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2018 Commonwealth Civil Society Policy Forum

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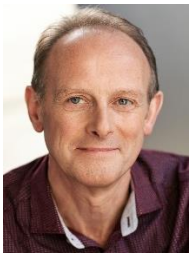

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The Commonwealth Nurses and Midwives Federation (CNMF), founded in 1973, is a federation of national nursing and midwifery associations in Commonwealth countries.

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from the PRESIDENT

Professor Kathleen McCourt CBE FRCN
CNMF President

The health and well-being of our Commonwealth country populations face major challenges. Responding to unhealthy lifestyles, increasing rates of communicable and non-communicable diseases, inequities of access to care, and internal and external conflict are faced by our nursing and midwifery communities every single day.

CNMF can support national nursing and midwifery associations, regulatory bodies, clinical specialist groups, diaspora groups, universities, colleges and individuals in promoting their work and forming supportive information and practice networks. This work continues on the ground, in country, and across borders in order to collectively improve health care for Commonwealth citizens and the working lives of nursing and midwifery practitioners.

Much activity has taken place within the CNMF since March. A particular focus has been the revision of mental health legislation, working with a number of countries across the Commonwealth as well as providing maternal health updates for midwives. Developing projects which improve and enhance wellbeing, human needs and career frameworks are very relevant to the work of the CNMF.

The focus of this edition of The Commonwealth Nurse is on universal health coverage. It is critically important that nurses and midwives are knowledgeable, not just about what is meant by universal health coverage, but what plans their governments are developing for the implementation of universal health coverage. These plans have significant implications for what services are provided; how they are provided; which health professionals will be providing them; and how the services are funded. Each nursing and midwifery association must ensure that nurses and midwives are represented in any high level discussions and decisions that are being made about the implementation of universal health coverage in their country.

The focus of the 2018 Commonwealth Civil Society Policy Forum held in Geneva in May in conjunction with the annual Commonwealth Health Ministers' meeting was on universal health coverage from the perspective of sustainable financing; a sufficient health workforce; and equitable access to quality medicines. The policy paper on sustainable financing is reproduced in this journal and I commend it to you. It is critically important that nurses and midwives, through their professional and industrial associations are kept informed.

The 13th CNMF Europe region conference will be held in Malta 8-9 March 2019 and I hope to see many of you there. Please refer to the ''Call for Abstracts'' on the last page of the journal.

The planning for the 5th CNMF Nurses and Midwives Conference 6-7 March 2020 in London is underway with the 'Call for Abstracts' to be issued 1 December 2018. The CNMF Conference is a wonderful opportunity for nurses and midwives across the Commonwealth to network with each other and share their research and practice experience.

The initial development of the Nursing Now campaign, which I have contributed to on behalf of CNMF, has now emerged as a global campaign and I am delighted that our Deputy President Rosemarie Josey is on the global committee. Nursing Now committees have been established in most countries across the world, and nurses and midwives are undertaking specific activities in their countries under the Nursing Now umbrella.

Also in this edition of The Commonwealth Nurses we introduce you to the CNMF Board and I want to welcome new Board members Bettyann Murray-John from Trinidad and Tobago and Evelyn Kannan from India to the CNMF Board. I look forward to sharing with you the work of our Board members within their regions in future editions of The Commonwealth Nurse.

Please make sure you read the information about the WHO initiative to produce the first ever State of the World's Nursing report. It is so important that nurses and midwives are actively involved in contributing to this report.

Finally, my best wishes go to each and every member of the CNMF. Please do whatever you can to support the family of the Commonwealth and the practice of nurses and midwives. There is so much to do and we must work collectively to enhance the lives of our Commonwealth populations.

2018 Commonwealth Civil Society Policy Forum

Universal health coverage: holding countries to account

POLICY BRIEF
Universal health coverage and sustainable financing

Civil Society across the Commonwealth, supported by the Commonwealth Foundation, host an annual policy forum addressing the theme of the annual Commonwealth Health Ministers' meeting (CHMM) which is held each year in Geneva on the eve of the World Health Assembly. Through the policy forum, Commonwealth civil society comes together to discuss, debate, and develop a consensus position or set of positions and recommendations and/or a declaration for action on the policy issues under discussion. These positions or requests for action are then presented by civil society to Commonwealth Health Ministers at their meeting. The 2018 Commonwealth Civil Society Policy Forum addressed the following issues:

- UHC and sustainable financing;
- UHC and a sufficient health workforce;
- UHC and access to quality essential medicines and vaccines.

Eminent speakers addressed these three issues and recommendations were developed which were shared with civil society across the Commonwealth through an online survey to gain input into and consensus about the proposed recommendations and action to be presented to Commonwealth Health Ministers at their meeting. This policy brief addresses Universal Health Coverage and Sustainable Financing.

The recommendations presented to Commonwealth Health Ministers can be found at the conclusion of the Policy Brief. Nurses and midwives are encouraged to refer these recommendations to their government for action.

DEFINING UHC

The World Health Organisation (WHO) defines universal health coverage as "all people receiving the health services they need, including health initiatives designed to promote better health, prevent illness, and to provide treatment, rehabilitation, and palliative care of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship".[1]

The WHO go on to note that a significant number of countries, at all levels of development, are embracing the goal of UHC as the right thing to do for their citizens. UHC, the WHO say, is a powerful social equalizer and contributes to social cohesion and stability. Supporting the right to health and ending extreme poverty can both be pursued through UHC. The WHO also note that UHC is a critical component of the new Sustainable Development Goals (SDGs) which include a specific health goal: "Ensure healthy lives and promote wellbeing for all at all ages".

Within this health goal, there is a specific target for UHC:

"Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[2]

WHAT ARE THE ISSUES?

Universal Health Coverage requires countries to ensure that all people have equitable access to needed quality health care services without experiencing financial risk, such as excessive out of pocket expenses. The 2010 World Health Report, put forward a number messages central to achieving UHC:

- raising sufficient resources for health,
- removing financial risk and barriers to access,
- promoting efficiency and eliminating waste,
- addressing inequalities in coverage.[3]

There is consensus in the literature that achieving UHC requires a predominant reliance on compulsory or public funding for health services which is central to ensuring access to health services whilst also protecting individuals and families from potentially impoverishing levels of out of pocket expenses. Whilst private financing plays a role in all health systems, the WHO state that evidence clearly shows that it is public financing which drives improvements in health system performance on UHC.[4,5]

No country has attained UHC by relying on voluntary contributions to insurance schemes regardless of whether they are run by non-government, commercial or government entities.[6]

Kutzin maintains that while public funding can come from general government revenues or compulsory social health insurance contributions (eg income and payroll taxes), the allocation of general government revenues is essential, especially for poorer countries where large segments of the population may not be in salaried employment and not subject to the collection of income or payroll taxes. This position is reinforced by the WHO, commenting that there will be a proportion of the population too poor to contribute through income taxes or insurance premiums and will need subsidisation from pooled funds, generally government revenue.[7]

The answer to the question "how much public spending is enough", Kutzin notes, is not straightforward and there is no single or simple answer.[8] A number of health expenditure targets exist but there is no agreed formula. These include targets based on absolute spending amounts and those based on spending relative to a denominator such as GDP or total government spending and there are wide variations between targets.

To add to the confusion, targets and estimates are not always explicit in stating whether they are referring to public expenditure on health as a percentage of GDP or total spending on health as a percentage of GDP.

The 2010 WHO World Health Report comments that "those countries whose entire populations have access to a set of services usually have relatively high levels of pooled funds in the order of 5-6% of gross GDP".[9]

Many countries however have achieved a high degree of UHC with less than 6% of GDP (Sri Lanka 3.5%; Malaysia 4.2%; and Jamaica 5.4%).[10] Conversely many Commonwealth countries already spend much more than 6% of GDP without achieving UHC. [11]

Although there is no agreed formula, it is clear that many households forgo care or face financial risk from out of pocket expenses or payment at time of service in those countries that rely predominantly on private sources of health care. It is also apparent that even at low levels of public spending, countries can make significant steps toward UHC.

UHC FUNDING MODELS

The two most commonly reported UHC financing systems are:[12]

(a) Social health insurance (or the Bismarck Model): Insurance contributions from government, employers and individuals are used to finance a public insurance scheme that pays for services, usually by private providers (examples include *Germany, Japan and Korea*). Kutzin notes however that countries that have initiated financing reforms with a health insurance scheme solely for particular groups such as the formal workforce, are focusing attention and resources on already advantaged and well organized groups, which tends to exacerbate rather than redress inequalities.[13] Government contributions are still required for those who are not covered by the social health insurance or who cannot afford to pay.

(b) Tax-funded systems (or the Beveridge Model): General revenue taxation is used to pay for the bulk of all health care services delivered predominantly, although not exclusively, through a public sector delivery system (examples include *United Kingdom, Sweden and New Zealand*). In this model, most, but not all hospitals and clinics are owned by the government: some doctors are government employees however there are also private doctors who collect their fees from the government and private hospitals and clinics.

These models, or their variations, face challenges however requiring at least 3% of GDP and often more. In developing countries this may be difficult to achieve because of the limited capacity of low-income countries to raise taxation funding or social insurance contributions to implement either Beveridge or Bismarck approaches to achieve UHC.

(c) Less researched is a mixed model of public and private health care provision which appears to achieve UHC at a surprisingly low proportion of GDP.[14] This model combines public provision of a universal package of health services for all, both rich and poor, with private health care provision meeting consumer demand for 'add on' services, such as reduced waiting times, doctor of choice, and enhanced amenities such as private rooms and choice of food. Examples include: Jamaica and many of its English-speaking Caribbean neighbours, Sri Lanka, Malaysia, Hong Kong, Ireland and Australia. Sri Lanka and Malaysia have achieved a high degree of UHC with public spending of 2.0% and 2.3% GDP and have health indicators comparable or better than some high income countries.[15]

In all cases of these mixed models reviewed, governments focused on maximizing universal or equitable access to a universal package of services for both rich and poor, and reducing exposure to financial risk, whilst minimizing government spending. Limited public funding benefits the poor more than the rich, not by means testing, but by differences in consumer quality.

WHAT NEEDS TO BE DONE AND HOW?

A significant number of countries are embracing the goal of UHC as the right thing to do for their citizens. UHC promotes social equality, social cohesion, and stability. Achieving UHC is also one of the health goals of the Sustainable Development Goals.

UHC that provides equitable access to needed health services for the entire population without exposing them to financial hardship is a priority for civil society across the Commonwealth. Commonwealth Health Ministers need to involve all sectors of government and civil society stakeholders in their countries in decisions about how UHC is to be provided and financed.

In addition, steps need to be put in place to define 'high priority' health services based on cost-effectiveness; prioritizing health services for the poor; and providing financial risk protection. Monitoring indicators could include coverage of these 'high priority' health services; household expenditures on heath as a share of total household expenditure and income; % of GDP spent on health (public/private); health outcomes such as infant mortality and life expectancy; and measures of financial risk protection, such as out of pocket expenditures on inpatient and outpatient care by income group.

Achieving and funding UHC is a significant challenge for countries, particularly low-income countries. Although calls to increase the overall proportion of GDP allocated to UHC should be supported, it is also important that quality core clinical care is provided in the most cost-effective manner if UHC is to be achieved.[16]

Empirical evidence suggests that amongst low and middle-income economies, mixed public/private health care models as described earlier have performed well in terms of health outcomes and have generally achieved this at a lower cost than the better-known UHC models, Beveridge and Bismarck.

The Commonwealth is in a unique position to examine the financing models of Commonwealth countries who have achieved, or mostly achieved UHC, to identify key characteristics and share these within the Commonwealth.

UHC SURVEY

Number of returns:	70
Europe:	16 (23%)
Asia:	15 (21%)
Pacific:	3 (4%)
Africa:	23 (33%)
International:	4 (6%)
Caribbean and Americas:	8 (11%)
Not stated:	1 (1%)
Female:	35 (50%)
Male:	33 (47%)
No response:	2 (3%)

RECOMMENDATIONS

1. By 2020, all Commonwealth governments have developed national UHC plans, with community-inclusive multi-stakeholder input. Publicly funded 'high priority' health services in terms of outcome and cost-effectiveness should be clearly defined and publicly communicated.
   Survey responses
   YES: 60 (86%)
   YES with revision: 8 (11%)
   NO: 2 (3%)

2. That Commonwealth governments include in their UHC plans strategies for access to safe, effective, quality and affordable essential medicines and vaccines for their citizens.
   Survey responses
   YES: 64 (91%)
   YES with revision: 6 (9%)

3. By 2020, all Commonwealth governments have developed mechanisms to monitor their UHC plans by, but not limited to, the following measures:
   - usage of 'high priority' health services by income group and area of residence,
   - household expenditure on health as % total household expenditure and income,
   - % GDP spent on health (public/private),
   - health outcomes,
   - measures of financial risk such as out of pocket expenditures on both inpatient and outpatient care by income group.

   Survey responses
   YES: 62 (88%)
   YES with revision: 6 (9%)
   NO: 2 (3%)

REFERENCES

1. World Health Organisation. *Tracking universal health coverage: first global monitoring report.* 2015. p.viii: http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf).
2. United Nations. *Sustainable Development Goals. Goal 3 2015:* http://www.un.org/sustainabledevelopment/health/#7e9fb9b0ec8c8e6e6).
3. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010: http://www.who.int/whr/2010/en/).
4. Jowett, J. and Kutzin, J. *Raising revenues for health in support of UHC: strategic issues for policy makers.* WHO Health Financing Policy Brief No.1 2015 p.2: http://apps.who.int/iris/bitstream/10665/192280/1/WHO_HIS_HGF_PolicyBrief_15.1_eng.pdf.
5. Jowett M, Brunal MP, Flores G, Cylus J. 2016. *Spending targets for health: no magic number*. WHO Health Financing Working Paper No.1 p.3: http://www.who.int/health_financing/documents/no-magic-number/en/).
6. Kutzin, J. *Anything goes on the path to universal health coverage?* 2012. Bulletin of the World Health Organization 90:867-868: http://www.who.int/bulletin/volumes/90/11/12-113654/en/).
7. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010 p.xiv: http://www.who.int/whr/2010/en/).
8. Kutzin, J. *Anything goes on the path to universal health coverage? No.* 2012. Bulletin of the World Health Organization 90:867-868: http://www.who.int/bulletin/volumes/90/11/12-113654/en/.
9. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010 p.xv: http://www.who.int/whr/2010/en/.
10. World Bank. *Health expenditure % GDP*: http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.XPD.TOTL.ZS&country.
11. Jowett M, Brunal MP, Flores G, Cylus J. *Spending targets for health: no magic number*. Geneva: WHO; 2016 (WHO/HIS/HGF/HFWorkingPaper/16.1; Health Financing Working Paper No.1. p.3): http://www.who.int/health_financing/documents/no-magic-number/en/.
12. Rannan-Eliya, R., Amarasinghe, S. and Nilamudeen, A. *Universal health coverage: the potential contribution of hybrid funding strategies*. 2016. Institute of Health Policy Sri Lanka: http://www.chpa.co.
13. Kutzin, J. *Anything goes on the path to universal health coverage? No.* 2012. Bulletin of the World Health Organization 90:867-868. http://www.who.int/bulletin/volumes/90/11/12-113654/en/.
14. Rannan-Eliya, R., Amarasinghe, S. and Nilamudeen, A. *Universal health coverage: the potential contribution of hybrid funding strategies*. 2016. Institute of Health Policy Sri Lanka: http://www.chpa.co.
15. World Bank. *Health expenditure, public, % of GDP*. http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.XPD.PUBL.ZS&country.
16. World Health Organization. *Health systems financing: the path to universal health coverage.* World Health Report 2010 p.xvi: http://www.who.int/whr/2010/en/

5th Commonwealth Nurses and Midwives Conference

SAVE THE DATE

The CNMF Board have confirmed that the 5th Commonwealth Nurses and Midwives Conference will be held Friday 6th and Saturday 7th March 2020 in London, United Kingdom.

There were a number of requests at the 4th Commonwealth Nurses and Midwives Conference held this year to have the conference on a Friday and Saturday rather than a Saturday and Sunday so the Board have decided to do that for the conference in 2020. The conference will again be held at the Royal College of Physicians, Regent's Park London.

The 'Call for Abstracts' will be available 1 December this year.

24th CNMF Biennial Meeting of Members

The 24th CNMF Biennial Meeting of Members will be held the day before the conference on Thursday 5th March 2020 in London, United Kingdom. The Biennial Meeting of Members is the decision making body of the CNMF. At the 23rd CNMF Biennial Meeting, three policy statements were endorsed: Career structures for nurses and midwives; Nursing and midwifery work; and Professional and industrial representation for nurses and midwives. These policy statements are available on the CNMF website and members are welcome to adapt them for their own use. http://www.commonwealthnurses.org.

Two further policy statements are open for discussion:

- The relationship between nursing and midwifery: how is education and practice linked across the Commonwealth?
- Continuing professional development for nurses and midwives: what is the status of CPD across the Commonwealth?

These statements will be presented to the 24th CNMF Biennial Meeting for endorsement. Please forward comments to: cnf@commonwealthnures.org.

UN Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is the ''gold standard'' for mental health legislation. The CRPD was adopted by the UN on 13 December 2006, opened for signature and ratification on 30 March 2007, and came into force on 3 May 2008. So far, 177 countries have ratified the CRPD. Has your country signed the CRPD? To find out, go to: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en

The WHO report that few countries have a legal framework that adequately protects the rights of people with mental disabilities, and that policy and practice needs to be based on a sound legal framework.

The CRPD is a legally binding international treaty. Countries which have ratified the CRPD are required to ''*adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the CRPD*'' and to ''*take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities*''. For a copy of the CRPD go to: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.

The CRPD is rights based. It marks a paradigm shift where persons with disabilities are no longer viewed as objects of charity but as active members of society, in control of their own lives, with legal capacity, capable of giving free and informed consent, and with the same rights to participation, engagement and inclusion on an equal basis to every other person.

The purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The general principles of the Convention are:

a. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
b. Non-discrimination;
c. Full and effective participation and inclusion in society;
d. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
e. Equality of opportunity;
f. Accessibility;
g. Equality between men and women;
h. Respect for the evolving capacities of children with disabilities.

Other articles cover:

- Equality and non-discrimination (Article 5);
- Women with disabilities (Article 6); and children with disabilities (Article 7);
- Accessibility (Article 9);
- Right to life (Article 10);
- Equal recognition before the law (Article 12);
- Access to justice (Article 13);
- Liberty and security of person (Article 14);
- Freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15);
- Freedom from exploitation, violence and abuse (Article 16);
- Liberty of movement and nationality (Article 18);
- Living independently and being included in the community (Article 19);
- Freedom of expression and opinion, and access to information (Article 21);
- Respect for privacy (Article 22);
- Respect for home and the family (Article 23);
- Education (Article 24); Health (Article 25);
- Work and employment (Article 27);
- Adequate standard of living and social protection (Article 28);
- Participation in political and public life (Article 29);
- Participation in cultural life, recreation, leisure and sport (Article 30).

The CNMF mental health legislation project assesses a country's mental health legislation against the CRPD and makes recommendations for reform if required. Mental health legislation when formulated according to human rights principles, can address access to care; rehabilitation; integration into the community, the promotion of mental health; and the prevention of stigma, discrimination and marginalisation.

New mental health legislation for the Seychelles and Botswana

The World Health Organisation estimate that 20% of the world's adults, adolescents and children, regardless of culture, will experience mental health issues in their lifetime and report that human rights violations of people with mental disability are routinely reported in most countries.

In 2013, the Indian Law Society Centre for Mental Health Law and Policy conducted a study of mental health legislation in Commonwealth countries. The study found that mental health legislation in 20 per cent of Commonwealth countries was enacted prior to 1960 before modern medical treatments for mental disability became available and before many of the international human rights instruments came into force.

The study report concluded that mental health legislation in most Commonwealth countries did not fulfil the country's international human rights obligations toward persons with mental disability; was not compliant with the UN Convention on the Rights of Persons with Disabilities; was based on an outdated understanding of mental disability; ignored advances in the care and treatment of mental disability; and denied the capacity of persons with mental disability to manage their lives.

The CNMF mental health legislation project, funded by the Commonwealth Foundation, involved working with two Commonwealth countries, the Seychelles and Botswana, to assess their existing mental health legislation against the UN Convention on the Rights of Persons with Disabilities and make recommendations for reform, if indicated. The Indian Law Society Centre for Mental Health Law and Policy were partners in the project, providing expert advice.

Project methodology included the establishment of a National Mental Health Advisory Committee to oversee the project in-country; the development of a communication strategy; and comprehensive stakeholder consultations.

The project in both countries resulted in a recommendation, which was accepted by Government, to write new legislation as the existing legislation was considered unsuitable for amendment.

Seychelles National Mental Health Advisory Committee October 2017

In the Seychelles, after comprehensive consultation with stakeholders and review by the National Mental Health Advisory Committee, new mental health legislation has been submitted to the Minister for Health and to Parliament.

Seychelles National Mental Health Advisory Committee meeting with the Seychelles Minister for Health

In Botswana, a series of stakeholder meetings with mental health personnel, members of the judiciary, and civil society organisations, finalised drafting instructions for a new Bill.

These drafting instructions have now been submitted to the Ministry of Health and forwarded to the Attorney General's Office for new legislation to be drafted. It is anticipated the new legislation will be submitted to Parliament early 2019.

Members of the Botswana National Mental Health Advisory Committee meeting with the Botswana Minister for Health.

Maternal Health Education
Sierra Leone

The CNMF was funded by The Burdett Trust for Nursing to provide three maternal health education programs in Sierra Leone: one urban and two rural. The first urban program was conducted in July 2017 in Freetown. The second and third rural programs were conducted in June 2018 in Makeni and July 2018 in Bo. The funding built on previous grants where five programs were provided in Sierra Leone 2012-2013 (one urban and four rural); two programs were provided in Lesotho (2015); two programs in Tanzania (2016); and one in Malawi (2016).

The most recent United Nations maternal mortality data (2015) for the Sub-Saharan Africa region indicates Sierra Leone now has a revised maternal mortality rate of 1,360 per 100,000 live births (the 2011 figure was 830 per 100,000 live births). The latest figures released by the United Nations Population Fund in May 2017 as part of the Maternal Death Surveillance and Response Annual Report put the figure at 1,165 per 100,000 live births.

Sierra Leone is still struggling to rebuild its health services following the devastating impact of Ebola in 2014-2015. Two hundred and ninety six health care workers in Sierra Leone became infected with Ebola and 221 died; a much higher proportion than in the general community. One hundred and fifty two were nurses (including 3 midwives; 33 maternal child health aides; and 9 traditional birth attendants).

The maternal health education programs for midwives in Sierra Leone were conducted in partnership with the Sierra Leone Ministry of Health and Sanitation and the Sierra Leone Nurses Association.

The programs are offered over five days of intensive training and cover global maternal health policies and statistics, including the Sustainable Development Goals; antenatal care; intrapartum care; obstetric complications; postnatal care; care of the neonate; women with special needs; communication, respecting diversity, and working in teams.

Makeni

Bo

Multiple teaching modes are used to maintain interest and role model effective education: pre and post- tests; didactic lectures; videos; group work; group exercises; individual self-reflection; and practical 'hands-on' training.

Local educators co-facilitate the training and all training resources are left in-country to enable further programs to be conducted. All participants receive a USB drive containing all training materials, links to videos, and additional resources.

One hundred and fifteen midwives participated in the education programs in Sierra Leone: 34 in Freetown (July 2017); 40 in Makeni (June 2018); and 41 in Bo (July 2018). In addition, five local educators participated and four support persons from the Sierra Leone Nurses Association.

The education program is evaluated by participants on a daily basis and at the conclusion of the program: 92.5% of participants said they had learned something new as a result of the education program and 99.6% said what they learned will help them to improve their practice. These results demonstrate the importance of the education and training to midwives in Sierra Leone. The CNMF acknowledges the valuable and ongoing support of The Burdett Trust for Nursing in the delivery of the education programs.

Bahamas prepares for the future

The Nurses Association of the Commonwealth of the Bahamas (NACB) has commenced a series of workshops to identify issues of concern to nurses and midwives in preparation for a review of the Bahamas National Nursing Strategy.

The first workshop in this proactive initiative was held in Nassau on Tuesday 2 October 2018. The workshop was attended by 32 nurses and midwives and addressed six key priority areas:

- Clinical practice,
- Education,
- Workforce sustainability,
- Research and information technology,
- Leadership and governance,
- Advocacy.

Working in small groups, a vision statement was developed for each of the priority areas.

To focus the discussion, two questions were generated for each area. The questions were developed from previous consultations by the NACB to identify issues of concern to nurses and midwives in the country. The small groups identified three key strategies to help resolve the issues identified in the questions. These strategies were then shared in plenary, and modified and refined with input from the larger group.

Other priority areas will be addressed in further workshops, and the findings of each workshop will be validated by exposure to the wider nursing and midwifery workforce in the Bahamas. The information will provide the NACB executive with a strong and informed position going into negotiations for the review of the National Nursing Strategy.

VISION STATEMENTS

Clinical Practice
By 2025, clinical nursing practice in the Bahamas will be transformed by embracing and integrating education, research, innovation, and technology for best practice in a people centered environment.

Education
By 2025, nursing in the Bahamas will have educational opportunities that are high quality, innovative, accessible, sustainable, and effectively integrate theory with practice.

Workforce sustainability
By 2025, the attraction of being a nurse in the Bahamas will be so compelling that it will retain a sustainable workforce through promoting employee satisfaction, advancement, and personal development.

Research and information technology
By 2025, nursing services in the Bahamas will provide innovative, evidence based quality care through the integration and implementation of research and information technology.

Leadership and governance
By 2025, nursing in the Bahamas will be transformed through a collaborative regulatory environment guided by innovative, empowered, and culturally competent leadership.

Advocacy
By 2025, nurses will be key advocates as stakeholders in developing and implementing national policies toward achieving optimal health and wellbeing for the people of the Bahamas.


Research and IT


Clinical practice


Leadership and governance


Advocacy


Workforce sustainability


Education

Declaration of Astana

October 2018

From Alma Ata toward universal health coverage and the Sustainable Development Goals

Available from:
https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

Heads of States and Governments, Ministers, and representatives of States and Governments met at Astana, Kazakhstan 25-26 October 2018 for the Global Conference on Primary Health Care and reaffirmed commitments made at Alma Ata in 1978 in pursuit of 'health for all'.

Their vision, outlined in the Declaration of Astana is for:

Governments and societies that prioritize, promote and protect people's health and wellbeing, at both population and individual levels, through strong health systems.

Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed.

Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and wellbeing.

Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

The Declaration acknowledges that in spite of remarkable progress over the last 40 years, people in all parts of the world still have unaddressed health needs; and noted that remaining healthy is challenging for many people, particularly the poor and people in vulnerable situations, and finding it ethically, politically socially and economically unacceptable that inequity in health and disparities in health outcomes persist.

The Declaration affirms that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social wellbeing, and that PHC is a cornerstone of a sustainable health system for achieving universal health coverage (UHC) and health-related Sustainable Development Goals.

Signatories strongly affirmed their commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind and reaffirmed their commitment to all the values and principles of the Declaration of Alma Ata, particularly to justice and solidarity, underlining the importance of health for peace, security and socioeconomic development, and their interdependence.

They committed to:

- Making bold political choices for health across all sectors.
- Building sustainable primary health care.
- Empowering individuals and communities.
- Aligning stakeholder support to national policies, strategies and plans.

What does the Declaration of Astana mean for nurses and midwives? Nurses and midwives have always been at the forefront of delivering primary health care services. Forty years after the Declaration of Alma Ata placing primary importance on primary health care to achieve ''health for all'' the focus of most health systems remains on acute in hospital care. Will anything change in the next forty years? The global emphasis on universal health coverage and the sustainable development goals suggest it will. Nurses and midwives and their representative associations need to be proactively engaged in formulating national plans for how the commitment to primary health care will be implemented.

http://www.wateraid.org

What is WaterAid?
WaterAid is an international not-for-profit organisation, established in 1981, and dedicated to making clean water, decent toilets and good hygiene normal for everyone, everywhere. Access to clean water and toilets is a human right and should be a normal part of daily life, however one in nine people on the planet still do not have access to clean water close to their home. One in three still don't have a decent toilet.

Extreme poverty cannot end until clean water, toilets, and hygiene are a routine part of everyday life for everyone. Women and girls are particularly vulnerable. Women waste precious time walking long distances to collect water. Young girls miss precious days of schooling or drop out of school altogether because there are no private facilities when they are mentstruating.

What are the facts?

- 844 million people do not have clean water (WHO/UNICEF Joint Monitoring Program Report 2017).
- 2.3 billion people do not have a decent toilet (WHO/UNICEF Joint Monitoring Program Report 2017).
- 31% of schools globally do not have access to clean water (UNICEF Advancing WASH in Schools Monitoring 2015).
- Around the world up to 443 million school days are lost every year because of water related illnesses (Human Development Report 2006).
- Every minute a newborn baby dies from infection caused by a lack of safe water and an unclean environment (WHO 2015).
- Diarrhoea caused by dirty water and poor toilets kills a child under five years of age every two minutes (WASHwatch.org).
- If everyone, everywhere had clean water, the number of deaths due to diarrhoea would be cut by one third (Tropical Medicine and International Health 2014).

How does WaterAid work?
By 2016, WaterAid had reached 24.9 million people with clean water, 24 million with decent toilets, and 16.7 million with good hygiene. WaterAid is effective in what they do because they convince governments to change laws; link policy makers with people on the ground; change attitudes and behaviours; pool knowledge and resources; and rally support from people and organisations around the world.

Photo: WaterAid.org

How can you help?
WASH = Water + sanitation + hygiene

Nurses and midwives know only too well the importance of clean water, sanitation, and good hygiene and are ideally placed to become WASH champions. Nurses and midwives in middle and high income countries can harness the good will in their workplaces to donate, or ''adopt'' a project or plan fundraising activities. The WaterAid website has great ideas for fundraising. There are also wonderful opportunities for volunteering, learning first-hand what the issues are and making a real contribution to improving the lives of other people. Nurses and midwives in low income countries can identify projects where WASH initiatives can make a difference and lobby their governments for action.

Photo: WaterAid.org

The State of the World's Nursing Report 2020
The State of the World's Midwifery 2020 Report

The year 2020 will mark the 200th anniversary of the birth of Florence Nightingale. Other important events are the culmination of the Nursing Now campaign and the release of two flagship reports by the WHO: the first ever State of the World's Nursing Report and the third State of the World's Midwifery Report.

The WHO say that the State of the World's Nursing Report will describe how the nursing workforce will help deliver Universal Health Coverage and the Sustainable Development Goals (SDGs) and highlight areas for policy development for the next three to five years. It will also provide a technical description of the nursing workforce, including the number and types of nurses, education, regulation, practice, leadership, and gender issues.

The State of the World's Midwifery 2020 will report on the progress and the future challenges to deliver effective coverage of quality midwifery services. Previous midwifery reports were published in 2011 and 2014.

The two reports will inform national policy dialogue on strengthening nursing and midwifery and accelerating progress to achieve the SDGs. The WHO consider that the evidence base on the role of nurses and midwives can help drive the development of national workforces and unlock investment in nursing, midwifery, and the gender equity agendas for generations.

The two reports will primarily use the National Health Workforce Accounts (NHWA) as the main source of data. NHWA are country-led systems that aim at improving availability, quality, analysis and use of health workforce data for policy development. In many countries, NHWA data collection efforts can be enhanced by contributions from employers, regulatory councils, educational institutions, professional associations, unions, and population based surveys.

The WHO encourages Chief Nursing Officers from each country to coordinate the data collection process. All data must be collated and validated by the the middle of 2019. The second half of 2019 will be dedicated to data analysis and report writing to be ready for a launch during the 73rd World Health Assembly.

The WHO's State of the World's Nursing Report will be developed in close collaboration with the International Council of Nurses (ICN) and the Nursing Now campaign. The State of the World's Midwifery Report will be a join endeavour of the United Nations Population Fund (UNFPA), and the International Confederation of Midwives.

To ensure the most robust evidence base for the State of the World's Nursing and the State of the World's Midwifery 2020 Reports, broad engagement of nursing and midwifery leaders and stakeholders is needed. Government officials have an important role in leading the data collection, validations, and policy dialogue processes, engaging relevant stakeholders.

The decision by WHO to produce the first ever State of the World's Nursing Report is an exciting initiative and comes at a time when global health leaders are focused on two important outcomes for their populations: universal health coverage and the achievement of the sustainable development goals. All nurses and midwives understand that, as the largest component of any health workforce worldwide, they have an important role to play in achiving those two outcomes. The recognition by the WHO of the important role played by nurses and midwives by the production of the State of the World's Nursing Report and the third State of the World's Midwifery Report places a big responsiblility on nursing and midwifery professional associations and unions and individual nurses and midwives to be actively involved in the process and ensure that the voices and views of nurses and midwives are reflected in both reports.

Urgent action for CNMF members

1. Be informed – what is happening in your country in relation to data collection. Who is responsible?
2. Be involved – Make contact. Be on the committee. Provide data. Provide comment.
3. Take action – Make sure that the data that becomes part of the State of the World's Nursing or Midwifery from your country is accurate and reflects the views of nurses and midwives.

Meet the CNMF Board

At the 23rd CNMF Biennial Meeting of Members held at the Royal College of Nursing London on Friday 9 March 2018, elections were held for CNMF President, Deputy President, and CNMF Board Members for the West Africa; East, Central and Southern Africa; Atlantic; and Asia Regions.

Professor Kathleen McCourt from the United Kingdom was elected President and Mrs Rosemarie Josey from the Bahamas was elected as Vice President.

Mr Paul Magesa Mashauri from Tanzania was re-elected as the CNMF Board Member for the East, Central and Southern Africa Region; and Ms Hossinatu Mary Kanu from Sierra Leone was re-elected as CNMF Board Member for the West Africa Region.

Mrs Bettyann Murray-John from Trinidad and Tobago is the new CNMF Board Member for the Atlantic Region and Ms Evelyn Kannan from India is the new CNMF Board Member for the Asia Region.

The newly elected or re-elected Board Members term of office is from the close of the Biennial Meeting of Members 2018 to the close of the Biennial Meeting of Members 2022. The term of office for Board Members for the Pacific and Europe Regions finishes at the close of the Biennial Meeting of Members 2020.

Ms Annie Butler from Australia continues as the CNMF Board Member for the Pacific Region and Mr George Saliba from Malta continues as the CNMF Board Member for the Europe Region.

Jill Iliffe has been CNMF Executive Secretary since April 2008 and Mr Brian Christopher has been CNMF Honorary Treasurer since January 2017.

Become a CNMF member

Membership of the CNMF is open to national nursing associations; national midwifery associations; specialist nursing associations (such as mental health, critical care, paediatrics, operating theatre etc); regional and international nursing, midwifery and health associations; regulatory bodies, universities, and individuals. By becoming a member of the CNMF, you can support the work of the CNMF and become involved in that work. Members can promote their own work through the monthly e-News, the CNMF website or the extensive CNMF network. Join online:

http://www.commonwealthnurses.org/membership.html

CALL FOR ABSTRACTS

13th CNMF Europe Region Conference

8-9 March 2019

St Paul's Bay Malta

For further information on 'Call for Abstracts' and registration go to:
http://www.commonwealthnurses.org