



the

# Commonwealth Nurse

JOURNAL OF THE COMMONWEALTH NURSES AND MIDWIVES FEDERATION

Issue 55 | 2016

<http://www.thecommonwealthnurse.com>



Maternal Health Education and Training Lilongwe, Malawi; Dar es Salaam, Tanzania; and Musoma, Tanzania 2016

# BOARD AND OFFICERS

## Elected Officers



**Ramziah Ahmad (Malaysia)**  
President



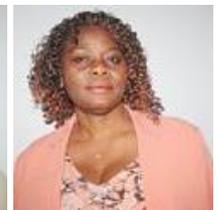
**Kathleen McCourt (UK)**  
Vice President



**Annie Butler**  
Australia  
Pacific Region



**Rosemarie Josey**  
Bahamas  
Atlantic Region



**Hossinatu Mary Kanu**  
Sierra Leone  
West Africa Region



**George Saliba**  
Malta  
Europe Region



**Paul Magesa**  
Tanzania  
East, Central and  
Southern Africa Region



**Keerthi Wanasekara**  
Sri Lanka  
Asia Region

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

Commonwealth Nurses and Midwives Federation  
c/o Royal College of Nursing  
20 Cavendish Square W1G 0RN London UK  
Tel: + 61 438 647 252  
Email: [cnf@commonwealthnurses.org](mailto:cnf@commonwealthnurses.org)  
Website: <http://www.commonwealthnurses.org>

ISSN 2054-1767  
© 2009 Commonwealth Nurses and Midwives Federation

Published by the Commonwealth Nurses and Midwives Federation

## Appointed Officers



**Jill Iliffe**  
Executive Secretary



**Angela Neuhaus**  
Honorary Treasurer

## from the PRESIDENT



**Ramziah Binti Ahmad**  
CNMF President

In this edition of *The Commonwealth Nurse* we say farewell to Miss Margaret Brayton OBE, the first Executive Secretary of the then, Commonwealth Nurses Federation (CNF), a position she held for twenty years. Miss Brayton had a distinguished nursing career, making a significant contribution, not only to the CNF and the national nursing associations she nurtured, but also to Commonwealth organisations in London. She was particularly interested in access to quality education for young girls across the Commonwealth.

Two senior officers of the CNMF, Professor Kathleen McCourt and Ms Jill Iliffe, attended Miss Brayton's funeral on Monday 23<sup>rd</sup> May. The funeral was well attended by nurses and midwives whose lives Miss Brayton had touched, particularly nurses and midwives from the Caribbean. It was also very pleasing that Ms Patricia Larby, the second CNF Executive Secretary, was also present to farewell Miss Brayton. Further information, including the CNMF tribute to Miss Brayton at her funeral, form part of this issue of *The Commonwealth Nurse*. Within the CNMF, Miss Brayton will always be remembered with affection and respect.

Also in this edition of *The Commonwealth Nurse*, we reproduce the Executive Summary of a report commissioned by the Commonwealth Health Professions Alliance (CHPA) for the Commonwealth Civil Society Forum held each year on the eve of the annual Commonwealth Health Ministers' meeting. The report written by Dr Ravindra Rannan-Eliya from the Health Policy Institute Sri Lanka, is titled, *Universal Health Coverage: the potential contribution of hybrid funding strategies. A review of Commonwealth mixed funding models*.

The achievement of universal health coverage (UHC) is a World Health Organisation (WHO) priority and all countries have made a commitment to pursue UHC. How to finance UHC is a vexed question for most countries and there is a great deal of literature, particularly from the WHO, about the best mechanism for countries to finance UHC. There are two popular UHC financing models. One uses public money (such as in the United Kingdom's national health service).

The other uses a social insurance model, such as that in Germany. Dr Rannan-Eliya, however, explored several Commonwealth countries who have achieved UHC using a mix of public and private financing. While public financing is the major source of financing, private finance is used to give choice and to finance 'extra services'. Dr Rannan-Eliya's report is well worth reading along with other literature on the subject. The report is available for download from the CHPA website, <http://www.chpa.co>. It is important for nurses and midwives to be involved in the planning and implementation of UHC in their country. National nursing and midwifery associations have a responsibility to be informed and to inform their members; to advocate on behalf of their clients; and to lobby to make sure that the UHC model adopted by their country is the best one for their population.

Another interesting article in this edition of *The Commonwealth Nurse* is the *Task Sharing Survey* conducted by nurse researchers from the University of Botswana in preparation for the development of a task sharing policy for nurses and midwives. The results make fascinating reading but even more impressive is the quality of the research and the report from the three nurse researchers. There is only room in *The Commonwealth Nurse* for a brief overview of the research, however the full report, *Exploring task sharing and task shifting opportunities, barriers, and policy implications for nursing and midwifery in Botswana*, is available and can be downloaded from the 'Resources' tab on the CNMF website, <http://www.commonwealthnurse.org>.

The report shares both quantitative and qualitative findings. Tasks shared are listed, the benefits and barriers of task sharing are identified, and the principles on which a task sharing policy should be based are outlined. Interestingly, 70% of nurse and midwife respondents to the survey said they received tasks shifted from other non-nursing health personnel while 88% said they did not shift tasks themselves to other non-nursing health personnel. This finding supports the notion that while tasks are being 'shifted to' or 'shared with' nurses and midwives, they are adding to their workload because nurses and midwives are not being relieved of existing tasks. Over half the nurse and midwife respondents reported experiencing some conflict over who should perform the task that was shifted or shared.

Finally, let me thank the Executive Secretary and Board of the CNMF for continuing to successfully progress the CNMF objectives to influence health policy throughout the Commonwealth, strengthen nursing and midwifery networks, enhance nursing and midwifery education, improve nursing and midwifery standards and competence, and strengthen nursing and midwifery leadership.

## VALE

### MISS MARGARET BRAYTON

Miss Margaret Abigail Brayton was the first Executive Secretary of the then Commonwealth Nurses Federation, a position she held for twenty years from 1973 to 1993. Margaret took the position with the CNF after a long and distinguished career in the United Kingdom, including 13 years as Regional Nursing Officer of the South Eastern Regional Hospital Board in Scotland.



Margaret as a young nurse; Margaret receiving her OBE; Margaret at her 90<sup>th</sup> birthday celebrations.

Margaret died of natural causes on 30 April 2016 just a few months before her 97<sup>th</sup> birthday after spending many years in care. Margaret's funeral was held on 23 May 2016 and was well attended by many of her nursing colleagues, particularly from expatriate nursing organisations from the Caribbean who had been close to and supported Miss Brayton in her later years. Professor Kathleen McCourt (CNMF Vice President) and Jill Iliffe (CNMF Executive Secretary) attended the funeral. Also, in attendance was Ms Patricia Larby, the second Executive Secretary of the CNF.



Miss Brayton's funeral.

Margaret led a full and productive life of service to the nursing profession and the Commonwealth. What we will remember most is her warm and friendly disposition and her complete devotion to the causes she held dear. Margaret lived a long and adventurous life and she will be remembered with love and respect. Thank you so much to so many members of the CNMF who sent tributes following the death of Miss Brayton. These were forwarded to Miss Brayton's closest relative, her niece who found them very comforting to know that her aunt was held in such high regard by her nursing colleagues.

## TRIBUTE TO MARGARET BRAYTON

7 July 1919 to 29 April 2016  
on the occasion of her funeral service Monday 23 May 2016

My name is Jill Iliffe and I am the Executive Secretary of the CNMF, formerly the CNF. I am the 4<sup>th</sup> Executive Secretary of the CNMF. Margaret Brayton was the first, holding the position for 20 years from 1973 to 1993. I was privileged to meet Margaret on many occasions when we shared our reflections on working for the CNF. I also came to know Margaret through the letters she wrote as Executive Secretary of the CNF to national nursing associations across the Commonwealth, many of whom came into being as a direct result of Margaret's encouragement and nurturing.

On learning of Margaret's death, tributes from national nurses associations across the Commonwealth were sent to the CNMF from the United Kingdom, Cyprus, Malta, Uganda, Tanzania, Namibia, Guyana, Sri Lanka, Brunei Darussalam, Australia, Solomon Islands, Barbados, Bahamas, and Trinidad and Tobago. I would like to share some comments from those tributes.

*Miss Brayton represented the best ambassador the CNMF could have had at that time. She always demonstrated concern for developing states and used her diplomatic and political skills to secure much needed assistance. Margaret's warmth and generosity and genuine concern for others were demonstrated throughout her life.*

*Through the CNF, Margaret pioneered an important professional association for nurses in the Commonwealth. We enjoyed many years of Margaret's warm friendship, wise advice, and professional support.*

*Despite a sense of loss, we are grateful and give thanks for the life of Miss Brayton. Her contributions and legacy to nursing and the Commonwealth will live on in the lives she has touched and the nursing leaders she has mentored as the baton is passed on.*

*Margaret took a great interest in Commonwealth educational co-operation and development, and we were proud to have her in membership of the Council for Education over a very long period. She was a regular attender at our meetings and always ready with a pertinent observation or probing question to visiting speakers: but what our members will remember most is her warm and friendly disposition and her complete devotion to the Commonwealth.*

*Margaret was devoted not only to the cause of nurses and midwives, but to the work of the modern Commonwealth. Long after retirement she proved her skill and spirit by delivering a baby at Cannon Street tube station, after seeing a pregnant woman in growing discomfort, and was happy to visit mother and baby, doing well, at Bart's Hospital the next day. I was glad to have known her.*

# MARGARET ABIGAIL BRAYTON

## A life well lived

Margaret was a formidable lady within the Commonwealth. On the occasion of her 93<sup>rd</sup> birthday, Margaret took a 'walk down memory lane' and shared some highlights of her life, career and work within nursing and the Commonwealth. Some of Margaret's memories are recorded in the following narrative.

Margaret was born 7 July 1919 and started her career as a nursery school teacher. In 1939 she joined the British Red Cross as a volunteer and was posted to the Royal Naval Nursing Service working in the United Kingdom, Malta, and the Royal Navy base at Scapa Flow in Scotland. Margaret was one of the oldest surviving nurses who had worked on the hospital ships during the evacuation of Dunkirk.

After qualifying as a registered nurse, Margaret joined the Medical Relief Teams working throughout Europe and enjoyed VE day in Berlin. On her return to the UK she trained as a midwife in Edinburgh, and later as a children's nurse at the Great Ormond Street Hospital for Sick Children.

Her next posting was with the Paediatric and Maternal Child Health Program in Newcastle after which she was appointed Principal Tutor at the West Cumberland School of Nursing. In 1954 she was granted a scholarship to study courses in maternal and child health in Canada and later at Yale University where she topped her class.

Margaret was then granted a British Red Cross and St. John's Fellowship to study Nursing Management and in 1960 was appointed Regional Nursing Officer for South East Region in Scotland, a post she held for thirteen years. She then went on to work with the World Health Organisation and UNICEF throughout Asia and the Far East.



Margaret on her 90<sup>th</sup> birthday surrounded by nursing colleagues and Commonwealth friends.



Margaret on her 90<sup>th</sup> birthday with the 4<sup>th</sup> Executive Secretary of the CNMF, Ms Jill Iliffe. Although increasing frail, Margaret's mind was sharp. She had a quick wit and a great sense of humour.

Margaret returned to London and on the 1 January 1973 was appointed the first Executive Secretary for the Commonwealth Nurses Federation, a post she held for 20 years. One of her first activities was to establish the West African College of Nursing.

In 1975, Margaret became a Councillor of the Royal Commonwealth Society and in 1981 its Vice President. She was also Chair of the Commonwealth Professional Association, an organisation she founded to encourage professionals to meet and exchange ideas and information.

In 1982, Margaret was elected a Freeman of the City of London, making her a member of the Guild of Freemen of the City of London. She was also awarded a Fellowship of the Royal Society of Arts.



Margaret on her 93<sup>rd</sup> birthday with Maura Buchanan, past President of the Royal College of Nursing UK and two expatriate nursing colleagues from Jamaica and Guyana.

Margaret was invited to join the Commonwealth Countries League and in 1987 was elected as the Chairperson of the Executive Committee.

After the end of her term as Chair, Margaret continued to represent the League at many Commonwealth high profile meetings nationally and internationally.

## CIVIL SOCIETY FORUM 2016

Margaret was also a very active member of Soroptimist International, Associated Country Women of the World, Women's Corona Society, Commonwealth Trust Women's Council, the Women's Advisory Council of the United National Association, and Friends of the Commonwealth Institute.

Margaret was awarded the MBE in the 1989 New Year's Honours List as Secretary of the Commonwealth Nurses Federation and was later appointed a member of the Most Excellent Order of the British Empire. She also received a Distinguished Service Award from the Trinidad and Tobago Registered Nurses Association on the occasion of their 60<sup>th</sup> Anniversary (June 1991).

Margaret was also involved in pioneering work with the International Network Toward Smoke Free Hospitals and also enjoyed being a School Governor of her local Junior School.

Margaret represented many Commonwealth organisations travelling extensively throughout the Commonwealth, organising and attending many workshops, seminars, conferences and meetings. In Western Samoa she was made an Honorary Chief. With such a full and distinguished career in health, Margaret also found time to do volunteer work with many national and international Commonwealth organisations.

In 2000, Margaret was privileged to attend the Thanksgiving service at St Paul's Cathedral and the pageant of the Horse Guards Parade to celebrate Queen Elizabeth, the Queen Mother's 100<sup>th</sup> birthday.

Throughout her life, Margaret's hobbies were as exciting and plentiful as her career. She had a passion for trains, Australian wines, hill climbing and all genres of the Arts and archeology which led her to take part in the dig on the London Wall. Margaret was also an active member of St Stephen and St John Church.

Margaret was a mentor to many and gave unstintingly of her time and energies to help others, particularly in women's organisations and in advancing opportunities for young people. Margaret was a good raconteur, much loved and respected. Vale Margaret and thanks – a life well lived indeed and a place in CNMF history and in our hearts.



Margaret receives a visit from close nursing colleagues from the Trinidad and Tobago Registered Nurses Association, Mrs Valerie Alleyne-Rawlins and Mrs Kathy-Ann Greenidge-Ottley.

The CNMF is a founding and executive member of the Commonwealth Health Professions Alliance (CHPA). The Alliance membership comprises Commonwealth accredited health organisations such as pharmacists, doctors, nurses, dentists, and community health workers. The major activity for the CHPA is hosting a civil society forum in Geneva on the eve of the annual Commonwealth Health Ministers' meeting which in itself is held on the eve of the annual World Health Assembly. Partners in the 2016 forum were the Commonwealth Foundation, McKinsey and Company, and the Third World Network.

The focus of the 2016 Commonwealth Civil Society Forum was on the essential contribution of universal health coverage to health security.

**Commonwealth Civil Society Forum**  
Saturday, 21 May 2016  
1500-1830 | Crans Room | Stirling Hotel Geneva  
Welcome reception | 1830-1930

In conjunction with the 28<sup>th</sup> Commonwealth Health Ministers' meeting  
Sunday 22 May 2016 | Stirling Hotel Geneva

**Health Security and Universal Health Coverage**

**Speakers:**  
Dr Neil Bhanoo-Dixie, Ms Tania Hoch, Ms Leana Manganera, Dr Penny Dash, Ms Christina Haggard, Dr Abu Baker Fatah, Ms Sangeeta Ramchandani, Dr Tony Nelson, Dr Penny Dash

Moderated by: Dr Penny Dash, McKinsey and Company  
Hosted by:  
Commonwealth Foundation, CHPA, McKinsey & Company

RSVP: For catering purposes, please email attendance to:  
Dr Tony Nelson, Secretary, Commonwealth Health Professions Alliance:  
[secretary@chpa.co](mailto:secretary@chpa.co). Please include: title, full name, position, organisation, and country

David Heymann et al (The Lancet vol.285 May 9 2015 pp.1884-1902) defines health security as protection from threats to health. He explains that health security has two interlinked components: collective health security and individual health security. Collective health security is the sum of individual health security. Some of the threats to collective and individual health security which are identified by Heymann et al are epidemics, natural disasters, conflict, migration, refugees, non-communicable disease, and sub-standard and falsified drugs. Heymann states that UHC - that is universal, equitable access to health care with financial protection - is indispensable for the achievement of individual health security and therefore, collective health security.

Eminent speakers discussed the importance of universal health coverage to health security from the perspectives of health financing, free trade agreements, non-communicable diseases, natural disasters, and man-made disasters such as internal and external conflict, migration and refugees. A report of the forum and the presentations are available on the CHPA website <http://www.chpa.co>.

## UNIVERSAL HEALTH COVERAGE: the potential contribution of hybrid funding strategies

### A review of Commonwealth Mixed Public-Private Funding Models

Dr Ravindra Rannan-Eliya



## Executive Summary

### Introduction

Commonwealth nations together with the other members of the global community have committed to a shared goal of universal health coverage (UHC) by 2030. This requires countries to move toward ensuring that all people have equitable access to needed quality health care services without experiencing financial risk.

To achieve this, countries need to mobilize sufficient public financing in the form of tax-financing or social health insurance. A key reason for this is to minimize out-of-pocket spending so as to reduce the exposure to financial risk. Two pathways to do this and achieve UHC are usually cited and offered to developing countries.

The Beveridge model involves using general revenue taxation to pay for the bulk of all health care services, usually, but not necessarily, delivered by a public sector delivery system.

The alternative Bismarck model involves using contributory social health insurance to finance a public scheme that pays for services by usually private providers. It provides benefits only to those who contribute, and coverage is limited to formal sector workers from whom mandatory deductions for insurance can be collected. In the second half of the 20<sup>th</sup> Century, many countries modified this prototype by using general revenue taxation to extend coverage beyond the formal sector to the whole population, often on a non-contributory basis.

Whether countries adopt the Beveridge or Bismarck models, in practice they need to mobilize at least 3% of GDP or more in either tax-financing or social health insurance or both. This is a minimum level of public financing, equivalent to what it cost the UK to establish the British NHS in 1948.

Most developing countries that are held up as UHC success stories have in fact had to mobilize even more, including Thailand (4%) and Brazil (4%). The problem is that these levels of public financing are in practice not realistic in the poorest developing countries.

Taxation and social health insurance compete for the same sources of money. The capacity of developing countries to raise money through either mechanism is inherently less than rich ones, owing to their smaller formal sectors and weaker administrative capacities.

Low-income developing countries mobilize in taxes only 13% of GDP, which means that the poorest countries would need to allocate a quarter or more of their government budgets to health in order to implement either the Beveridge or Bismarck approaches. This is not realistic, and not surprisingly no low or lower-middle income nation has been able to achieve UHC through either the Beveridge or Bismarck models.

### The hybrid or mixed public-private financing model

Despite necessary realism or pessimism about whether the Beveridge or Bismarck models offer viable routes to UHC in developing countries with limited money, there is evidence that a few developing countries (and also advanced economies) have been able to progress substantially toward UHC, despite modest levels of government spending and using approaches that do not fit either the Beveridge or Bismarck models. These cases include Jamaica, Sri Lanka, Malaysia, Hong Kong, Ireland and Australia. All of these are either members of the Commonwealth, or have close links with Commonwealth nations. Their experiences have been given scant attention in the global discussion, and they are rarely cited as potential role models for UHC.

Yet, the evidence shows that they tend to out-perform in overall health outcomes, achieve high levels of equitable access to health care and good financial protection, whilst spending less than their peers. Although these health systems come from all parts of the world and all stages of economic development, we show that they share many common features, indicating that they represent an unrecognized third approach to financing progress toward UHC.

In all the cases reviewed in this study, governments have focused on maximizing universal or equal access to services for both rich and poor, and reducing exposure to financial risk, whilst minimizing government spending. Government financing has been exclusively tax-based, with no adoption of social health insurance mechanisms. All experts agree that universal health coverage will never be achieved without the significant contribution of public funds.

In all the cases, government funding is used to pay for a universal package of services available at zero or minimal cost on an equal basis to both rich and poor.

In Jamaica, Sri Lanka, Malaysia and Hong Kong, governments have funded a public delivery system, whilst Australia and Ireland also use public funding to pay for access to private doctors and hospitals. The publicly funded package in each case includes substantial funding for hospitals and inpatient treatment, ensuring that the poor are not exposed to significant financial risk. Governments have also taken steps to ensure that the publicly funded set of services is genuinely available to the poor by building a widely dispersed delivery network where necessary.

Despite the strong emphasis on public funding, the need to minimize government spending has meant that all the governments have been unable to increase spending to emulate either the Beveridge or Bismarck models. Instead they have had to allow private financing and provision to fill the gap.

However, unlike most developing countries, where under-funded public systems benefit the rich more than the poor, these health systems have managed to ensure that their limited public funding benefits the poor more than the rich. This has generally been achieved not by explicit targeting or means testing, but by using differences in consumer quality to encourage the non-poor to voluntarily seek out and pay for private care.

Richer patients desire greater doctor choice, shorter waiting times and better amenities in their hospitals and clinics. In these hybrid systems, the government has generally skimmed on providing these aspects of service, whilst focusing on maintaining the availability of the core clinical components of care.

Consequently, richer patients have gone to the private sector to obtain these, allowing the limited amount of public funding to pay for comprehensive services, albeit with lower consumer quality, for the poor. Whilst the rich end up using more private services than the poor, the pro-poor reach of the public scheme in each case has ensured reasonable equity in overall access to medical care.

## Implications

### For the global community

This short review has identified a number of health systems at all levels of economic development that have adopted a common approach to financing and delivering health care that differs significantly from the standard Beveridge and Bismarck models. In all these systems, governments spend much less on health care than their peers. Yet, we have noted that they generally out-perform their peers in terms of access to health care and ultimate population health outcomes.

The challenge of achieving UHC – equitable access to quality health care combined with financial risk protection – has been accepted by the global community as a shared goal over the next two decades. In order for this goal to be realized, developing countries need realistic options to expand coverage. Realism requires finding strategies that are compatible with the limited fiscal capacity that is an inevitable corollary of being a developing nation. The evidence indicates that the standard Beveridge and Bismarck models are not fiscally feasible in most developing nations. They both require substantial spending of tax monies that poor countries cannot realistically afford. The global community and developing countries in particular need additional options that help extend coverage without breaking the bank.

There is sufficient evidence to indicate that the hybrid systems we have detailed have found one answer to this challenge of improving coverage with limited fiscal resources. However, they have generally not been the object of the intensive global search for solutions but they are worth further analysis.

The leading international organizations – the World Bank, WHO and other bilateral development agencies, as well as countless independent initiatives and academic investigations, have paid little attention to these examples. There is little awareness of what they have achieved, or how they have done this. Given the enormity of the challenges facing poor countries as they strive toward UHC the time has come for a proper look at these experiences to identify what has been critical and what can be learnt and transferred.

### For the Commonwealth

Almost all the cases identified have their roots in the Commonwealth, and are either members of the Commonwealth or have strong links with Commonwealth nations.

This is not a coincidence. It stems from a fortuitous combination of common institutional legacies and shared policy discourses.

We have noted that the global community has tended to ignore these experiences, despite their great relevance to contemporary development challenges. This has been a loss not only to the global community as a whole, but also Commonwealth nations.

The large majority of Commonwealth nations still face the challenge of how to move toward UHC whilst still economically developing and managing with limited fiscal resources. Yet, it is unfortunately true that most of these Commonwealth nations know more about the success stories outside the Commonwealth than the hidden success stories within the Commonwealth. This represents a loss not only for the Commonwealth as a whole, but also a failure to realize the benefits that flow from a shared history and common sets of values.

Given the past failure of the global community to look more closely at these success stories in the Commonwealth, we urge Commonwealth nations to:

- look more closely themselves at this experience within the Commonwealth, and
- work with and encourage others to take more seriously these experiences.

Practical actions include fostering a systematic program of investigation to understand and document these hybrid systems better, and creating mechanisms to share understanding of the critical elements of these systems with other Commonwealth nations.

## Recommendations

The challenge of achieving UHC – equitable access to quality healthcare combined with financial risk protection – has been accepted by the global community as a shared goal over the next two decades.

In order for this goal to be realized, developing countries need realistic options to expand coverage. Realism requires finding strategies that are compatible with the limited fiscal capacity that is an inevitable corollary of being a developing nation.

The evidence indicates that the standard Beveridge and Bismarck models are not fiscally feasible in most developing nations. They both require substantial spending of tax monies that poor countries cannot realistically afford. The global community and developing countries in particular need additional options that help extend coverage without breaking the bank.

There is sufficient evidence to indicate that the hybrid systems we have detailed have found one answer to this challenge of improving coverage with limited fiscal resources. We recommend that the Commonwealth and the wider global community:

### Recommendation 1

Give more serious attention and prominence to the experience of these hybrid health systems as potential role models for achieving UHC in developing countries.

### Recommendation 2

Support efforts to systematically document and assess these experiences in order to identify lessons that can be transferred to other countries.

### Recommendation 3

Support the sharing of these experiences between Commonwealth nations as part of the Commonwealth's shared heritage.

Key indicators for selected mixed model systems and comparable peers (2013)

	Hong Kong	Ireland	Australia	UK	New Zealand	Germany
Health system type	Mixed	Mixed	Mixed	Beveridge	Beveridge	Bismarck
Infant mortality rate (deaths/1,000 live births)	1.8	3.2	3.4	3.9	5.2	3.2
Life expectancy at birth (years)	84	81	83	81	82	81
Skilled birth attendance (%)	99	100	99	99	97	99
Hospital discharges per 100 people	18	13	17	13	15	25
Doctor consultations per person	11	4	7	5	4	10
Government health spending (%GDP)	2.6	5.5	5.9	7.0	7.6	8.4
Private health spending (% of total health expenditure)	36	32	33	16	17	23

Source: World Health Statistics 2015 (World Health Organization 2015), and Food and Health Bureau, Government of the Hong Kong Special Administrative Region (<http://www.fhb.gov.hk>) for additional statistics for Hong Kong [accessed 10 May 2016].

Key indicators for selected mixed funding model systems (2013)<sup>18, 19</sup>

	Sri Lanka	Jamaica	Malaysia	Hong Kong
Income category	Lower-middle	Upper-middle	Upper-middle	High
GDP per capita (USD constant 2005)	1,977	4,094	7,052	33,639
Infant mortality rate (deaths/1,000 live births)	8.7	14.4	6.4	1.8
Life expectancy at birth (years)	74.7	75.5	74.6	83.8
Skilled birth attendance (%)	99	99	99	99
Government health spending (%GDP)	1.6	3.4	2.2	2.6
Out-of-pocket health spending (% of total health expenditure)	44	25	36	36

This report was prepared by Ravindra Rannan-Eliya, Sarasi Amarasinghe, and Amaani Nilamudeen from the Institute for Health Policy Sri Lanka for the Commonwealth Health Professions Alliance (<http://www.chpa.co>) on the occasion of the 2016 Commonwealth Health Ministers' meeting where the goal of universal health coverage (UHC) was the focus of discussion. The report highlights a funding model to achieve UHC which has been successfully implemented by a number of Commonwealth countries and recommends further examination of this 'hybrid' model for wider adoption. The study was funded by the Commonwealth Foundation.

# THE GLOBAL YOUTH DEVELOPMENT INDEX



The potential for young people to contribute to a happy, healthy and prosperous future is threatened by widespread joblessness, unequal access to health and education and lack of political influence. This is the conclusion of the Global Youth Development Index, an initiative of the Commonwealth Secretariat, which ranked 183 countries according to 18 indicators covering employment, education, literacy, health, and civic and political engagement. The first-ever Global Youth Development Index shows that:

- The top ten countries, with the exception of Australia and Japan, are from Europe. The ten lowest-ranked countries are all from Sub-Saharan Africa, however the region also recorded the largest improvement in the last five years.
- Young people are twice as likely as adults to be jobless.
- Young women are much less likely to enjoy access to education, health services, financial services and digital technology than young men.
- Participation in formal politics is declining, underscoring growing frustration amid unmet aspirations, although digital activism, protests and volunteering are growing.
- Young people suffer disproportionately as victims of violent crime. However, young people also play an active role in peace-building.

The Commonwealth defines youth development as: "Enhancing the status of young people, empowering them to build on their competencies and capabilities for life. It will enable them to contribute to and benefit from a politically stable, economically viable, and legally supportive environment, ensuring their full participation as active citizens in their countries."

The top ten Commonwealth member countries are: Australia (3), United Kingdom (4), New Zealand (11), Canada (14), Malta (20), Barbados (28), Brunei (31), Sri Lanka (31), Malaysia (34) and Cyprus (38) (<http://bit.ly/2eVeKQB>).

The YDI score is a number between 0 and 1. For a country to receive a perfect score of 1, it would represent the highest possible level of youth development attainable. This scoring system is the same as the one underpinning the Human Development Index produced by the United Nations.

The index is guided by the Commonwealth definition of youth as people between the ages of 15 and 29 years of age.

The YDI index is a composite index of 18 indicators that collectively measure progress on youth development in 183 countries, including 49 of the 53 Commonwealth countries. It looks at five themes, or domains, measuring levels of education, health and wellbeing, employment and opportunity, political participation, and civic participation among young people. The domains were selected on the basis of their impact on the development of young people.

Young people make up approximately one quarter of humanity, but in many countries, particularly in South Asia and Africa, one in three people is a young person

State	Global Rank	2016 YDI Overall Score
Germany	1	0.894
Denmark	2	0.865
Australia	3	0.838
Switzerland	4	0.837
United Kingdom	4	0.837
Netherlands	6	0.836
Austria	7	0.826
Luxembourg	8	0.825
Portugal	9	0.816
Japan	10	0.815
New Zealand	11	0.813
Slovenia	12	0.811
Sweden	13	0.810
Canada	14	0.809
Ireland	15	0.806
Norway	16	0.804
Belgium	17	0.802
South Korea	18	0.797
France	19	0.795
Malta	20	0.794

# MATERNAL HEALTH: Education and training programs for midwives

Funded by: The Burdett Trust



The CNMF has been fortunate to have been funded by The Burdett Trust for Nursing for a number of years to provide maternal health education and training programs for midwives. The purpose of the programs is to provide an opportunity for midwives to take time out to update their skills and knowledge, reflect on the care being provided in their country, and share best practice with their peers.

In 2012, five programs were provided in Sierra Leone, four in rural areas. In 2013 two programs were provided in Zimbabwe with a further two programs provided in 2014. In 2015, two programs were provided in Lesotho. In 2016, the CNMF was funded to provide one program in Malawi and two in Tanzania.

Twenty four midwives attended the program in Malawi which was conducted in partnership with the Malawi Midwives Association and the Malawi Department of Health.



Participants in the Lilongwe program, Malawi

In Tanzania, twenty nine midwives attended the program held in Dar es Salaam and forty one midwives attended the program in Musoma.

The five-day program is a mix of different delivery styles: pre and post-test quizzes, formal presentations, group work, group activities, practical simulations, videos, and self-reflection. The program puts maternal health care in a global perspective as well as covering, antenatal, intrapartum, and postnatal care, as well as care of the neonate. The program also includes communication and team building activities.



Participants in the Dar es Salaam program, Tanzania



Participants in the Musoma program, Tanzania

The maternal health programs are co-facilitated by local midwifery educators and all resources used are left in-country so that further programs can be conducted locally. The videos used in the program are produced by Medical Aid Films or Global Health Media. These videos are wonderful educational resources for both midwives and their clients and participants are encouraged to make them available to their peers and their clients for ongoing education.

All programs are evaluated and rated highly by participants. Participants are asked how the information gained would assist them to improve their practice; whether they learned anything new and if so, what it was; and whether the content was useful to them. In Lilongwe, 100% of participants stated what they had learned would help them to improve their practice; 90% found the content useful; and 93% gained new knowledge. In Dar es Salaam, 99% of participants stated what they had learned would help them to improve their practice; 96% found the content useful; and 97% gained new knowledge. In Musoma, 99% of participants stated what they had learned would help them to improve their practice; 94% found the content useful; and 99% gained new knowledge.

The programs were delivered by Ms Minnesha Yasmine, Education Consultant for the CNMF. Reports from the programs are available on the CNMF website: <http://www.commonwealthnurses.org>.

## THE DEVELOPMENT OF A TASK SHARING POLICY IN BOTSWANA

At the end of 2014, a project to develop a task sharing policy for nurses and midwives in Botswana was initiated and funded by the Centres for Disease Control and Prevention Country Office in Botswana (CDC) through the Public Health Informatics Institute which is part of the USA Task Force for Global Health. The purpose of the project was to explore opportunities for, barriers to, difficulties with, and experiences of task sharing and task shifting for nurses and midwives in Botswana. The results were to guide the development of a task sharing policy for nurses and midwives in Botswana.

The methodology for the project was the administration of a descriptive cross sectional self-administered questionnaire using both quantitative and qualitative questions, supported by face-to-face interviews of key informants, and a comprehensive literature review. Development of the methodology, data collection, analysis, and report writing were conducted by the Nursing School of the University of Botswana under the leadership of Dr Mabel Magowe as principal researcher.

Traditionally, nurses and midwives have shared tasks with other health care providers such as doctors, pharmacists, laboratory assistants, and other health care auxiliary staff. In the absence of other health care providers however, nurses and midwives had tasks shifted to them or had to assume tasks which were not their traditional responsibility. At the same time, other lower level non-nursing cadres, including non-qualified cadres, performed nursing tasks. The purpose of a task sharing policy was to make sure that when tasks are shared or shifted, they are undertaken by the most appropriate person with the necessary knowledge, skills and expertise; that the tasks shared or shifted are supported by resources, mentoring, supervision, legislation and regulation; and that processes are in place to deal with an adverse outcome or an emergency.

Task shifting is defined by WHO (2007) as a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications to make more efficient use of existing human resources and ease bottlenecks in service delivery. It may also involve the delegation of some clearly delineated tasks to newly created cadres of health workers who receive specific, competency-based training.

Task sharing is a similar concept to task shifting which recognizes that different levels of providers do similar work, and that rarely are tasks completely shifted from one health cadre to another, but instead shared between health care providers (Janowitz, Stanback and Boyer, 2012).

For example, 'shifting' the task of voluntary male medical circumcision to nurses does not mean that doctors will no longer undertake that task. The task will be shared by both health cadres. Task sharing has the potential for enabling countries to build sustainable, cost-effective and equitable health care systems, thus moving closer not only to achieving the SDGs, but also universal health coverage.

The expected effect of a task sharing and task shifting policy is that it would enable nurses and midwives to undertake specified tasks within an endorsed policy framework enhancing consumer health outcomes and filling niches in health service delivery. Similarly, delegation of aspects of care to others by nurses and midwives would not promote or condone the substitution of unlicensed workers for nurses and midwives when the competence of a licensed nurse or midwife was required. Planned decisions grounded in professional judgment and evidence, in partnership with consumers, is a safer and more sustainable strategy than those strategies that are ad hoc, unregulated by the relevant professional body, and achieved through the mechanical addition of tasks through certification.

The study was conducted in 10 health districts in Botswana selected using a systematic sampling process where every 3<sup>rd</sup> district from a total of 27 was selected, making a total of 9 health districts in the study. An additional district was added because it had a referral hospital making a total of 10. Health facilities in the districts were selected purposively through cluster sampling to include three national referral hospitals, five district or primary hospitals, six clinics, six health posts, and two private hospitals, making a total of 22 health facilities. Nurses and midwives in each health facility were selected through purposive sampling to obtain a representative sample by cadre, age, experience, and qualification, based on specified inclusion and exclusion selection criteria.



Botswana Project Advisory Committee

A selected group of nurse managers from the data collection sites were trained on the study purpose, objectives, design, sites, population, sampling and sample size, data collection tools and procedures to support the administration of the questionnaire. A selective sample of the results of the nurses and midwives questionnaire appear below.

More than half the respondents (n=491) were under the age of 35 (54.6%) and had been in nursing less than 10 years (42.5%). The majority of respondents were female (74.1%) with 25.9% male.

A diploma in nursing was the most common qualification (50.5%), with 16.3% of respondents holding a bachelor degree and 1.8% a masters' degree. Only 4.4% had a specialist qualification in nursing.

Respondents were asked about the frequency of sharing tasks with other nurses. Almost 55% of respondents said they share some of their work tasks with other nursing staff all the time, 40.8% said they shared tasks often; 4.0% rarely shared; and 0.6% said they never share tasks with other nursing staff.

Respondents were asked about the frequency of sharing tasks with other non-nursing staff. Fifteen per cent said they shared tasks with other non-nursing staff all the time; 49.1% said they often shared tasks with other non-nursing staff; 27.7% rarely shared tasks; and 8.2% said they never share tasks with other non-nursing staff.

Respondents were asked whether, in the past five years, they had assumed full responsibility for tasks that had been shifted to them from other health care cadres. The results show that a high percentage (70.3%) of respondents said they had assumed full responsibility for tasks that had been shifted to them from other health cadres. An equally high percentage (87.9%) said that over the same period they had not shifted any tasks they had full responsibility for to other health cadres. More than half of respondents (57.4%) agreed that when they shared tasks with other staff, they experienced conflict over who should be doing the task.

Respondents were asked which other health care cadres they most often shared tasks with. Overwhelmingly the most common 'other health care cadre' with whom nurses and midwives shared tasks were doctors. There were very few task shared with either pharmacists or laboratory personnel. This is not an unexpected result but was important when considering the implementation of a task sharing policy for nurses and midwives and the stakeholders who needed to be consulted and involved.

To inform the task sharing policy, a set of principles were developed from the literature, particularly with reference to the publications of the World Health Organisation on the topic. Respondents were asked to rate these principles on task sharing and task shifting according to how important they considered them to be according to a five category Likert scale. The responses to this question were used to inform the development of the task sharing policy.

The percentages in brackets after each principle reflect the number of the nurses and midwives who considered that principle 'extremely important' or 'very important'.

- Adequate consultation with all cadres affected by the sharing or shifting of tasks and with other relevant stakeholders = 97.1%.
- Balanced and fair distribution of responsibilities and workload between all cadres = 98.6%.
- Reviews of current position description before new tasks are added to balance rather than increase workload = 98.9%.
- Availability of research to justify shifting tasks between cadres = 97.4%.
- Acceptability of shifting or sharing the task by all cadres affected = 93.1%.
- Demonstrated benefit to the general population of the task being shared or shifted = 92.0%.
- Recognition and incentives for additional responsibilities of a shared or shifted task = 96.9%.
- Relevant legislation, regulation or policy is already in place to support the task being shared or shifted = 96.2%.
- Availability of adequate resources = 97.3%.
- Adequate education and training provided before task is shared or shifted = 98.2%.
- Adequate supervision is available to support undertaking the shared or shifted task = 91.4%.
- Strategies are already in place to monitor and evaluate the impact and effect of sharing or shifting the task = 91.4%.
- The sustainability of sharing or shifting the task has been considered = 89.7%.
- The sharing and shifting of the task is cost effective = 85.2%.

Other findings important to the development of the task sharing policy were:

- 53.8% of respondents considered their job description did not accurately reflect the range of activities they undertake.
- 63.7% however felt supported by government or institutional policies in their work.
- 54.6% felt they were able to use the full range of their knowledge.
- 46.4% felt they had autonomy in their role.

The draft policy was exposed to three stakeholder consultations of nurses, midwives, doctors, pharmacists and laboratory personnel before being finalised. The final draft of the policy can be found on the CNMF website:

<http://www.commonwealthnurses.org/Activities.html>.



Botswana Project Advisory Committee



## GLOBAL HEALTHY START CAMPAIGN

World leaders have promised that everyone, everywhere will have water, sanitation and hygiene by 2030, and that Universal Health Coverage will be a reality. Clean water, proper toilets and soap for hand-washing are fundamental to delivering quality health care for mothers and babies. But as many people know, too many health clinics and hospitals lack these basics.

On Global Handwashing Day (15 October), the CNMF, ICM and WaterAid launched a global campaign to change this. The aim was to ensure every health professional (midwives, nurses, doctors, obstetricians and others) and every health care facility in the world has water, sanitation and hygiene by 2030.

A WHO and UNICEF study of 66,000 health facilities across 54 low- and middle-income countries showed that:

- 38% did not have an improved water source,
- 19% did not have improved sanitation,
- 35% did not have water and soap for handwashing.

The consequences are catastrophic. One in five babies die in their first month of life in the developing world even though just being washed in clean water and cared for in a clean environment by people who have washed their hands could have prevented their deaths. Four babies die every five minutes in Sub-Saharan Africa or Southern Asia from highly-preventable causes such as sepsis, meningitis or tetanus – all infections strongly linked to unhygienic conditions.

WaterAid has produced simple, powerful campaign materials to enable individuals, and health care professional associations and unions, to take action. From organising national events to writing to health ministers; from meeting parliamentarians to signing a petition: you CAN make a difference. Action materials are available in English, French, Portuguese and Spanish.

For more information and to access campaign materials visit:

<http://www.wateraid.org/healthystart>

To sign the petition:

[http://www.wateraid.org/policy-practice-and-advocacy/healthy-start-join-the-campaign?utm\\_source=CNMF&utm\\_medium=comms&utm\\_content=partner&utm\\_campaign=Global\\_Health\\_Professionals](http://www.wateraid.org/policy-practice-and-advocacy/healthy-start-join-the-campaign?utm_source=CNMF&utm_medium=comms&utm_content=partner&utm_campaign=Global_Health_Professionals).

## MEDICAL AID FILMS

<http://www.medicalaidfilms.org>



### DIABETES IN PREGNANCY

Diabetes is considered to be the biggest global health crisis today. Around 422 million adults live with the condition, resulting in 1.5 million deaths per year, and these numbers are expected to double in the next 20 years. Gestational diabetes develops in pregnancy and affects an estimated 3.7 million births each year.

Medical Aid Films has launched *Diabetes in pregnancy: stories from Saint Lucia*, new films that tell the stories of women affected by diabetes during pregnancy. Filmed in Saint Lucia with the help of the Saint Lucia Ministry of Health, Wellness, Human Services and Gender Relations and the Saint Lucia Diabetes and Hypertension Association, the films aim to raise awareness of gestational diabetes in pregnancy, how to manage the risks through healthy diet and exercise, and how to reduce the chances of developing type 2 diabetes later in life.



*Obstructed Labour: An Introduction for Midwives*

### OBSTRUCTED LABOUR

Filmed in Kenya, with funding from the Vitol Foundation, the film explains the main causes of obstructed labour, what happens during obstructed labour, how signs of obstructed labour can be identified, and steps to be taken for effective management. The film follows Kandie, a midwife, as she monitors a mother in early labour, and a mother with suspected obstructed labour. This film aims to provide valuable support for midwifery training.

## POOR PROGRESS FOR 'LEAST DEVELOPED' COUNTRIES

Every ten years since 1971, the United Nations has convened a special conference to consider global action programs to support development in 'least developed' countries (LDC) which currently number 48 countries. This group of countries is deemed to be the most disadvantaged in the development process and face the greatest risk of failing to overcome poverty.

LDC IV Monitor recently conducted a mid-term review of the Istanbul Program of Action 2011-2020 (IPoA). The IPoA is a global policy agenda for 'least developed' countries, including targets to help them progress from this ranking. The target was for 24 countries to move out of that ranking by 2020 however with existing support mechanisms only 10 countries are predicted to change their ranking by 2020.

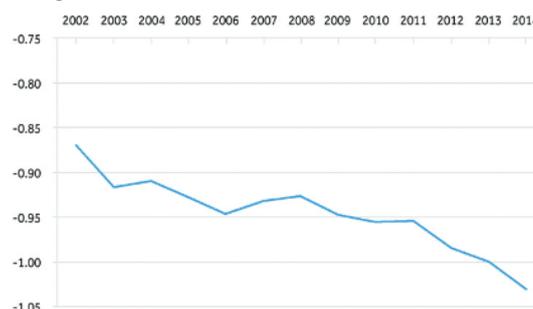
In the 'least developed' country list, 34 countries are located in Africa; 9 in Asia; 4 are Pacific Island countries; and 1 is located in Latin America. Thirteen countries with a 'least developed' ranking are Commonwealth countries.

LDC IV Monitor, established in 2011, is a consortium of seven development partners which includes the Commonwealth Secretariat, established to provide independent and objective monitoring of the IPoA. The mid-term review of the IPoA focused on four themes: structural transformation; export diversification; prospects for countries' graduation from 'least developed' classification; and implications for achieving the sustainable development goals (SDGs). The report found that many objectives set out in the IPoA are unlikely to be achieved.

The review report, *Achieving the Istanbul Programme of Action by 2020: Tracking Progress, Accelerating Transformations*, published in 2016 showed that over the forty years since the Least Developed Countries (LDC) category was created, international efforts to eliminate the conditions that make these countries 'least developed' have shown only meagre results. Only four countries have graduated from the LDC status in four decades (Botswana 1994, Cape Verde 2007, Maldives 2011 and Samoa 2014). 'Graduation' is based on an analysis of specific income criteria, a human assets index, and an economic viability index.

The report found that the LDCs face a set of interconnected global challenges: economic, technological, demographic, environmental, security and governance, with the potential to seriously undermine their prospects of achieving the SDGs, as well as the IPoA goals.

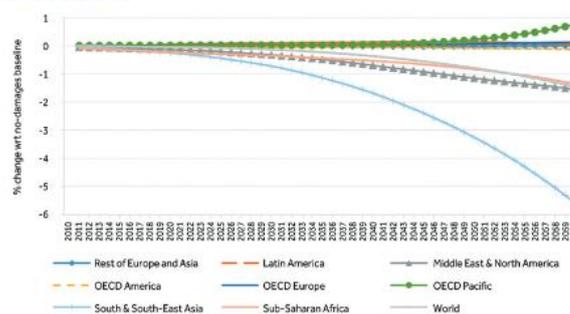
**Figure 4.8 Perceptions of government effectiveness in LDCs have been declining**



Source: World Bank (2015b).

Note: Estimate of governance ranges from approximately -2.5 (weak) to 2.5 (strong) governance performance.

**Figure 4.6 Climate change will reduce economic growth in most regions (OECD projection of regional economic impact (in % of GDP) owing to climate change)**



Source: OECD (2014b).

**Table 4.2 LDCs are among the world's most fragile states**

Ranking	Country	Fragility Index 2015	Status since 2006
<b>Very High Alert</b>			
1	South Sudan*	114.5	Some worsening
2	Somalia*	114	Worsening
3	Central African Republic*	111.9	Significant worsening
4	Sudan*	110.8	Some improvement
<b>High Alert</b>			
5	Congo (D. R.)*	109.7	Marginal change
6	Chad*	108.4	Some worsening
7	Yemen*	108.1	Worsening
9	Syria	107.9	Significant worsening
8	Afghanistan*	107.9	Worsening
10	Guinea*	104.9	Some worsening
11	Haiti*	104.5	Marginal change
12	Iraq	104.5	Strong improvement
13	Pakistan	102.9	Marginal change
14	Nigeria	102.4	Some worsening
15	Cote d'Ivoire	100	Strong improvement
16	Zimbabwe	100	Strong improvement
<b>Alert</b>			
17	Guinea Bissau*	99.9	Critical worsening
18	Burundi*	98.1	Marginal change
19	Niger*	97.8	Significant worsening
20	Ethiopia*	97.5	Some worsening
21	Kenya	97.4	Significant worsening
21	Liberia*	97.3	Some improvement
23	Uganda*	97	Marginal worsening
24	Eritrea*	96.9	Significant worsening
25	Libya	95.3	Critical worsening
26	Mauritania*	94.9	Some worsening
27	Myanmar*	94.7	Some improvement
28	Cameroon	94.3	Some worsening
29	North Korea	93.8	Some improvement
30	Mali*	93.1	Critical worsening
31	Sierra Leone*	91.9	Strong improvement
32	Bangladesh*	91.8	Some improvement
33	Congo (Republic)	90.8	Some improvement
34	Sri Lanka	90.6	Marginal change
34	Timor-Leste*	90.6	Some improvement
36	Nepal*	90.5	Some improvement
37	Rwanda*	90.2	Some improvement
38	Egypt	90	Marginal worsening

Note: LDCs are marked with an asterisk. Source: Fund for Peace (2015).

The report can be downloaded from: <http://ldc4monitor.org/wp-content/uploads/2016/05/Achieving-the-Istanbul-Programme-of-Action-by-2020.pdf>.

# SAVE THE DATE

London Friday 9 to Sunday 11 March 2018



## LEADING THE WAY: Nurses and midwives for a safe, healthy and peaceful world

The 4th Commonwealth Nurses and Midwives Conference

Royal College of Physicians, Regent's Park, London, UK  
Saturday 10 and Sunday 11 March 2018

### 4<sup>TH</sup> COMMONWEALTH NURSES AND MIDWIVES CONFERENCE 10-11 MARCH 2018

*Leading the way: nurses and midwives for a safe, health and peaceful world.*

The 4<sup>th</sup> Commonwealth Nurses and Midwives Conference will be held in London, United Kingdom 10-11 March 2018.

Our world today is far from being safe, healthy or peaceful. Many countries are experiencing war or civil conflict; there are more refugees than ever before seeking a safe place to live for themselves and their families; bush fires, floods, earthquakes and tsunamis are a frequent occurrence; diseases such as Ebola and Zika threaten health and stability; climate change threatens entire populations.

Nurses and midwives are in a unique position to act as role models and lead the way in promoting a safe, healthy and peaceful world. The conference has four key themes:

- Promoting health and wellbeing,
- Alleviating illness and disease,
- Promoting social harmony and cohesion,
- Contributing to a safe environment.

A 'Call for Abstracts' will be issued early 2017 on the CNMF website:

<http://commonwealthnurses.org>. Nurses and midwives from across the Commonwealth and beyond are encouraged to submit abstracts addressing the conference themes. Abstracts will be able to be submitted online from early 2017 through the conference website.

The CNMF conference provides an opportunity for nurses and midwives to showcase their practice, their projects, and their research and to share, network, and establish friendships with nurses and midwives from other countries.

### 23<sup>RD</sup> CNMF BIENNIAL MEETING OF MEMBERS Friday 9 March 2018

The 23<sup>rd</sup> CNMF Biennial Meeting of Members will be held on Friday 9 March 2018, generously hosted by the Royal College of Nursing (RCN) 20 Cavendish Square London W1G 0RN.

The Biennial Meeting of Members is the decision making body of the CNMF where reports are received from the President, the Executive Secretary, the Treasurer, and Regional Board Members; where decisions are made; and strategic directions are set for the coming two years.

An election will be held for President and Deputy President of the CNMF 2018-2022 as well as voting on proposed constitutional changes.

There are three policy statements for endorsement:

- Career structures for nurses and midwives.
- Professional and industrial representation of nurses and midwives.
- Nursing and midwifery work.

Two new policy statements will be debated:

- The relationship between nursing and midwifery.
- Continuing professional development for nurses and midwives.

All CNMF members and friends are welcome to attend however registration is essential. The Biennial Meeting of Members will be followed by a short reception.



CNMF Biennial March 2016