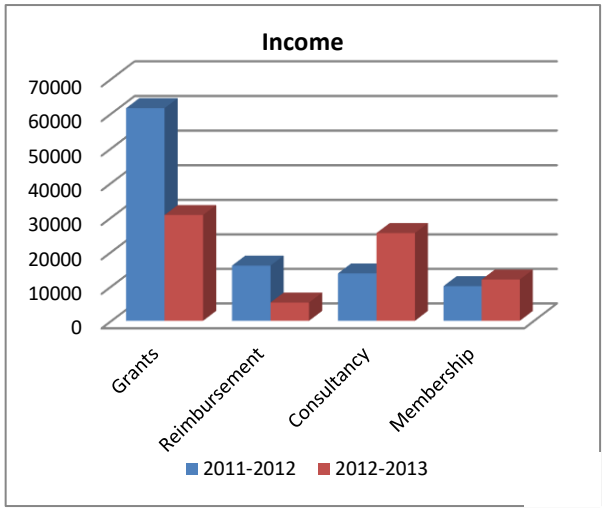
Consultancy
This is income earned through providing services to the African Regulatory Collaborative (ARC). These services include administrative support for the meeting (writing meeting reports, and providing technical assistance with projects). The ARC is a four year partnership between the CDC Centre in Atlanta; Emory University; the East, Central and Southern Africa Health Community; the Commonwealth Secretariat; and the Commonwealth Nurses Federation. The initiative provides PEPFAR funding to countries in the ECSA region to undertake small projects to improve regulation and standards for nursing and midwifery. The amount shown as income is for administrative purposes and is offset by expenditure. For example, in 2012-2013 income was £56,606 and expenditure was £56,308.

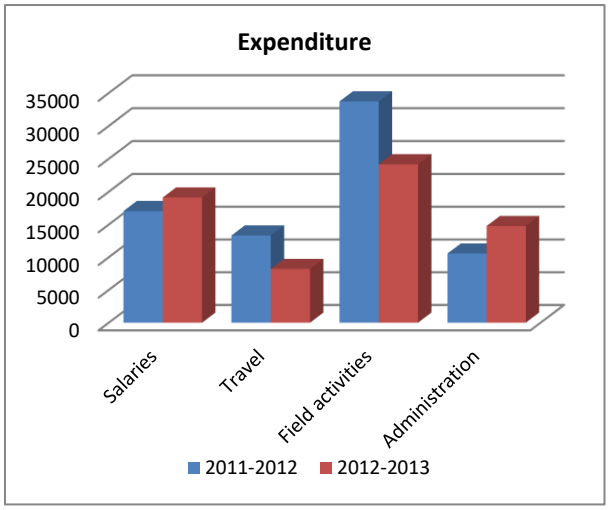
EXPENDITURE

Members' travel and accommodation
In 2011-2012 this related to expenses incurred in Board members and sponsored delegates attending the Inaugural Commonwealth Nurses Conference.

Officers' travel and accommodation
Most of the expenses in this line are reimbursed (see 'Meetings' below). The biggest item of expenditure is always the annual Commonwealth Health Ministers' meeting in Geneva and the associated Commonwealth Partners' Forum.

Field activities
The increase in expenditure on field activities in 2011-2012 reflects the funding from the Burdett Trust for Nursing for the Maternal Health Updates.





Publications
The increase in costs in 2012-2013 relates to the construction of a dedicated website for The Commonwealth Nurse. In addition, the costs for 2011-2012 included only one issue whereas in 2012-2013 there were three issues. This was a timing issue.

Office attendance
This has been kept low, particularly in the 2012-2013 financial year by 'piggy-backing' office attendance with other meetings, particularly meetings where the costs have been met by other organisations such as the Commonwealth Secretariat or the African Regulatory Collaborative.

Administrative functions
Most of the administrative functions are relatively stable or show a reasonable increase from one financial year to the other.

Website
Website costs are able to be kept low because website maintenance, such as uploading and removing items from the website, is done 'in-house'.

CHMM Mental Health Legislation Research
This research, conducted by the Centre for Mental Health Law and Policy, for the CHPA in preparation for the 2013 Commonwealth Health Ministers' meeting, was funded by the Commonwealth Foundation.

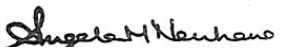
Commonwealth Fellows
In the 2011-2012 financial year this related to the two Commonwealth Fellows from Cameroon, Clarisse Lamnyam and Tita Ndogjem. Expenses associated with the two Commonwealth Fellows from Zimbabwe, Alice Mvuu and Chido Katsambe will appear in the 2013-2014 accounts.

CNF Registration
The CNF needs to be registered to be eligible for Commonwealth Foundation funding. The CNF has now been registered as a company limited by guarantee in the United Kingdom and is currently applying for charity status.

End of year result in both financial years showed a small surplus which is necessary to build up reserves over time.

COMMONWEALTH NURSES FEDERATION
RECEIPTS AND PAYMENTS ACCOUNT
Year ended 30 June 2013

Receipts	**2013 £**	**2012 £**	**2011 £**
Grant Income - Commonwealth Foundation	22,500	18,000	19,500
Grant Income - Other	8,179	43,525	15,000
Reimbursement	5,291	16,006	11,424
Sponsorship	6,776	600	10,830
Consultancy	25,445	13,736	4,037
Member subscriptions	11,950	10,050	10,288
African Regulatory Collaborative	56,606	50,910	0
Biennial Meeting	0	3,036	10,497
	136,747	**155,863**	**81,576**
Payments			
Executive Secretary - consultancy fee	19,120	17,053	14,934
Meetings - members' travel / accommodation	0	9,088	0
Meetings - officers' travel / accommodation	8,206	13,325	6,267
Biennial Meeting expenses	0	0	21,932
Field activities	24,168	33,730	17,480
Publications	7,508	1,557	1,487
Office attendance	718	2,900	1,729
Office services - stationery, printing, postage, telephone etc	3,159	3,550	3,345
Bank fees - CNMF	550	735	978
Currency exchange (gain) loss on AU$	455	0	0
Auditor's fee	500	400	400
Website	1,144	863	898
Capital equipment	732	560	1,211
CHPA	252	967	35
African Regulatory Collaborative	56,308	57,989	4,754
CHMM Mental Health Legislation Research	7,582	0	0
Ramphal Commission on Migration and Development	0	7,448	2,811
Subscriptions	50	50	0
Reimbursement	0	923	0
Commonwealth Fellowships	0	2,396	0
Ghana workshop 2009-2010	0	0	1,477
CNF Registration	823	0	0
	131,275	**153,534**	**79,738**
Surplus for the year	5,472	2,329	1,838
Surplus brought forward at 1 July 2012	14,614	12,285	10,447
Surplus carried forward at 30 June 2013	**20,086**	**14,614**	**12,285**
Surplus represented by:			
Bank balance	13,567	8,246	26,691
Add debtors and prepayments	50,519	6,375	27,292
	64,086	14,621	53,983
Less creditors and un-presented cheques	(44,000)	(7)	(41,698)
	20,086	**14,614**	**12,285**

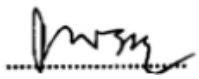


Honorary Treasurer

Executive Secretary

AUDITOR'S REPORT

I have audited the Receipts and Payments Account of the Commonwealth Nurses Federation (CNF) with the books and vouchers of the CNF and have obtained all the necessary information and explanations. In my opinion the receipts and payments are properly drawn up so as to exhibit a true and fair view of the affairs of CNF for the year ended 30 June 2013.



Peter Westley BA, FCCA
Chartered Certified Accountant
08 October 2013