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Reforming mental health legislation across the Commonwealth

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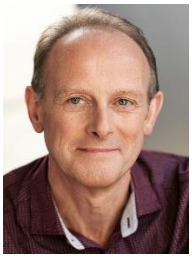

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The Commonwealth Nurses and Midwives Federation (CNMF), founded in 1973, is a federation of national nursing and midwifery associations in Commonwealth countries.

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# from the PRESIDENT

**Professor Kathleen McCourt CBE FRCN**
CNMF President

The focus of this edition of The Commonwealth Nurse is on mental health. The World Health Organisation (WHO) has estimated that one in five people across the world will experience a mental illness in their lifetime. Twenty per cent of the world's children and adolescents regardless of culture are estimated to have a mental disorder. Women, adolescents and children are particularly vulnerable with mental health laws in most countries providing little protection for them. Research conducted in 2013 by the Indian Law Society Centre for Mental Health Law and Policy in 2013 found that laws in only two Commonwealth countries restrict involuntary admission of minors with mental health problems and laws in only three Commonwealth countries ban irreversible treatments on children with mental health problems.

The CNMF has been working with two Commonwealth countries to reform their mental health legislation to bring it in line with the UN Convention on the Rights of Persons with Disabilities. Changes to policy and practice need to be based on a sound legislative framework, and mental health practitioners should not be in breach of legislation in providing compassionate, humane and human rights based care. Legislation must be changed to provide a sound foundation on which to base policy and practice. Change to legislation must be the first step.

In other news, the CNMF is preparing for the 24th CNMF Biennial Meeting of Members to be held at the Royal College of Nursing London UK on Friday 5 March 2020. The Biennial Meeting of Members is the decision making body of the CNMF, debating and endorsing constitutional changes, policy statements, and strategic directions so it is important that all CNMF members plan to attend. Observers are also welcome.

The CNMF is also preparing for the 5th Commonwealth Nurses and Midwives Conference to be held 6-7 March 2020 in London UK. The theme for the conference is *Celebrate … nurse and midwives, breaking down barriers, leaving no-one behind.* Presentations will showcase how individual nurses and midwives, or nursing and midwifery groups, associations or institutions are contributing to global health and wellbeing across the lifespan in all settings where they work.

There will be a lot to celebrate in 2020 apart from it being the 200th anniversary of the birth of Florence Nightingale. Nursing and midwifery globally strongly anticipate that the WHO 2020 will be designating 2020 as the International Year of the Nurse and the Midwife and release the long anticipated first State of the World's Nursing Report. I hope you will join the CNMF in our celebrations at the conference.

I was very pleased to have been able to join nurses and midwives from West Africa at the West African College of Nursing conference in Sierra Leone in March. This was such a wonderful opportunity to meet with colleagues, network, and share experiences. Congratulations to the Sierra Leone Nurses Association for excellent conference organization.

I was also able to attend the 13th CNMF Europe Region conference hosted by the Malta Union of Midwives and Nurses in Malta in March. This was an excellent conference with high quality papers and great organization. It is a great privilege to have the opportunity to attend such events and see what wonderful work nurses and midwives across the Commonwealth are doing.

I would encourage all CNMF members and friends to take note of the recommendations from the 2019 Commonwealth Civil Society Policy Forum, and bring these to the attention of your Ministry of Health. The theme of the forum was on universal health coverage (UHC) with a focus on the need to design UHC policies and services that addressed the health needs of vulnerable populations such as people with disabilities; women and girls; young people and children; older men and women; carers; people who are poor; people living in isolated rural or remote communities; other vulnerable groups such as transient populations, refugees and people seeking asylum, people who identify as LGBTQI, people who are homeless, and prisoners – a long list of groups that are so often left behind.

# Reforming mental health legislation across the Commonwealth

Mental ill health is estimated to affect one in four people worldwide at some time in their life according to the World Health Organisation (WHO). Human rights violations of psychiatric patients, they say, are routinely reported in most countries, including physical restraint, seclusion and denial of basic needs and privacy. Few countries have a legal framework that adequately protects the rights of people with mental disorders and only 59% of WHO member states have dedicated mental health legislation.[1]

The WHO argues that mental health legislation is equally as important as mental health policy. Mental health legislation, when formulated according to human rights principles, provides a legal framework to address important mental health issues such as access to care, rehabilitation, integration of people with mental disorders into the community, the prevention of discrimination, upholding the full human rights of people with mental disorders, the provision of mental health services that promote access to care; and the promotion of mental health.[2]

Legislation, provides the legal framework for protecting individuals against human rights violations and also for providing mental health services that promote access to care. Reform of mental health legislation is urgent and essential because of the unique vulnerabilities of people with mental disorders who face stigma, discrimination, and marginalization which inhibit them from seeking care.[3] Policy and practice therefore needs to be based on a sound legal framework to protect people in need of care and the practitioners who provide that care.

Mental ill health is the third leading cause of disease burden in the world, predicted to be the leading disease burden by 2030.

The global economic impact of mental ill health is estimated to increase to US$ 6 trillion by 2030. Mental ill health is typically left off the list of non-communicable diseases (NCDs), however it alone is estimated to account for over US$ 16 trillion or one third of the overall US$ 47 trillion anticipated spend on NCDs over the next 20 years. Additionally, mental disorders are common co-morbidities of NCDs, infectious diseases, and poverty.[5]

The World Health Organisation report that:

- About half of mental disorders begin before the age of 14. Around 20% of the world's children and adolescents, regardless of culture, are estimated to have mental disorders. Regions of the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources.
- Mental health issues are frequently hidden, ignored or stigmatised. Stigma about mental disorders and discrimination against patients and families prevent people from seeking mental health care. Mental disorders are a major risk factor for communicable and non-communicable disease. They can also contribute to unintentional and intentional injury.
- There is huge inequity in the distribution of skilled human resources for mental health across the world. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are one of the main barriers to providing treatment and care in low and middle income countries. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater.
- War and other major disasters have a large impact on mental health and psychosocial wellbeing. Rates of mental disorder tend to double after emergencies.
- Few countries have a legal framework that adequately protects the rights of people with mental disorders.[4]

At the 66th World Health Assembly (WHA) held in Geneva Switzerland 20-25 May 2013, member states endorsed a Mental Health Action Plans 2013-2020 (WHA Resolution 66.8).[6] The resolution for a mental health action plan followed an earlier resolution at the 65th World Health Assembly (WHA 65.4)[7] which encouraged WHO member states to pay urgent attention to mental health services and adopt a 'rights based' approach to care and treatment.

The WHA Mental Health Action Plan[8] defines mental health as: *a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.* In relation to mental health legislation, the WHA Mental Health Action Plan notes that: *mental health law, whether an independent legislative document or integrated into other health and capacity-related laws, should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community (p.8).*

The Mental Health Action Plan 2013-2020 proposes that member states: *develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions (p.8).*

In 2012-2013, a research team from the Indian Law Society Centre for Mental Health Law and Policy (CMHLP) led by Dr Soumitra Pathare, Coordinator of the CMHLP, examined the mental health legislation of 46 Commonwealth countries to obtain an insight as to how mental health legislation across the Commonwealth complied with the United Nations Convention on the Rights of Persons with Disability (CRPD), the 'gold standard' for mental health legislation. The research was commissioned by the Commonwealth Health Professions Alliance and funded by the Commonwealth Foundation.

The report of the research was released in May 2013 at the meeting of Commonwealth Health Ministers in Geneva.[9] The theme of the meeting was mental health. The major findings of the research were that mental health legislation in many Commonwealth member states is not compliant with the CRPD; is based on an out-dated understanding of mental disorders; ignores advances in the care and treatment of mental disorders; and denies the capacity of persons with mental disorders to manage their lives. It was noted that not all countries across the Commonwealth had signed or ratified the CRPD.

Table 1: CRPD status Commonwealth countries 2013

| | Low | Low to middle | Upper middle | High | Total |
|---|---|---|---|---|---|
| Ratified | 5 | 11 | 6 | 6 | 28 |
| Signed | 0 | 5 | 2 | 3 | 10 |
| Neither | 2 | 2 | 2 | 1 | 7 |

The provisions of the CRPD, were used to enable systematic comparison of legislation from different countries. Analysis was restricted to dedicated mental health legislation. Mental health legislation was sought from 53 of the 54 countries of the Commonwealth (the exception being Fiji). Mental health legislation was obtained from 45 countries and included in the analysis.

Mental health legislation was unable to be obtained from seven countries: Cameroon, Maldives, Mozambique, Rwanda, St Lucia, St Kitts and Nevis, and St Vincent's and the Grenadines, and an official English translation for the mental health law of Cyprus was also not available. Therefore these eight countries were not included in the analysis.

**Research findings**

Mental health legislation in 20 per cent of Commonwealth member states was enacted prior to 1960 before modern medical treatments became available and before many of the international human rights instruments came into force. Mental health legislation in only 11 per cent of Commonwealth member states specifically include provisions that state mental health care should be provided on an equal basis with physical health care.

Mental health laws in all Commonwealth member states allow involuntary admission to a mental health facility. Only half (51 per cent) of country mental health laws require the person to be discharged as soon as they do not meet the criteria for involuntary admission.

Eighty per cent of mental health legislation in Commonwealth countries does not apply the principle of least restrictive alternative to involuntary admission. Only 9 per cent of Commonwealth member states promotes voluntary admission and treatment as the preferred alternative for treatment of mental disorders. While laws in 24 per cent of member states had some provisions promoting community care, no legislation met all the criteria to be rated as promoting community care and deinstitutionalisation.

Mental health legislation in only 29 per cent of Commonwealth member states gives persons with mental disorders the right to be informed of their rights when receiving mental health care or treatment. Only four Commonwealth member states had provisions for supported decision making including the provision of Advance Directives in their mental health legislation.

More than two-thirds of the mental health laws do not have a judicial/quasi-judicial body to review involuntary admissions and treatment.

Provisions for protection from cruel, inhuman and degrading treatment are included in the legislation in only 23 (51 per cent) countries. The informed consent of persons with mental disorders for participating in clinical and experimental research is specifically mandated in mental health legislation in only five (11 per cent) countries; mental health laws in only nine (20 per cent) countries include a provision on the protection of confidentiality; and only eight (18 per cent) countries include a provision on privacy for persons with mental disorders. Legislation in only three (7 per cent) countries specifically outlaws forced or inadequately remunerated labour within mental health facilities.

Very few laws have specific provisions for the involvement of families and care-givers. Legislation in 12 (27 per cent) countries provides for information to be given to families and caregivers; in 10 (22 per cent) countries families and care-givers are encouraged to participate in the formulation of treatment plans. The law in only one Commonwealth country mandates that users of mental health services are involved in mental health policy, legislation development and service planning.

Mental health laws in most Commonwealth countries provide very little protection to minors and children. Laws in only two (4 per cent) countries restrict involuntary admission of minors with mental health problems, and laws in only three (7 per cent) countries ban any irreversible treatments on children with mental health problems.

The word "lunatic" is used in the mental health laws of 12 countries; the term "insane" is used in the mental health laws in 11 countries; the term "idiot" is used in the mental health laws in 10 countries; two mental health laws use the term "imbecile"; and two mental health laws use the term "mentally defective". Overall 21 (47 per cent) laws use one of the above terms.

**Research conclusions**

The research concluded that mental health legislation in many Commonwealth member states is out-dated and does not fulfil member states' international human rights obligations toward persons with mental disorders and is not compliant with the Convention on the Rights of Persons with Disabilities.

Substantive and procedural provisions related to guardianship in mental health laws are particularly problematic in this regard. Many mental health laws reviewed in the report treat persons with mental disorders as needing protection rather than as subjects with rights. As a result, mental health legislation, instead of protecting the rights of persons with mental disorders, is likely to lead to violation of rights.

Mental health legislation in many countries is based on an out-dated understanding of mental disorders; ignores advances in the care and treatment of mental disorders and denies the capacity of persons with mental disorders to manage their lives.

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

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

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

Of concern was that there is little participation of persons with mental disorders and their families and care-givers in the development and implementation of legislation.

**Research recommendations**

1. Commonwealth member states should urgently undertake reform of mental health legislation.

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

**CNMF PROJECT**

Following the release of the report, the Commonwealth Nurses and Midwives Federation (CNMF) successfully applied to the Commonwealth Foundation for a participatory governance grant to work with two Commonwealth countries to conduct an in-depth analysis of their mental health and other related legislation to assess its compliance with the CRPD and make any recommendations considered necessary following the assessment.

The overall aim of the project was that, within the two countries, the human rights of people with mental ill health are respected within legislation which empowers them, protects them, and cares for them.

**Methodology**

The project had three main strategies:

1. The first was the commitment of the Government to participate in the project and the establishment of a National Mental Health Advisory Committee (NMHAC) by the Government to oversee the project in-country. The project stipulated that the NMHAC had to include a user of mental health services and the carer of a person with a mental health disorder.

2. The second was the assessment of the country's dedicated mental health and other related legislation (such as employment, property, marriage, criminal etc) against the CRPD and consideration of the recommendations.

3. The third was the development and implementation of a communication strategy to educate politicians, bureaucrats, health professionals, relevant stakeholders, the media, and the general public about mental health issues particularly in relation to human rights.

**Objectives**

The specific objectives of the project were that there would be:

- Increased awareness and cooperation by Government of the need for mental health legislative reform.
- Increased communication and dialogue between the NMHAC, Government, and other stakeholders around mental health reform issues.
- Increased understanding by the NMHAC of the need for mental health legislative reform and a commitment to pursuing necessary reform.

**Findings**

In the two participating countries, the NMHAC was established by Government who also appointed the Chair. A prerequisite for the assessment of the mental health and related legislation and follow up of the recommendations was Cabinet approval. In each country, the NMHAC undertook the preparation of a memorandum to Cabinet to obtain approval, which was subsequently obtained. Mental health and related legislation and policy was identified by members of the NMHAC and soft copies obtained for analysis. The analysis was conducted by a team from CMHLP led by Dr Pathare.

**Country 1**

Country 1 had ratified the CRPD and therefore had a legal obligation to ensure its domestic legislation, including mental health legislation, is in compliance with obligations under the International Conventions and Treaties it had ratified which included the CRPD.

The assessment of the mental health and related legislation found that the current mental health legislation was not in compliance with articles of the CPRD which deal with: 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); protecting the integrity of the person (article 17); living independently and being included in the community (article 19); respect for privacy (article 22); and habilitation and rehabilitation (article 26). The assessment concluded that, as the fundamental premise of the current legislation was completely at variance with the fundamental premise of the CRPD, it would be easier to draft new legislation compliant with the CRPD than try to amend existing legislation.

The assessment further recommended that persons with mental illness, their care-givers, and representative organisations, are part of the consultation and law drafting process. Additionally, the issues of access, prevention, care, treatment, rehabilitation, quality of care, and protection of CRPD rights needed to be specifically addressed as well as other non-health areas, such as discrimination in employment, marriage, education, and housing. Finally, the new legislation needed to incorporate models of supported decision making, and specifically address the mental health needs of children and older persons.

**Country 2**

Country had not signed or ratified the CRPD and consequently is not bound by it. However several other international treaties and conventions which had relevance to mental health legislation had been ratified. Additionally, the National Policy on Mental Health required a framework for periodic review of legislation in line with local, regional and international trends in good mental health practices; and the Public Health Act directed the health officer to "take all lawful, necessary and reasonably practicable measures to ensure equal access and equity to health care services for all including those with mental illness" which is in line with international best practice.

On assessment, Country 2's mental health legislation was found not to comply with the CRPD in a number of important respects. The Act was written in such a way that voluntary care and treatment were the exception while involuntary detention was the norm. Definitions used outdated terminology while the classification of persons with mental disorders was illogical and arbitrary. Many of the sections violated international human rights principles such as equality before the law, access to justice, and due process and were open to potential abuse by individuals as well as institutions. Additionally, there were no provisions for review of decisions or appeal against decisions.

The assessment concluded that it would be extremely difficult to amend the Mental Health Act to bring it in line with international conventions and standards as the Act was premised on a custodial solution and exclusion of persons with mental illness rather than a rights based approach to care and treatment.

In both countries, the NMHAC accepted the assessment report and recommended to the Minister for Health the repeal of the existing Act and the writing of new legislation. Drafting instructions were drawn up for both countries and after extensive stakeholder consultation, new legislation was drafted and submitted to Parliament for ratification.

**Contributing factors**

One of the most important factors contributing to successful project outcomes in both countries was the support given to the project by the Minister for Health and the Ministry of Health, particularly the Permanent Secretaries for Health. As legislation requires the endorsement of the respective Ministry for it to progress successfully through parliament, the support of the relevant government ministry is essential. The governments of both countries, through their Ministries of Health and other government departments, also supported the work of the NMHAC by releasing participants to attend in work time.

The commitment and dedication of the members of the NMHAC in both countries was also critical to the project proceeding to its agreed outcome. The experience and expertise of the consultant to the project from the CMHLP with an in depth knowledge of the CRPD at its translation into mental health legislation was also critical to the success of the project. The vision of the Commonwealth Foundation in funding the project and their patient support throughout the implementation of the project was also critical to its success.

**Challenges**

In both countries, progress of the project was slower than anticipated largely because the external project manager, the Chair, and members of the NMHAC all had other commitments. Should the project be replicated in other countries, the appointment of a part-time in-country project manager two days a week would eliminate this challenge.

Political changes in both countries also delayed progress of the project with changes in Health Ministers, and elections which led to a change in Government. Although this caused delay, the commitment to writing new mental health legislation remained.

Modern service provision for people with mental health disorders needs to be based on a legislative foundation that provides protection for service recipients and service providers and which meets the 'gold standard' of the CRPD. This project, to assess existing mental health and related legislation against the CRPD and follow through with amended or new legislation which meets the requirements of the CRPD, has demonstrated that the methodology used can efficiently and effectively achieve this objective. Key to success is the support and involvement of government; and the establishment of an in-country committee and dedicated project manager to oversee the project.

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# West African College of Nursing Conference

Freetown, Sierra Leone
March 2019

The West African College of Nursing (WACN) held its 15th Biennial General Meeting, 24th Scientific Session, and 38th Council meeting in Freetown Sierra Leone 18-20 March 2019. The Sierra Leone Chapter of WACN hosted the conference.

The CNMF President, Professor Kathleen McCourt attended the conference together with 300 West African nurses and midwives.

The theme for the conference was *Health service partnerships: the role of nurses and midwives in building global health security.* The President of Sierra Leone, the Hon Julius Maada Bio officially opened the conference. The international conference program provided an opportunity for nurses, midwives, other health care professionals, and the general public to come together to discuss community and health workforce responses to current health issues.

The West African College of Nursing was officially inaugurated on 14 April 1981. Countries currently comprising membership are Nigeria, Liberia, Sierra Leone, Ghana, Benin and The Gambia.

# 2019 COMMONWEALTH CIVIL SOCIETY POLICY FORUM

A successful Commonwealth Civil Society Policy Forum (CCSPF) with the theme *Universal Health Coverage: leaving no-one behind* was held Saturday 18 May 2019 in Geneva Switzerland. The CCSPF is held the day before the annual Commonwealth Health Ministers' meeting on the eve of the World Health Assembly. Eminent speakers addressed universal health coverage as it impacted on people with disabilities; women and girls; and young people and also discussed how official development aid can be adjusted to reach vulnerable individual and groups who are potentially at risk of being left behind as countries move toward universal health coverage. Recommendations from the CCSPF were shared with Commonwealth Health Ministers at their meeting.

## WHAT WE UNDERSTAND BY 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".

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".

The achievement of Universal Health Coverage (UHC) is a key aim of the global health agenda, and an important target of the Sustainable Development Goals. There is increasing recognition however that some groups may fall behind in the effort to achieve UHC, including people living with disabilities, women and girls, and young people. Strategies that allow inclusivity will result in improvements in health system equity. Development assistance for UHC needs to be adjusted to specifically target those people who may be left behind as countries move toward UHC.

## WHO ARE THOSE WHO MAY BE LEFT BEHIND?

People with disabilities; women and girls; young people and children; older men and women; carers; people who are poor; people living in isolated rural or remote communities; other vulnerable groups such as transient populations, refugees and people seeking asylum, people who identify as LGBTQI, people who are homeless, and prisoners.

The recommendations from the CCSPF covered the following areas: UHC system planning; Essential package of care; Financing of UHC; Data; Communication and information; Health worker education; Legislation and policy; Other issues.

## UHC SYSTEM PLANNING

*''Planning without us is against us''*

**Key Action 1**

In developing new, or adjusting existing health systems for the implementation of UHC, Commonwealth Health Ministers in partnership with civil society, as a first step, commit to engaging with those individuals and groups who may be left behind, so their health needs can be met on an equal basis with others and equity of access to quality and affordable health care and services is assured.

## ESSENTIAL PACKAGE OF CARE

''Those hardest reach need primary prevention services most of all''

**Key Action 2**
Commonwealth Health Ministers in partnership with civil society, give priority to the development of quality, accessible, affordable and flexible primary health care and rehabilitation services to individuals and groups who may be left behind: outreach services, youth friendly services, drop in services, and innovative use of digital technology.

**Key Action 3**
Commonwealth Health Ministers in partnership with civil society, include consultation with those who may be left behind in the development of any essential package of care, services, and medicines, to make sure their specific health care needs are included.

## FINANCING OF UHC

*''Donor driven development assistance programs don't prioritise the hardest to reach so they continue to be left behind''*

**Key Action 4**
Commonwealth Health Ministers in partnership with civil society, ensure that mechanisms for the financing of UHC specifically address financial risk and enable access to health care for those individuals and groups who may be left behind.

**Key Action 5**
Commonwealth Health Ministers, through the Commonwealth Secretariat, engage with ODA donors in order to re-align and re-position development assistance to specifically enable both middle and low income countries to reach out to those individuals and groups who may be left behind in the implementation of UHC.

## DATA

*"If you don't count us, you don't see us, but we are still there''*

**Key Action 6**
Commonwealth Health Ministers request the Commonwealth Secretariat to examine existing data collection tools to identify data gaps and submit recommendations to the 2020 Commonwealth Health Ministers' meeting about closing the gaps identified.

- monitoring access to health care by those individuals and groups who may have difficulty accessing health care disaggregated by age, gender, location, type of disability, and out of pocket costs, and
- collecting data in relation to informal carers and the support they receive in their caring capacity.

## COMMUNICATION AND INFORMATION

*''No-one is listening: the blind ones cannot see, the crippled cannot walk, the deaf ones cannot hear the health messages, and still the mad ones, no-one is even interested to treat them - invite them in and let them speak''*

**Key Action 7**
Commonwealth Health Ministers in partnership with civil society, ensure that comprehensive health information across all mediums is provided to those individuals and groups who may be left behind, in consultation with them, so that information is provided in a form that is acceptable and effective. (For example, signs in braille or audio speaker points for people who are visually impaired; information in pictures and symbols for people who are illiterate or who have a learning disability; interpreters who can use sign language for people who have hearing impairments; and use of social media, music and drama to engage with young people.)

## HEALTH WORKER EDUCATION

*''Inclusion and human rights becomes the standard for health service delivery and the training of all health workers''*

**Key Action 8**
Commonwealth Health Ministers in partnership with civil society, ensure that initial and ongoing training and education programs for all health workers include sensitisation to individuals and groups who may be left behind in the pursuit of UHC and the development of knowledge, attitudes and skill that reduce stigma, prejudice and fear, and enable culturally appropriate non-discriminatory care.

## LEGISLATION AND POLICY

*''One house, same for all''*

**Key Action 9**
Commonwealth Health Ministers enshrine in legislation and policy (if not already in place), the right to health on an equal basis with others without discrimination of any kind and respect for the human rights of those most likely to be left behind in the pursuit of UHC.

The Commonwealth Secretariat was requested to provide a report at the 2020 Commonwealth Health Minister's meeting on the implementation of these key actions from the Civil Society Policy Forum (available from: http://www.chpa.co/Documents/2019KeyCivilSocietyActionsforCommonwealthHealthMinisters_000.pdf

# TEN THREATS TO GLOBAL HEALTH IN 2019

The world is facing multiple health challenges, ranging from outbreaks of vaccine-preventable diseases like measles and diphtheria, increasing reports of drug-resistant pathogens, growing rates of obesity and physical inactivity to the health impacts of environmental pollution and climate change and multiple humanitarian crises.

The WHO have identified ten threats to global health. The World Health Organization's new 5-year strategic plan begins in 2019 and will address these and other threats. The plan focuses on a triple billion target: ensuring 1 billion more people benefit from access to universal health coverage; 1 billion more people are protected from health emergencies; and 1 billion more people enjoy better health and well-being.
https://www.who.int/emergencies/ten-threats-to-global-health-in-2019

### Air pollution and climate change

Nine out of ten people in the world breathe polluted air every day. In 2019, air pollution is considered by the WHO as the greatest environmental risk to health.

### Non communicable diseases

Non communicable diseases, such as diabetes, cancer and heart disease, are collectively responsible for over 70% of all deaths worldwide. The rise of these diseases has been driven by five major risk factors: tobacco use, physical inactivity, the harmful use of alcohol, unhealthy diets and air pollution.

### Global influenza pandemic

The world will face another influenza pandemic: the only thing we don't know is when it will hit and how severe it will be. Global defences are only as effective as the weakest link in any country's health emergency preparedness and response system.

### Fragile and vulnerable settings

More than 1.6 billion people (22% of the global population) live in places where protracted crises (through a combination of challenges such as drought, famine, conflict, and population displacement) and weak health services leave them without access to basic care. Fragile settings exist in almost all the regions of the world.

### Antimicrobial resistance

The development of antibiotics, antivirals and antimalarials are some of modern medicine's greatest successes. Antimicrobial resistance – the ability of bacteria, parasites, viruses and fungi to resist these medicines – threatens to send us back to a time when we were unable to easily treat infections such as pneumonia, tuberculosis, gonorrhoea, and salmonellosis. The inability to prevent infections could seriously compromise surgery and procedures such as chemotherapy.

### Ebola and other high threat pathogens

The WHO strategic plan identifies diseases and pathogens that have the potential to cause a public health emergency, but lack effective treatments and vaccines. The watchlist includes Ebola, several other haemorrhagic fevers, Zika, Nipah, Middle East respiratory syndrome coronavirus (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS) and disease X, which represents an unknown pathogen that could cause a serious epidemic.

### Weak primary health care

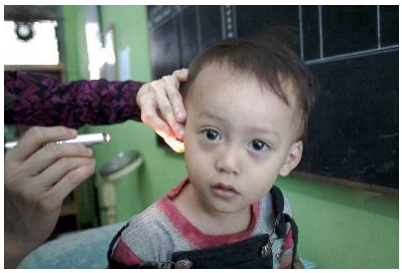
Primary health care is usually the first point of contact people have with their health care system, and ideally should provide comprehensive, affordable, community-based care throughout life. Primary health care can meet the majority of a person's health needs of the course of their life. Health systems with strong primary health care are needed to achieve universal health coverage. Yet many countries do not have adequate primary health care facilities.

### Vaccine hesitancy

Vaccine hesitancy – the reluctance or refusal to vaccinate despite the availability of vaccines – threatens to reverse progress made in tackling vaccine-preventable diseases. Vaccination is one of the most cost-effective ways of avoiding disease.

### Dengue

Dengue, a mosquito-borne disease that causes flu-like symptoms and can be lethal and kill up to 20% of those with severe dengue, has been a growing threat for decades. An estimated 40% of the world is at risk of dengue fever.



### HIV

The progress made against HIV has been enormous in terms of getting people tested, providing them with antiretrovirals, and providing access to preventive measures such as a pre-exposure prophylaxis (PrEP). However, the HIV epidemic continues to rage with nearly a million people every year dying of HIV and AIDS.

### WHO TRIPLE BILLION TARGETS

**Universal health coverage**
One billion more people benefitting from universal health coverage without financial hardship. Two key components will be measured: coverage of essential health services and financial hardship.

**Health emergencies protection**
One billion more people better protected from health emergencies. Three aspects will be measured: emergency preparedness, emergency prevention, and emergency detection and response.

**Healthier populations**
One billion more people enjoying better health and wellbeing. Sixteen indicators will be measured: stunting among children under 5; overweight children under 5; wasting among children under 5; suicide mortality; harmful use of alcohol; death rate due to road traffic injuries; tobacco use; children under 5 who are developmentally on track; partner violence against women; safely managed drinking water; safely managed sanitation services; primary reliance on clean fuels and technology; ambient air quality; violence against children; obesity; and trans fats policy.
https://www.who.int/data/stories/the-triple-billion-targets-a-visual-summary-of-methods-to-deliver-impact

# GENDER INEQUALITY INDEX (GII)

No country in the world is on track to achieve gender equality by 2030 according to the first index to measure progress against a set of internationally agreed targets.

Gender inequality remains a major barrier to human development. The United Nations report that girls and women have made major strides since 1990, but they have not yet gained gender equity. The disadvantages facing women and girls are a major source of inequality. All too often the UN say, women and girls are discriminated against, for example in health, education, political representations, and the labour market with negative consequences for development of their capabilities and their freedom of choice.

The GII is an inequality index. It measures gender inequalities in three important aspects of human development: reproductive health - measured by maternal mortality ratio and adolescent birth rates; empowerment - measured by the proportion of parliamentary seats occupied by females and the proportion of adult females and males aged 25 years and older with at least some secondary education; and economic status - measured by the labour market participation rate of female and male populations aged 15 years and older. The GII measures the human development costs of gender inequality. Thus the higher the GII value, the more disparities between females and males and the higher the loss to human development.

The table opposite shows the Gender Inequality Ranking for Commonwealth countries. The ranking demonstrates that there is a great deal of room for improvement. Nurses and midwives have a role to play in promoting gender equity to improve health outcomes for women and girls. The table also shows the ranking for the Human Development Index (HDI).

The HDI was created to emphasize that people and their capabilities should be the ultimate criteria for assessing the development of a country, not economic growth alone. The Human Development Index (HDI) measures the average achievement in key dimensions of human development: a long and health life; being knowledgeable; and having a decent standard of living.

| COUNTRY | GII | HDI |
|---|---|---|
| Singapore | 12 | 9 |
| Cyprus | 17 | 32 |
| Canada | 20 | 12 |
| Australia | 23 | 3 |
| United Kingdom | 25 | 14 |
| New Zealand | 34 | 16 |
| Malta | 45 | 29 |
| Brunei Darussalam | 51 | 39 |
| Barbados | 60 | 58 |
| Malaysia | 62 | 57 |
| Trinidad and Tobago | 73 | 69 |
| St Lucia | 74 | 90 |
| Bahamas | 75 | 54 |
| Maldives | 76 | 101 |
| Fiji | 79 | 92 |
| Sri Lanka | 80 | 76 |
| Samoa | 82 | 104 |
| Mauritius | 84 | 69 |
| Rwanda | 85 | 158 |
| Jamaica | 95 | 97 |
| Tonga | 96 | 98 |
| Botswana | 89 | 101 |
| Belize | 89 | 106 |
| South Africa | 90 | 113 |
| Namibia | 115 | 129 |
| Guyana | 122 | 125 |
| Zambia | 125 | 144 |
| Uganda | 126 | 162 |
| India | 127 | 130 |
| Zimbabwe | 128 | 156 |
| Tanzania | 130 | 154 |
| Ghana | 131 | 140 |
| Pakistan | 133 | 150 |
| Bangladesh | 134 | 136 |
| Lesotho | 135 | 159 |
| Kenya | 137 | 142 |
| Mozambique | 138 | 180 |
| Eswanti (Swaziland) | 141 | 144 |
| Cameroon | 141 | 151 |
| Malawi | 148 | 171 |
| Gambia | 149 | 174 |
| Sierra Leone | 150 | 184 |
| Papua New Guinea | 159 | 153 |

Commonwealth countries did not score well on the Gender Inequality Index. The table below shows the Commonwealth country rank for the GII and the corresponding rank for the Human Development Index (HDI).

There is no GII ranking for the Seychelles, Antigua and Barbuda, Grenada, St Vincent and the Grenadines, Dominica, Kiribati, Vanuatu, Solomon Islands, Nigeria, Nauru and Tuvalu.

http://hdr.undp.org/en/content/gender-inequality-index-gii

## SAVE THE DATE

### 6-7 March 2020 London UK

Registration opening soon


The 5th Commonwealth Nurses and Midwives Conference will be held 6-7 March 2020 in London UK. The CNMF is very excited to announce that the Commonwealth Children's Orchestra and Choir will be performing at the conference opening and closing ceremonies.

The Commonwealth Children's Orchestra and Choir brings together children from across the 53 countries of the Commonwealth and uses music as a means of international dialogue, transcending all cultural, political, social and economic boundaries. The Children's Orchestra and Choir will also be performing at Commonwealth Day celebrations.


## SAVE THE DATE

### 24th CNMF Biennial Meeting 2020

Thursday 5 March 2020 London UK

The 24th CNMF Biennial Meeting of Members will be held on Thursday 5th March 2020 in London, United Kingdom. The Biennial Meeting of Members is the decision making body of the CNMF.

All CNMF members are entitled to attend and participate in the debate and decision making. CNMF friends are welcome to attend as observers.

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## BREAKING NEWS!

The Executive of the World Health Organisation have recommended that 2020 be designated as the *Year of the Nurse and Midwife.* The proposal needs to be confirmed by the World Health Assembly in May however there is general confidence that the recommendation will be formally endorsed.

The first "State of the World's Nursing" report will be released in 2020, expected to be released on International Nurses Day 12 May. In 2020 we will also be celebrating the 200th anniversary of the birth of Florence Nightingale, the pioneer of modern nursing.

The CNMF will start 2020 with its own celebration of nursing and midwifery at the 5th Commonwealth Nurses and Midwives Conference. The ''Call for Abstracts'' is now open. Go to the conference website for abstract guidelines and to submit. The ''Call for Abstracts closes 31 May 2019.
https://www.commonwealthnurses.org/conference2020

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Stay up to date with all the very latest news from the CNMF

# Call for Abstracts

## 5th Commonwealth Nurses and Midwives Conference

Friday 6 and Saturday 7 March 2020, London UK

## Celebrate …

nurses and midwives, breaking down barriers, leaving no-one behind

2020: a year of celebration of nursing and midwifery

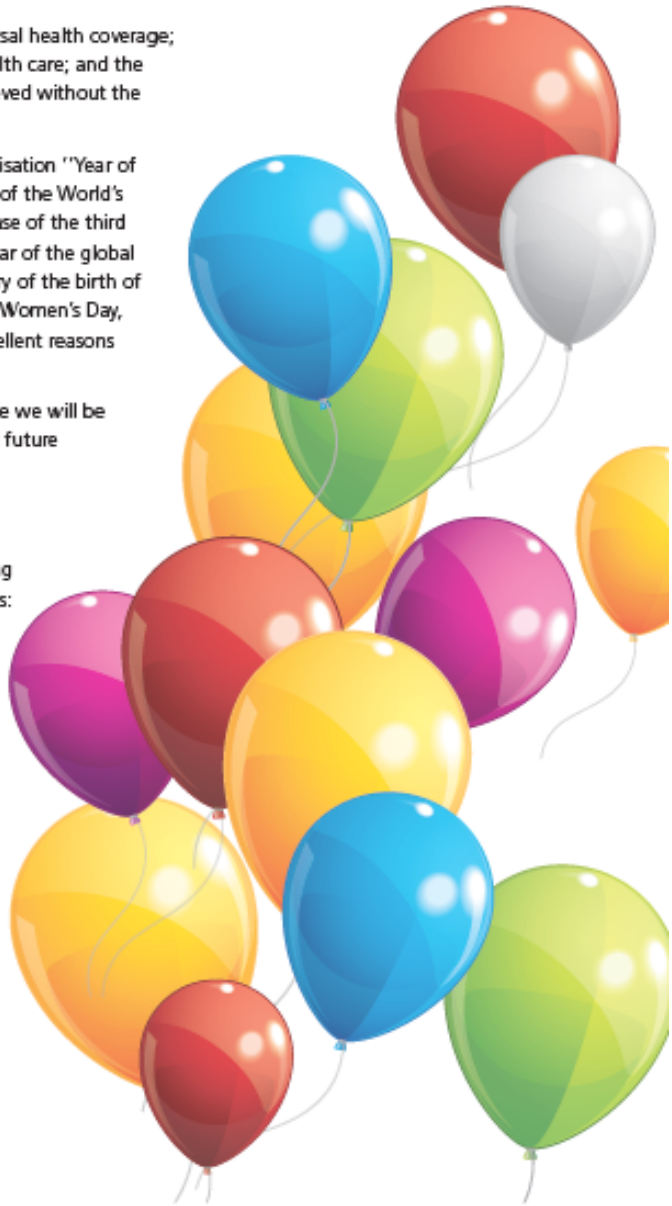
World leaders have committed to the achievement of universal health coverage; tackling non-communicable disease; promoting primary health care; and the Sustainable Development Goals. None of these can be achieved without the contribution of nurses and midwives.

2020 is anticipated to be named as the World Health Organisation ''Year of the Nurse". The first ever World Health Organisation "State of the World's Nursing" report will be launched in 2020 as well as the release of the third ''State of the World's Midwifery" report. 2020 is the final year of the global ''Nursing Now" campaign; and 2020 is the 200th anniversary of the birth of Florence Nightingale. Sunday 8 March 2020 is International Women's Day, and Monday 9 March 2020 is Commonwealth Day – all excellent reasons to celebrate.

At the 5th Commonwealth Nurses and Midwives Conference we will be celebrating the past achievements, present endeavours, and future contributions of nurses and midwives.

Abstracts should showcase how individual nurses and midwives, or nursing and midwifery groups, associations or institutions are contributing to global health and wellbeing across the lifespan in all settings within the following themes:

- Clinical practice
- Leadership and management
- Education and training
- Policy and projects
- Research and innovation.



### ABSTRACT SUBMISSION

Submit your abstract of no more than 300 words to the Commonwealth Nurses and Midwives Federation by 31 May 2019.

Abstracts should be submitted using the template which can be downloaded from the CNMF website: http://www.commonwealthnurses.org/conference2020

### MORE INFORMATION

If you require further information please email: cnf@commonwealthnurses.org

Commonwealth Nurses and Midwives Federation

http://www.commonwealthnurses.org