

Nursing and Midwifery in the History of the World Health Organization
1948-2017

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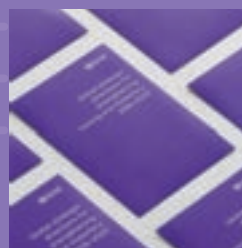


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FOREWORD



A handwritten signature in black ink, which appears to read "Tedros Adhanom Ghebreyesus".

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

Every country needs a competent, motivated, well-distributed and supported health workforce.

Health workers are the cornerstone of the strong, resilient health systems needed to achieve universal health coverage. These are the people who keep the world safe, improve health, and protect the vulnerable.

These are the people who detect, prevent and manage health emergencies, and who promote the well-being of women, children and adolescents.

Nurses and midwives are the unsung heroes of the health workforce and the backbone of primary health care systems. Making up over half of the health workforce in many countries, nurses and midwives can transform the ways health actions are organized and how health care is delivered.

Over the years, nurses and midwives have contributed to major global health landmarks, like the eradication of small pox and the dramatic reductions in maternal and child mortality that have occurred in many countries. But nurses and midwives need support and they need recognition.

This report on the history of nursing and midwifery in the World Health Organization celebrates the work of these core health workers. It provides a vivid account of the contributions they have made to strengthening global health systems. It shows how WHO has endeavoured to give them a voice over several decades, and highlights the critical role they will play in improving health outcomes in the coming years as the world strives to meet the Sustainable Development Goals.

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EXECUTIVE SUMMARY

Since the founding of the World Health Organization (WHO) in 1948, nursing and midwifery development has maintained a distinguished status within the human resources for health programme of the Organization. This report documents the progress made by using chronological and thematic approaches to chart the key historical timelines and events that have shaped the nursing and midwifery policy discourse through the decades. It also examines available strategic opportunities to build effective programmes that will ensure a socially responsible and fit-for-purpose nursing and midwifery workforce to meet the health needs of today and the future.

The early years of nursing and midwifery within WHO witnessed a deliberate attempt by the Organization to establish, clarify and scale up the role of nurses and midwives in providing health care services in countries. WHO established expert committees on nursing (and subsequently midwifery) to provide technical advice to WHO in addressing critical challenges affecting nursing and midwifery, such as the acute shortage of skilled nurses and midwives serving at the time, the need for training, better recruitment and employment standards. Other initiatives such as the WHO fellowship programme also helped to rapidly introduce and expand skilled nursing and midwifery services to individuals and communities in benefitting countries. The multilateral adoption of the primary health care (PHC) approach by Member States in the 1970s resulted in marked changes to the organization and delivery of health care services at country level. Nurses and midwives consequentially assumed greater relevance for delivering PHC services given their relative abundance in many settings, as health planners aimed to achieve an appropriate mix of skills for the delivery of people-centred care. The overwhelming significance of PHC as pivotal for UHC triggered the need for greater support and led WHO to strengthen its collaborative activities with key nursing and midwifery professional associations and international NGOs. WHO also established collaborating centres on nursing and midwifery at regional and global levels to assist with the provision of scientific norms and technical assistance to Member States.

Establishing nursing and midwifery leadership at governance and service levels in countries has remained a major challenge to date. WHO continues to engage ministries of health, government chief nursing and midwifery officers and other relevant stakeholders and government bodies to enable effective planning, coordination and management of nursing and midwifery programmes in countries. More recently, WHO and Member States, through the Global Strategy on Human Resources for Health: Workforce 2030 and the Global Strategic Directions for Strengthening Nursing and Midwifery 2016–2020, aim to ensure the availability of quality, cost-effective and acceptable nursing and midwifery care based on population needs and in support of Universal Health Coverage (UHC) and the Sustainable Development Goals. Additionally, ILO, OECD and WHO, through the five-year action plan of the United Nations High-Level Commission on Health Employment and Economic Growth, are promoting multi-stakeholder and intersectoral efforts to enhance women's contribution to the nursing and midwifery health labour market. Integrating and scaling these efforts will require greater political will, effective leadership and an enabling environment to ensure that nurses and midwives are adequately motivated and empowered to discharge their duties with better effectiveness and satisfaction.

BACKGROUND

The policies developed by WHO to help strengthen national health systems have evolved over the past 60-plus years. During the first decades attention was given to developing basic health services, which centered on local health units within a regional health system structure. In the early 1970s the focus of attention shifted to primary health care with an emphasis on the community level and the active participation of communities and individuals in safeguarding their health. Today, primary health care remains central to WHO's work as part of the Agenda for Sustainable Development. Throughout the years nurses and midwives have played key roles both in providing health services and in shaping health systems.

This account of nursing and midwifery in the history of the World Health Organization has been written on the basis of detailed reviews of published and unpublished documents. WHO Collaborating Centres for Nursing and Midwifery Development and former WHO regional and headquarters focal points for nursing and midwifery also provided insights. This work shows not only how WHO influenced the development of nursing and midwifery but also how nursing and midwifery influenced the development of WHO.

A report based on the literature reviews was the key document considered during a two-day meeting on the history of nursing and midwifery held at WHO's headquarters in September 2015. More than 30 senior nurses and midwives participated, representing all regions of the world. Most had been or were still staff members of WHO or of a WHO collaborating centre, or had served as WHO focal points for nursing and midwifery at headquarters or regional level.

The purpose of the meeting was to share experiences and to discuss strategies and key elements to be included in an analysis of the history of nursing and midwifery. The paper included resolutions adopted by WHO's governing bodies, recommendations formulated by nursing and midwifery expert committees, and perspectives on nursing and midwifery from WHO's successive global programmes of work from 1950 onwards.

There was unanimity on the need for a documented history as it would provide evidence of a continuity of effort from the early years of the Organization, as well as point out obstacles encountered and strategies used. The fact that these strategies were inevitably shaped by the overall policies adopted by WHO's governing bodies to advance the Organization's work led to the recognition that this history of nursing and midwifery had to be developed in the wider context of WHO's history.

INTRODUCTION

Nursing and midwifery services form essential elements of all national health systems. Nurses and midwives have been providing essential care for centuries. They form the majority of health personnel in many countries in the world. Their importance has been recognized by WHO from its very beginning.

The past perspectives on nursing and midwifery differ significantly from that of the present. As we look at the WHO documents from the 1940s and 1950s we see many references to nurses and the nursing role but – strangely from our twenty-first century perspective – midwives are rarely mentioned as a distinct body of health workers. The assumption was that nurses had the skills to advise mothers on the health of their children, and doctors should be called in case of an emergency. It was in the 1960s that midwives started to receive growing attention from WHO as a group with unique skills and enormous influence on the health of mothers and newborns.



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In the 1960s midwives started to receive growing attention from WHO as a group with unique skills.

In WHO's first few decades, the Organization's work with nurses (and, as time progressed, midwives) was primarily focused on helping countries organize educational programmes for these professions, while at the same time providing advice on the role of both in different health service contexts. A whole series of reforms was – and still is – necessary at all levels of society before nurses and midwives can make their maximum contribution to human health. Much of this document, which combines both chronological and thematic approaches, is devoted to describing the content and evolution of these reforms – improving the quality of education and practice as well as ensuring that nursing and midwifery services are available to the populations they serve.

TARGET AUDIENCES

This document is broadly intended for all persons interested in understanding the contribution WHO has made towards nursing and midwifery development. The document focuses on nursing and midwifery within the context of WHO's work. Furthermore, the document does not include all the work WHO has done but provides some highlights that illustrate general trends. In documenting the history, there is a recognition that WHO's partners have also made outstanding material, human, financial and technical contributions to this work.

The document is addressed to, first and foremost, national and global health leaders who are responsible for shaping the agendas of their countries and organizations. A key message that emerges from this history is the importance of mobilizing political will and building effective governance for nursing and midwifery development.

It is hoped that nurses and midwives around the world will not only read this report but use it as a vehicle to promote discussions concerning the future of their respective disciplines. This document can be used as a reference point for making adjustments and improvements to the WHO nursing and midwifery programme.

STRUCTURE OF THE REPORT

The report has four parts. Part I presents the period between 1948 and 1973, outlining initial WHO priorities and the attempts to clarify the role of nurses in the health-care delivery system. Part II brings into perspective primary health care which helped to shape nursing and midwifery in the period 1974–2000. This section also provides examples of types of nursing and midwifery interventions carried out in various regions with support from WHO. Part III sets the scene for nursing and midwifery in the context of universal health coverage and the Sustainable Development Goals. Finally, Part IV outlines the way forward. The traditional roles of nurses and midwives are no less important than they were when WHO was founded, but the global health context has become significantly more complex and, as a consequence, more challenging. The response to this challenge, as reflected in Part IV, is more fully addressed in WHO's *Global strategic directions for strengthening nursing and midwifery 2016–2020*, the *Global Strategy on Human Resources for Health: Workforce 2030* and the work of the United Nations High-Level Commission on Health Employment and Economic Growth.





PART I

Early decades (1948–1973)

A lot happened with regard to nursing during the early years of WHO. The International Council of Nurses (ICN) had been founded in 1899 and was the world's first and widest reaching international organization for health professionals, laying the foundation for a number of developments that fed into WHO's policies and activities related to nursing. The founding of WHO, an organization of Member States, helped not only to bring even greater focus on the roles that nurses played but also drew the attention of politicians and diplomats to the importance of nursing.

Several international meetings were held which resulted in the establishment of WHO and its constitution.



Ethel Bedford Fenwick, first ICN president.

© ICN



The International Health Conference, held in New York, June–July 1946 produced the Constitution of the World Health Organization.

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First World Health Assembly (WHA1), Geneva, 24 June–24 July 1948.

Since its inception, WHO has utilized Expert Committees whose members are appointed by the Director General to serve in any particular meeting of a specific Committee.

In 1951 the focus of one such Committee was “medical and auxiliary personnel” and the need to train them all, wherever they were, to a satisfactory standard. It soon became clear that most of the emphasis was on training doctors with less focus on nurses and auxiliaries. There was an early recognition that training doctors was important but training of nurses also needed improvement in many parts of the world, and there was need to increase the number of nurses to relieve pressure on physicians.

By the 1960s it became evident that training of nurses was hampered by the fact that there were not enough qualified nursing educators. It also

became clear that population health depended not just on medical care but also on the need to give advice on the prevention of illness. Many of the auxiliary workers and nurses, drawn from local communities, were able to do this more effectively than the doctors.

In the 1960s – a period during which many former colonies became independent nations – the emphasis shifted again to include the need to help those nations to train their own health staff in their own training facilities.

SETTING PRIORITIES

The first priorities of WHO were malaria, tuberculosis, venereal diseases, maternal and child health, and environmental sanitation. These were quickly followed by health system-related subjects, such as public health administration and medical care. The strengthening of national

health services soon came to shape the preparation and implementations of WHO's programmes, not only of the projects concerned with public health and medical administration as such, but in all fields where the Organization responded to requests from governments for technical assistance.

Because many people lived in rural and remote districts where health services were often non-existent, WHO promoted the notion of basic health services that were meant to meet the everyday needs of the population.

Although the provision of basic health services would differ from country to country, depending on their state of development, certain features were judged to be universally applicable, such as the integration of services across levels of care and specialty areas. Medical care, especially that delivered by hospitals, was also to be integrated in order to

promote the role of the general hospital as part of a general social and medical organization that would provide for both curative and preventive services.

In 1958 the WHO Expert Committee for Public Health Administration, which outlined the basic health services model, considered that **the smallest unit that could operate economically and efficiently required a staff of “a physician, some five to ten nurses, several sanitarians and a number of auxiliary workers”**.¹

It is against this background that the early nursing and midwifery activities of the Organization developed.

Organizing the structure for nursing in WHO

Since WHO's founding in 1948, its governing bodies gave top priority to nursing, requesting the establishment of posts and granting of funds to organize an expert committee. The delegations of **Ireland and the United States were the first to propose that:**

“the fundamental importance of nursing in the improvement of health services” be recognized and that the Director-General “give full consideration to the importance of

the nursing function when organizing the Secretariat and committees”.²

Even in these early days, nursing was seen by lay people as important in making a difference in people's lives. Nell Hodgson Woodruff whose interest in nursing was well known was impressed to be nominated by United States President Dwight D. Eisenhower to attend the World Health Congress in Geneva in 1954, as she was qualified “only because of her long interest in medicine and nursing”.³

An Expert Committee on Nursing is established

Nursing was incorporated in the public health administration section of the Organization, with one public health nurse assigned to that unit. The decision to establish an expert committee on nursing was taken by the Second World Health Assembly in 1949. The Expert Committee on Nursing met four times during WHO's first decade of existence and once during the second decade. Composed largely of chief nursing superintendents and directors of nursing schools from all parts of the world (with the exception of sub-Saharan Africa) it advised both WHO and Member States on all matters relating to nursing services.



Public health intervention in rural areas.

© WHO/Karl Frucht

The early priority given to nursing on the part of WHO's governing bodies was driven by multiple concerns – the shortage of all types of nursing and midwifery personnel, the existence of many different methods for ensuring their adequate supply (including countries applying different approaches within their entities to finding a solution to the shortage of personnel), and the need for training, recruitment and employment standards. The responsibility for advancing midwifery services in the world rested with the nursing sections of the Organization during these early years.

The United Nations Economic and Social Committee (ECOSOC) recognized the importance of nursing as part of its concern with the social status of women; it called attention

¹ The first ten years of the World Health Organization. Geneva: World Health Organization; 1958:336.

² Document A/Prog/356. First World Health Assembly, July 1948. Geneva: World Health Organization.

³ Kennedy DL. Devotedly Miss Nellie. Atlanta (GA): Emory University; 1982.

to the “world-wide shortage of health workers, especially of nurses”, and called on WHO to ascertain where this need was greatest, and encouraged a “prompt expansion of training facilities for the nursing profession in those areas”.¹

Increased WHO nursing and midwifery capacity impacts countries

In 1948 WHO's nursing staff in the field consisted of seven nurses, of whom two were members of a team assisting the Ethiopian Government in training local health personnel and five were doing similar work in China.

By the end of the 1950s there were 163 nurses serving in 45 countries to help with basic and post-basic nursing and midwifery training, nursing administration at national and state levels, and – as members of teams – in public health programmes. They constituted nearly one fifth of the total WHO field personnel. This number continued to rise during the 1960s, mostly to meet the needs of the WHO African Region where the number of Member States had grown from three at the end of 1957 to 29 at the end of 1967 as more African states became independent.

WHO regional nursing advisors were responsible for coordinating training

assistance provided to Member States. The assistance took different forms, including advice and information on training, teaching methods and equipment for institutions; provision of lecturers and consultants for teaching or for organizing teaching; provision of teaching equipment and of medical literature; fellowships; and assistance in the organization of group training (courses, seminars, study groups). Recognizing the great diversity of educational systems, and the different health and sickness needs for nursing service from one country to another, it was expected that “individual schools will vary in respect to their ability to meet each individual standard”.²



It was seen to be particularly important for nurses to receive training which included public health elements, and that senior staff should be trained in the supervision of auxiliary nursing and midwifery personnel. In 1964 WHO reported: “**Teaching in public health is being introduced into the training of midwives at all levels: professional nurse–midwives with training in public health are being used increasingly in administrative and teaching posts; and the broad public health aspects of maternal and child care are being included in the training programmes for midwives and in the refresher courses of auxiliary personnel – including traditional birth attendants.**”³

An anti-malaria campaign launched by the Government of Uttar Pradesh, in 1949, was the first in the world to be led by experts from WHO and to use supplies and equipment from the UNICEF.

© WHO

¹ Resolution 242 (IX) F. Geneva: United Nations Economic and Social Council; 1949.

² WHO Expert Committee on Nursing: report on the first session. Geneva: World Health Organization; 1950 (WHO Technical Report Series, No. 24; accessed 12 April 2016).

³ The work of WHO, 1964. Annual report of the Director-General to the World Health Assembly and to the United Nations. (Official Records, No. 139). Geneva: World Health Organization; 1965:38.

By the end of the 1960s, 95 countries were receiving assistance from WHO in the field of nursing in 223 projects, half of which were concerned solely with nursing, while in the rest this focus was associated with comprehensive or specialized health programmes.

NURSING IN THE WORKPLAN

The need for professional and technical education

All WHO programmes are guided by the Organization's General Programme of Work (GPW) that covers a specific period of years. As required by Article 28(g) of the WHO Constitution, the GPW is submitted to the World Health Assembly by the WHO Executive Board. All of the GPWs during WHO's early decades had direct relevance to nursing and midwifery.

The first GPW, which covered the period 1951 to 1956, included a section entitled *Professional and technical education of medical and auxiliary personnel*. Several points reflect the spirit of the time (Box I.1).

The first GPW endorsed the conclusions of the Expert Committee on Professional and Technical Education of Medical and

Box I.1.

Professional and technical education of medical and auxiliary personnel (1951)

Extension of professional and technical education by such methods as the granting of fellowships and the promotion of wider teaching facilities, is an investment which gives returns out of all proportion to the original outlay, and to which governments should give much greater weight in their planning and budgeting. International collaboration is a useful stimulant to, and component of, national efforts.

The programme for education and training consists of a series of activities, of which some can be carried out only centrally, others only regionally and locally. The problem of agreed minimum international standards in professional training is worldwide, as is also the question of the orientation of medical and related education in connection with social development. However, studies will be based on local experience and programmes directly aiming at the development of educational institutions and training. The work on standards of training will be carried out mostly in regions and countries.¹

¹ First General Programme of Work. Geneva: World Health Organization; 1951: p. 11 (http://apps.who.int/iris/bitstream/10665/127970/1/EB7_81_eng.pdf?ua=1, accessed 12 April 2016).

Source: First General Programme of Work, 1951–1956.

Auxiliary Personnel, which had met in February 1950. That Committee's report included a short statement on nursing education which drew attention to the need to coordinate training of nurses with that of other medical students (Box I.2).

There was also a specific recommendation "that the undergraduate training of nurses be re-examined with the objective of introducing specific instruction on the social, mental, and industrial aspects of nursing and expressed the hope that the Expert Committee on Nursing would take up such matters".¹

¹ WHO Expert Committee on Technical and Professional Education of Medical and Auxiliary Personnel. First meeting, 6–10 February 1950. Geneva: World Health Organization; 1950:7 (WHO Technical Report Series, No 22; http://whqlibdoc.who.int/trs/WHO_TRS_22.pdf, accessed 12 April 2016).

Box I.2.

The need to coordinate training (1950)

The Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel found that the nursing curriculum tended to be even more overloaded at both undergraduate and postgraduate levels than that of the doctor. It was essential, therefore, to re-balance nursing education with the twofold objective of overcoming outdated practices and grafting specific practical teaching in social and preventive nursing.

In the training of public health nurses, the committee accepted as a general principle the view that this should be closely coordinated with the public health training of medical and engineering postgraduate students. It was of vital importance that each should understand the scope and limitations of the other's work.

Source: Report of the WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel; First meeting, 6–10 February 1950. Geneva: World Health Organization; 1950:10 (WHO Technical Report Series, No 22; http://whqlibdoc.who.int/trs/WHO_TRS_22.pdf, accessed 12 April 2016).



The Minister of Health of New Zealand, the Honourable Henry Greathead Rex Mason, presents diplomas to eleven nurses from Burma, Japan, Singapore and Thailand on completion of a nine-month course at the Post-Graduate Nursing school of Wellington. Five of the nurses were on fellowship from WHO.

WHO fellowship programme

Several recommendations were made by the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel concerning what WHO should do to assist countries. The recommendations included that:

- Basic standards of training for the practice of public health were needed, with WHO assistance, if requested, through assessment of the courses and impartial advice, in consultation and collaboration with a panel of experts set up under the aegis of WHO.
- WHO should promote increased production and improved distribution of teaching material by various methods available on an international scale.

The committee strongly recommended that assistance to educational institutions should also be included in the Technical

Assistance Programme, because it would not be possible otherwise to raise the economic standards of living and the public health in a country. The provision of fellowships abroad was only a first step (although an indispensable one) towards the establishment and support of educational institutions in underdeveloped areas. Economic development goes hand in hand with progress in health status and service delivery.

The committee recommended that the work of WHO in organizing highly specialized teams to take part in study groups and seminars should be developed and extended.¹

Finding the funds

The United Nations Technical Assistance Programme was an important source of funding at the time; initially WHO-supported programmes were guaranteed 20% of the total funds available. This lasted for only a few years; subsequently, there was a call for a much stronger demonstration that **investing in health improved national economies. This helps explain the implicit argument that training of health workers would raise the economic standards of living in a country.**

¹ WHO Expert Committee on Technical and Professional Education of Medical and Auxiliary Personnel. First meeting, 6–10 February 1950. Geneva: World Health Organization; 1950:25 (WHO Technical Report Series, No 22; http://whqlibdoc.who.int/trs/WHO_TRS_22.pdf, accessed 12 April 2016).

Stressing the need to train more nurses

The Second and Third GPW identified professional and technical education of national health personnel as “one of the more important functions of the Organization”. Nurses were required along with other personnel because **“the physician by himself cannot cope fully with the health needs of his community”**.

WHO would assist countries to analyse the local requirements so that the training of each group could be adapted to the needs and circumstances. It was recognized that in many countries it was not yet practicable or possible to provide full professional services for the whole population. It was therefore “necessary to train ‘sub-professional’ or auxiliary workers, and WHO should be ready to help in training them”.²

Finding the teachers to train the nurses

The third GPW, which covered the period 1962–1965, lamented the shortage of trained auxiliary staff and stressed the urgent need for training of persons selected to teach auxiliaries in their own countries. The third GPW outlined WHO’s responsibility to help countries identify their needs and to

² Second General Programme of Work. Geneva: World Health Organization; 1957 (Annex 4:419).

Box I.3.
Education and training of professional and auxiliary personnel (1962)

Activities related to the education and training of professional and auxiliary personnel will remain for a long time one of the most important functions of the Organization, in many countries the shortage of adequately-trained staff still impedes the development of health programmes. Since the professional and technical education of personnel is of fundamental importance to the strengthening of national health services, these two objectives must be closely connected in the policy of the Organization.

The problem is both quantitative and qualitative; with the necessary differences in approach from one country to another, the common purpose is: (a) to reduce the shortage of trained staff by increasing the opportunities for teacher training and encouraging the entrance of suitable persons into the medical teaching profession; and (b) to provide the highest possible technical efficiency among undergraduates and trainees by improving the type and raising the quality of education.

In developing countries more attention to the study of local circumstances of health and disease is called for. This includes the development of departments of preventive and social medicine and of pediatrics in medical schools and post-graduate courses. Governments are also becoming more interested in problems of mental health and in the need for increasing their personnel in this field; assistance in improving the knowledge of the undergraduate and the general physician will be useful.

Much emphasis has been laid until now upon education and training of health personnel as a whole, but, in the light of ten years' experience, more specific needs are apparent. It is realized, for instance, that particular attention should be given to the education of persons who are to assume, within the health services of their countries, high technical or administrative responsibilities, or who are to become senior teachers. This is a notable example of the close link between the two objectives referred to above.

Specific efforts towards the education of auxiliary personnel of all categories appear as a more and more pressing need, not only in countries where the availability of such personnel represents a remedy for the lack of fully-qualified staff, but also in well-developed countries where auxiliaries are considered no less indispensable.

The most urgent need is the instruction of those who are selected to teach auxiliaries in their own countries; the next step would be to promote the creation of local schools for auxiliaries on a broad basis prior to specialized training.

It will be the responsibility of WHO to continue during this specific period to develop its fellowships programmes, consultant services, assistance to educational institutions and exchange of scientific information, in order to help countries to realize what their needs are and to promote such measures as are required by national and local conditions.

Source: Third General Programme of Work. Geneva: World Health Organization; 1962.

tailor solutions to local conditions. The full GPW section devoted to *Education and training of professional and auxiliary personnel* is shown in Box I.3.

Setting up training in newly independent countries

The fourth GPW (1967–1972) paid “particular attention” to the health needs of countries that had recently become independent. WHO’s objective was to

“enable assisted countries to have as rapidly as possible their own cadres of well-prepared staff in all fields of health” through the award of fellowships for the expatriate training of their staff or through advice and support in the establishment of schools or other training facilities. The programme continued to cover the undergraduate, postgraduate and specialist fields of medical education, as well as the education and training of nurses, sanitary engineers, midwives,

health visitors, health educators, public health inspectors, and all types of auxiliaries. In those countries where medical staff was very scarce and where there was little or no provision of their own for medical education, it was deemed necessary “to devise training programmes for auxiliaries and their supervisors to establish an initial skeletal service, staffed by adequately supervised aides”.

KEY OBSERVATIONS

- ✓ Early recognition of the importance of nursing in the health system
- ✓ Elaboration of a nursing structure within WHO
- ✓ A rising number of focal points for nursing with nursing backgrounds in Member States
- ✓ Visibility of nursing in WHO's Global Programme of Work
- ✓ Education and training as the main emphasis
- ✓ Fellowship programmes established.
- ✓ Recognition that investing in the training of health workers would raise the economic standard of living in a country.

Many nurses became more specialized – and nursing became widely accepted as a profession. By the 1960s it was clear that the world population was growing rapidly and people were living longer than their ancestors. As that happened, people expected health services to expand too to meet their changing needs. Nurses became the key to making that possible and, as they grew more professional and more in demand, the nursing and midwifery profession felt the need for stronger leadership to speak out for nurses and nursing at local, national and international levels.

The Second Expert Committee on Nursing

Expert committees played an important role in the work of WHO. Their reports did not represent the official views of the Organization but their recommendations became WHO policy if and when adopted by the governing bodies.

The expert Committee on Nursing was established in response to a WHA resolution of 1949.

DEFINING THE ROLE OF NURSING AND MIDWIFERY

The fact that WHO established an Expert Committee on Nursing as early as 1950 and that it met four times during WHO's first decade of existence is clear evidence that the governing bodies of this new world organization took the need for adequate and effective nursing very seriously. Significantly also, a WHO Expert Committee on Midwifery met as early as 1954. In those early years, nurses and midwives were often seen as having distinct roles and both groups took on far more roles than supporting doctors and assisting deliveries. The medical model of service delivery came to be seen as outdated and the roles of nursing and midwifery staff expanded considerably.



The second meeting of the Expert Committee on Nursing, in October 1951, endeavoured to find answers to four basic questions:

1. What are the health needs of people and the methods of meeting them?
2. How can nursing help to meet these needs?
3. What principles are involved in planning a programme designed to prepare nursing personnel?
4. How can nursing make its maximum contribution?

The Expert Committee's report is replete with examples drawn from a wide range of situations – such as public health nursing in North Borneo, school health in the Amazon Valley, health visitors working with the malaria programme in India, and the treatment of tuberculosis in India.

A passing observation on how history has shaped the role of nursing is still relevant today: **“The great systems of curative medicine, based on hospitalization, which in western civilizations have grown out of the historical past, have obscured the fact that nursing is essentially a team activity.”**¹

The third meeting of the Expert Committee, which met in 1954, defined nursing service as follows:

1. “The nursing service is that part of the total health organization which aims to satisfy the nursing needs of the community. The major objective of the nursing service is to provide:
 2. the nursing care required for the prevention of disease and the promotion of health;
 3. the nursing care of the patient required;
 - a) in the interest of his mental and physical comfort; and
 - b) by reason of the disease from which he is suffering.”²

The Expert Committee noted the inadequate status of nursing and/or of women, and the insufficiency of financial support for nursing services. Nurses “have been excluded from policy-making bodies ... authority has been withheld, and the nurse has not been able, or has not been permitted, to assume the full responsibility of an administrator”.²

Insufficient funding contributed to the “lack of auxiliary workers to supplement the nursing staff, lack of supplies and equipment which make possible the economical use of nursing time, lack of facilities which permit efficient planning, and lack of adequate accommodation for nursing staff”.²



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Giving more prominence to midwifery

Following a recommendation made by the Expert Committee on Maternity Care, a joint committee composed of members of the Expert Advisory Panels on Nursing and on Maternal and Child Health convened a meeting in August 1954 on midwifery training.

The first meeting of **the Expert Committee on Nursing in 1950 stressed the need for a greater number of nurses than other categories of health workers because**

¹ WHO Expert Committee on Nursing: second report. Geneva: World Health Organization; 1951:7 (WHO Technical Report Series, No. 49).

² WHO Expert Committee on Nursing: third report. Geneva: World Health Organization; 1954:4 (WHO Technical Report Series, No. 91).

Box 1.4.
Technical competence must be combined with cultural considerations (1954)

The Committee discussed the importance of understanding the customs, beliefs and traditional practices of the people for whom midwifery services are to be provided. Technical knowledge is essential, but without this understanding of cultural backgrounds its application is less effective. Dependent on traditional beliefs, there are many variations in the practices relating to pregnancy, child-birth and the newborn. A sympathetic approach when interpreting these factors of custom and culture will give the best opportunities of obtaining progressive changes. Some customs will be found to be definitely valuable, others will have no recognized harmful effects, while a number will be considered as harmful and undesirable. Respect for traditional beliefs that are harmless and the full utilization of those that are valuable will give the best opportunities for gaining the confidence of the mother and her family. This will be a sound basis for success in a programme of continuous health education which will steadily and progressively aim at the disappearance of those practices that are dangerous.

The Committee agreed that, to be effective, the local worker must have a thorough knowledge of local customs and practices; it also recognized that an appreciation of these factors is very important for those responsible for the planning and administration of maternity care services. The planning of these, however, must essentially be based on a study and analysis of the existing health problems. Furthermore, a programme for maternity care presupposes general health planning for short-term and long-term needs. The Committee recognized that in every country a maternity-care programme (as part of the maternal and child health programme) is dependent on the development of other basic health services such as communicable disease control, environmental sanitation, maintenance of records for public-health purposes and vital statistics, health education of the public, public-health nursing, and medical care.

The Committee recognized the relationship of the health programme to the social and economic development of the area, and the extent to which changes in these broad programmes will necessitate constant review of administrative patterns and in turn continuing revision of training programmes.

Source: WHO Expert Committee on Midwifery Training: first report. Geneva: World Health Organization; 1954 (WHO Technical Report Series, No. 93).



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Nurses meeting the health needs of communities.

“they have direct, individualized, and lasting contact with people, sick and well. In this sense, nurses are the final agents of health services”.¹

The first meeting of the WHO Expert Committee on Midwifery Training, which took place in The Hague in 1954, discussed the “importance of understanding the customs, beliefs and traditional practices of the people” for whom midwifery services were to be provided (Box 1.4). Technical knowledge

¹ WHO Expert Committee on Nursing: report on the first session. Geneva: World Health Organization; 1950:4 (WHO Technical Report Series, No. 24; <http://apps.who.int/iris/handle/10665/39806#sthash.paUeu7A6.dpuf>FRS 24, accessed 12 April 2016).

was essential, “but without this understanding of cultural backgrounds its application” was less effective. It also recognized that “an appreciation of these factors is very important for those responsible for the planning and administration of maternity care services”.² Three types of midwifery personnel were discussed: the traditional birth attendant, the auxiliary midwife, and the fully-trained midwife. Noting that in some countries midwifery training was a specialty based on nursing and that this trend was increasing, it agreed that, where possible, midwifery training should be given jointly with nurses.

The meeting of the Expert Committee on Midwifery met in 1964 to discuss the midwife in maternity care and adopted the following definition of a midwife:

“A midwife is a person who is qualified to practice midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and the post-natal period, to conduct normal deliveries on her own responsibility, and to care for the newly born infant. At all times she must be able to recognize the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor, and to carry out emergency measures in the absence of medical help. She may practice in hospitals, health units or domiciliary services.

² WHO Expert Committee on Midwifery Training: first report. Geneva: World Health Organization; 1954:4 (WHO Technical Report Series, No. 93).

In any one of these situations she has an important task in health education within the family and the community. In some countries, her work extends into the fields of gynaecology, family planning and child care.”¹

The nurse of tomorrow (as foreseen in 1966)

The fourth meeting of the Expert Committee on Nursing in October 1958 brought together all of the constructive features of previous reports,² while the fifth meeting in 1966 reviewed the general aspects of nursing in relation to the many changes that had occurred within health and medical care programmes since its third meeting some 12 years earlier. Attention was drawn to developments in science (and particularly the medical sciences), the increase in the world’s population (leading to increased demands for health care), and improved methods of communication between widely separated areas of the world.

The fifth meeting of the Committee described the context in which nursing “must be considered for the future” in terms that still apply today. Advances in science and technology imply “increasing specialization, whereas changes in social philosophy are leading to expectations of a health service of greater breadth and improved quality”.³ Where infectious

diseases and deficiency diseases had been largely controlled, “emphasis had tended to shift to degenerative diseases and the problems presented by a growing population with a greater life expectancy”.⁴ With the trend toward mass medical care and the changing patterns of health services, **“the nurse of tomorrow will have to accept unprecedented responsibilities. Minor modifications of existing nursing systems will be inadequate to meet new situations and demands in a rapidly changing society”**.⁵

The Committee noted with favour the definition of a nurse that had resulted from a study carried out by the International Council of Nurses (ICN),⁶ namely:

“The nurse is a person who has completed a programme of basic nursing education and is qualified and authorized in her country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness and the care of the sick.”

The Committee was convinced of the value of developing a “rational system within which nursing personnel could be employed in each country”. It was stressed that such a system should ensure that **nursing leadership** would

give guidance to the development of nursing as a whole, while permitting the delegation of appropriate functions to less expensively trained personnel. Fragmentation of service and uncertainty in the chain of control should be minimized, the Committee urged, and persons who were not so highly trained should be enabled to progress **“as far as their individual talents permit”** through ability and additional training.⁷

KEY OBSERVATIONS

- ✓ Establishment of an Expert Committee on Nursing by the Second World Health Assembly (1949)
- ✓ 1954 Expert Panel on Nursing and on Maternal and Child Health meet in The Hague and recognize the importance of midwifery
- ✓ Emphasis on the need for greater numbers of nurses
- ✓ Nursing and midwifery seen as distinct professions
- ✓ Culture, local customs and social economic factors important for nursing and midwifery education
- ✓ Need for specialization emphasized
- ✓ Importance of nursing and midwifery leadership for nursing and midwifery development.

¹ The midwife in maternity care: report of a WHO Expert Committee. Geneva: World Health Organization; 1966:8 (WHO Technical Report Series, No. 331).

² Public health nursing: fourth report of the Expert Committee on Nursing. Geneva: World Health Organization; 1959:7 (WHO Technical Report Series, No. 167).

³ WHO Expert Committee on Nursing: fifth report. Geneva: World Health Organization; 1966:6 (WHO Technical Report Series, No. 347).

⁴ WHO Expert Committee on Nursing: fifth report. Geneva: World Health Organization; 1966:7 (WHO Technical Report Series, No. 347).

⁵ WHO Expert Committee on Nursing: fifth report. Geneva: World Health Organization; 1966:7 (WHO Technical Report Series, No. 347).

⁶ WHO Expert Committee on Nursing: fifth report. Geneva: World Health Organization; 1966:7 (WHO Technical Report Series, No. 347).

⁷ WHO Expert Committee on Nursing: fifth report. Geneva: World Health Organization; 1966:11 (WHO Technical Report Series, No. 347).

STRENGTHENING NURSING AND MIDWIFERY EDUCATION AND TRAINING

As the training of nurses and midwives was strengthened, WHO put fresh emphasis on the importance of improving training curricula. What were the nurses and midwives being taught, and how should it change? There was said to be a need not only for competency in knowledge and skills but also the right attitudes to patients. Guidelines on establishing basic educational programmes were developed with WHO's support, and ministries of health were urged to gear these to the local context.

Technical support was provided by international advisers and both the WHO Executive Board and the World Health Assembly took an active interest in what came to be known as “human resources for health”, discussing how to improve recruitment and attitudes to the nursing and midwifery professions.

In many places in the 1960s, nurses were still seen as auxiliary staff. However, that attitude was changing, helped by the efforts of WHO and ICN to boost recognition of nurses as professionals. Governments were urged to set up a division of nursing in their national health administrations and to appoint chief nursing officers to the division to raise standards of education and practice.

It was stated not only that continuous professional development should be provided for nurses but also that medical students should be familiarized with nursing work.

The ways in which WHO could assist countries in improving the number and quality of its nursing and midwifery personnel was not clearly defined by the early World Health Assemblies, but “gradually there ... emerged a pattern of assistance which had as its main objects that there should be enough nurses in each country to assure the nursing service required for preventive and curative work, nurses capable of assuming positions of leadership in teaching and administration, and nurses able to participate in the planning of health services”.¹ **The need for assistance in training midwives was understood to be as great as in the case of nurses.**²

WHO recognized early that training programmes for educators in general nursing, in midwifery and in public health nursing had “too often provided for these three groups separately”. With the help of WHO, programmes were developed with a common basic curriculum for the three groups on the principle that this method would ensure a better understanding of each type of work and better teamwork in the nursing service.³

¹ The first ten years of the World Health Organization. Geneva: World Health Organization; 1958:391.

² The first ten years of the World Health Organization. Geneva: World Health Organization; 1958:395.

³ The work of WHO, 1955: annual report of the Director-General to the World Health Assembly and to the United Nations. Official records of the World Health Organization, No. 67. Geneva: World Health Organization; 1956:21.

Collaboration between stakeholders

The first Expert Committee on Nursing found that a guide developed by the International Council of Nurses (ICN) to assist schools working to establish basic programmes in professional training was particularly useful and suggested that WHO should request the ICN to continue its development. An early draft of this guide was reviewed by a group of nurses with international experience who met in Tokyo, Japan, in March 1957. A second draft was completed in December 1958 and distributed for review in a variety of situations in many countries. The final publication was issued in 1961.⁴ The guide concluded that, if there is a golden rule for planners of nursing and midwifery education, **“it is that the plan must be made to fit the local situation and that all who will have a part in carrying out the plan should have a share in making it”** (Box 1.5).⁵

Other sources of technical advice for nursing and midwifery in WHO

Another source of advice and experience was that of the technical discussions, which the Executive Board in 1953 decided should be included in World Health Assemblies on subjects

⁴ Lyman K. Basic nursing education programmes: a guide to their planning. Geneva: World Health Organization; 1961.

⁵ Lyman K. Basic nursing education programmes: a guide to their planning. Geneva: World Health Organization; 1961:76.

Box 1.5.**A call for nurses to assume leadership, administration and participation in planning of health services**

Planning takes time, either for a new nursing education programme or for the modification of an existing one ... It is essential, therefore, that individuals or groups involved in planning make provision for a continuing programme of study – planning, action, evaluation, restudy, replanning, re-evaluation. Planning must be co-operative. There may or may not have been a committee for the fact-finding phase, but planning for the kind of nursing education which will effectively serve the community requires the co-operation of representatives of nursing, medicine, health administration, education, and the public. These individuals are needed not only for their contributions to the making of effective plans but because of their potential interest and support in interpreting and implementing the programme.

Leadership in this group effort should be taken by nurses. The group should include nurses from the government department responsible for health services and for nursing education, the nursing association, existing schools of nursing, and nursing services. Planning may be initiated by any one or by a combination of these, or by nurses of an international agency. Representatives of the national health administration other than nurses are needed. Their comprehensive knowledge of all the services and of processes involved in implementing the programme will be essential. Representatives of the medical profession and other health professions are also essential. In countries where there has been little nurse leadership in the past, and where physicians have planned whatever training has been available for nursing personnel, there will be individual doctors keenly interested in new developments ...

An overall plan for nursing education will make provision for preparing all nursing personnel needed: auxiliary workers, staff nurses, leaders for supervision, administration and education. It will be necessary also to plan for in-service training of existing personnel; only by including this group can nursing services evolve smoothly without a sharp cleavage between the old and the new. Before planning for individual schools, a series of proposals covering the whole range of nursing education needs should be drafted. Such proposals might:

1. name and define the types of nurses and midwives needed;
2. estimate the numbers of each level to be prepared in a specified time period;
3. propose plans for the preparation of each type of worker;
4. suggest a plan for employment of graduates in actual and proposed health services;
5. propose a programme for evaluation; a periodic review of how the graduates meet needs, of changing needs, and of implications for replanning;
6. project a possible raising of standards and goals at the end of a specified time period.

Source: Lyman K. Basic nursing education programmes: a guide to their planning. Geneva: World Health Organization; 1961.

“of universal interest and suitable for group discussion by national health administrators”!¹

There was a cluster of such discussions in the mid-1950s and the end of the 1960s. The first group seemed to be associated

with the fact that the ninth World Health Assembly in 1956 discussed “nurses: their education and their role in health programmes”, while the late 1960s witnessed a general concern with all types of human resources for health.

WHO’s Regional Committee for South-East Asia discussed nursing requirements in relation to health programmes in 1954. Besides the urgent call for “an increase in training programmes”, the discussions recommended that “steps be taken to provide adequate nursing staff in all hospitals and health units attached to medical colleges” to provide opportunities for medical students to familiarize themselves with the role which the nurse can and should play in the health team.²

In 1955 the WHO Regional Committee for the Western Pacific addressed home-based midwifery as an approach in the development of rural health services, as well as the scope and limitations of the midwife’s functions and the kind of training needed.³ While there was a consensus concerning the importance of organized home-based midwifery in any rural health programme, with respect to training, some members of the Regional Committee believed that efforts should be concentrated on the development of qualified personnel while others maintained that both professional training and training of unqualified workers should be carried out simultaneously.

In 1949, support to develop nursing and midwifery in Member States started

¹ (EB11.R67). World Health Organization, Executive Board 11. Technical discussions at future Health Assemblies (Twenty-seventh meeting, 4 February 1953). Available at http://apps.who.int/iris/bitstream/10665/87046/1/EB11R67_eng.pdf

² Recommendations of Sub-Committee on Technical Discussions on Nursing Requirement in the South East Asia Region in Relation to the Countries’ Planned Health Programmes. Regional Committee for South-East Asia document SEA/RC7/14. New Delhi: World Health Organization Regional Office for South-East Asia; 1954 (https://extranet.who.int/iris/restricted/bitstream/10665/131025/1/sea_rc7_14.Pdf, accessed 20 May 2016).

³ WHO Regional Committee for the Western Pacific. Working papers: Domiciliary midwifery as an approach to the people in the development of rural health services. Available at http://apps.who.int/iris/bitstream/10665/143297/1/WPR_RC006_TD03_Add1_1955_en.pdf



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Ninth World Health Assembly (WHA9), Geneva, 8–25 May 1956. Dame Elizabeth Cockayne, Chief Nursing Officer, Ministry of Health, United Kingdom, during the technical discussions on “nurses, their education and their roles in health programmes”.

under the national nursing programme in the programme of work of WHO EMRO. The first Regional Expert Advisory Panel of Nurses was established in 1965 and the first meeting was held in Alexandria, Egypt.

In 1966, the first Regional Nursing Seminar was organized by EMRO in Lahore, Pakistan.¹

Attracting new students of nursing

Countries were encouraged to discuss training in advance of the

¹ Report of the Fifth Meeting of the Regional Advisory Panel on Nursing and consultation on advanced practice nursing and nurse prescribing: implications for regulation, nursing education and practice in the Eastern Mediterranean Region. Islamabad, Pakistan. 2002. WHO Regional Office for the Eastern Mediterranean Region. Cairo, Egypt.

ninth World Health Assembly’s technical discussions. Forty comprehensive reports were returned to WHO and formed the basis for the background paper.² Two themes dominated the discussions: recruitment of students and post-basic education. Attracting a sufficient number of qualified candidates for schools of nursing and selecting the most suitable ones was seen to be a major problem.³ Suggestions for overcoming it included improving the attitude of the public towards the nursing profession, the provision of comfortable living quarters for students, and conveying accurate and attractive information to the public, teachers and students regarding the activities of and opportunities for nurses. With regard to post-basic education, there was a consensus that teachers, supervisors and administrators in both hospital and public health nursing services “needed additional preparation beyond that received in the basic nursing schools”. Refresher courses, seminars and conferences for supervisors and teachers needed to be provided to permit nurses to

² Nurses: their education and their role in health programmes. Document A9/Technical Discussions/1. Ninth World Health Assembly, May 1956. Geneva: World Health Organization; 1956 (http://apps.who.int/iris/bitstream/10665/105181/1/WHA9_TD-1_eng.pdf?ua=1, accessed 13 April 2016).

³ Report of the Technical Discussions at the Ninth World Health Assembly. Document A9/Technical Discussions/3. Ninth World Health Assembly, May 1956. Geneva: World Health Organization; 1956:6 (https://extranet.who.int/iris/restricted/bitstream/10665/105183/1/WHA9_TD-3_eng.pdf, accessed 13 April 2016).

be kept up to date with scientific discovery and progress in the health sciences.⁴

The technical discussions in the late 1960s, while covering much of the same ground as the earlier ones especially concerning educational requirements, paid more attention to the needs of persons in rural areas and the facilities needed to meet those needs.

The important role of chief nursing and midwifery officers

There was progressive awareness⁴ of the need for authorities responsible for national health planning to consider the availability of nursing personnel, the need for additional programmes of nursing education or the modification of existing ones, and the need for policies and standards applicable to educational institutions. Seven countries of the Eastern Mediterranean region had set up a nursing division within their national health administrations. **The appointment of a chief nurse to this division was said to have “greatly facilitated the establishment of national policies for nursing, the raising of standards of nursing practice, and the coordination of nursing services and nursing**

⁴ Report of the Technical Discussions at the Ninth World Health Assembly. Document A9/Technical Discussions/3. Ninth World Health Assembly, May 1956. Geneva: World Health Organization; 1956:8–9 (https://extranet.who.int/iris/restricted/bitstream/10665/105183/1/WHA9_TD-3_eng.pdf, accessed 13 April 2016).

education”. Many countries were delayed in the setting up of a nursing division through the lack of budgetary or other facilities, including the fact that there was “no nurse yet qualified for leadership”.¹

Preparing teachers

The first step in preparing teachers, administrators, supervisors and nurses qualified in public health would be to “strengthen the existing facilities which are expected to serve as the practice field for students in a programme of post-basic nursing education”. It was felt that public health nurses could not be prepared “unless there is at least a pilot service which provides generalized public health nursing care and in which the student can relate principles to practice.”² The technical discussions at the August 1969 meeting of the Regional Committee for South-East Asia addressed the training of paramedical personnel in health centres.³ Most of the discussion concerned nursing personnel, auxiliary nurse-midwife, the nurse-midwife, the midwife and the health visitor. As was the case in the Eastern Mediterranean Region, the bulk of the population in South-East Asia was rural and principally engaged in agriculture.

¹ Review of the education and training of nurses to meet the needs of the region. Document EM/RC19/Tech.Disc./2. WHO Regional Committee for the Eastern Mediterranean, nineteenth session. Alexandria: WHO Regional Office for the Eastern Mediterranean; 1969:17.

² Review of the education and training of nurses to meet the needs of the region. Document EM/RC19/Tech.Disc./2. WHO Regional Committee for the Eastern Mediterranean, nineteenth session. Alexandria: WHO Regional Office for the Eastern Mediterranean; 1969:33.

³ Twenty-second session of the World Health Organization Regional Committee for South-East Asia. Final Report and Minutes of the Meetings. Available at <http://apps.who.int/iris/bitstream/10665/130257/1/RC%2022%20final%20report.pdf>

Public health nursing and rural health services

Specific attention was given to the role of public health nurses in the delivery of rural health services. In the South-East Asia region, it was noted that most were appointed at supervisory levels but were “often severely restricted in carrying out their functions by the lack of transport and the non-availability of living quarters and other amenities for them when they are on tour”.⁴ Also noted was a lack of understanding of the functions of the public health nurse on the part of the responsible medical officer. Consequently, such nurses were frequently placed in administrative positions in the health office or assigned as assistants to the medical directors. They were said to be “given responsibility for supervision, without the necessary authority also being delegated”.⁵

To address these and other problems, a call was made to “develop a realistic system by which nursing personnel can be prepared and employed”. This system should ensure a level of nursing personnel which could produce nurses who can give skilled nursing care and who are equipped to take advanced training for positions of leadership in health and nursing planning, supervision, teaching and the delivery of direct patient and community nursing care. It was stated that auxiliary staff could perform tasks requiring less costly training.

⁴ Training of paramedical personnel in health centres. Document SEA/RC22/8. Delhi: WHO Regional Committee for South-East Asia; 1969:9.

⁵ Training of paramedical personnel in health centres. Document SEA/RC22/8. Delhi: WHO Regional Committee for South-East Asia; 1969:10.



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August 1969 Regional Committee Meeting for South-East Asia addressing training of paramedical personnel in health centres.



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Visiting health nurse.

The relative number of auxiliaries to nurses was considered to vary greatly, depending on the health needs of patients and families, on the general health programme, and on economic and human resources. Studies were required to determine this ratio, which may differ from country to country and from situation to situation.⁶

⁶ Training of paramedical personnel in health centres. Document SEA/RC22/8. Delhi: WHO Regional Committee for South-East Asia; 1969:13.



Skills lab.



Improving practice sites for teaching

The Regional Committee for South-East Asia, when addressing lack of uniformity in education standards, concluded that if conditions were allowed to remain as they were, “it would be quite impossible to provide good teaching”.¹ It was,

¹ Nursing in South East Asia, SEA/RC3/23 August 1950 Page 3.

however, judged possible to upgrade many of the existing hospitals and turn them into good teaching schools for nurses. The nursing schools attached to these hospitals should be able to offer nursing courses along generally accepted lines and in accordance with accepted methods of nursing education. The aim should be **“a basic training of uniform standard so that future developments can be planned along general lines and not special for each individual state or country”**. This applied also to midwifery, public health nursing and any other branch of nursing existing at that time.

An early effort to identify acceptable standards was a Working Conference on Nursing Education, convened in Geneva in early 1952, at which nine senior nurses (all heads of schools of nursing and all working in countries with similar patterns of nursing education) engaged over a two-week period in informal discussions on “the type of nurse required in the various countries, planning for her preparation, and how this planning might be implemented”.²

The kind of nurse who was needed in all parts of the world was one prepared “to share as a member of the health team in the care of the sick, the prevention of disease, and the promotion of health” (Box 1.6).

Redefining nursing curricula

In 1953, the Working Conference on Nursing Education developed what

² Working Conference on Nursing Education. Geneva: World Health Organization; 1953:4 (WHO Technical Report Series, No. 60).

was termed “the situation approach” for the training of nurses with these desired qualities and outlined ways that such an approach could be developed. The use of such an approach “makes learning a dynamic process. A dynamic teaching situation is one which requires the student to apply her knowledge and skills in analysing the needs of individuals or families and in planning and carrying out the care necessary to meet these needs”.³

In 1966, the fifth Expert Committee on Nursing, after noting that training curricula should be geared to the needs of the students and of the community to be served, stressed that emphasis should be on the development of “an understanding of human behaviour; an alert, questioning, and critical mind; power of observation; insight and foresight; imagination and creativity; adequate knowledge and skills in nursing; ability to communicate effectively; and, within the ambit of their own competence, ability to make sound judgments and decisions; ability to anticipate health needs and to institute nursing measures; and willingness to grow professionally”. It followed from this that the “curriculum must be rich in learning experiences, both theoretical and practical, that will provide a foundation for the practice of nursing in a rapidly changing world”.⁴

The Expert Committee on Midwifery that met in 1954 outlined a set of

³ Working Conference on Nursing Education. Geneva: World Health Organization; 1953:10. (WHO Technical Report Series, No. 60).

⁴ Working Conference on Nursing Education. Geneva: World Health Organization; 1953:18 (WHO Technical Report Series, No. 60).

Box I.6.**A nurse who is ready to share in the care of the sick, prevention of disease and promotion of health would be a nurse who ... (1952)**

1. possesses the personality, the education (both general and professional), the degree of maturity, and the possibility of development which will enable her to work effectively within the social structure of the community in which she lives;
2. is prepared to recognize and to adjust to changing social, economic, medical, nursing, and health conditions;
3. is well adjusted in her own living, in her work, and in her relationships with others; utilizes her education to help find security and satisfaction in her living and her work and to help make the necessary changes for improvement in her situation; and has developed a sense of personal and professional responsibility;
4. has the capacity for, and the will to seek, continued growth and educational development;
5. is equipped, through generalized preparation, to work in all fields of nursing;
6. is prepared to give total nursing care, including the physical, mental, emotional, and social elements;
7. is prepared:
 - (a) as the nurse member of the health team, to analyse the nursing needs of individuals, both sick and well, and to plan and carry out the nursing care necessary to meet these needs;
 - (b) to carry out techniques of nursing care skillfully herself;
 - (c) to teach and supervise appropriate nursing and health care to nurses, auxiliary workers, patients, families, and community groups; and
 - (d) to participate in community programmes and nursing organizations.

Working Conference on Nursing Education. Geneva: World Health Organization; 1953:18 (WHO Technical Report Series, No. 60).

attitudes, knowledge and skills that midwifery personnel should possess, as shown in Box I.7.

The challenge to unify standards

The desire to develop global unified standards had to contend with a variety of influences, especially a country's history, its financial and human resources, and social and cultural patterns. As noted in technical discussions held during the meeting of the Regional Committee for the Eastern Mediterranean in 1969, the diversity of standards in the region was particularly pronounced, as illustrated by the fact that "it was as long ago as 1955 that the High Institute of Nursing enrolled its first students in a basic degree programme at the University of

Alexandria. Fifteen years later, in 1969, there are still countries where the existing programmes for nurses are at auxiliary level only".¹

At the end of the 1960s, many countries were still training nurses and midwives separately; in these countries, little or no teaching of obstetrical nursing or of the care of the newborn was given in the nursing curriculum.

In 1960, when the Regional Committee for Africa turned its attention to postgraduate nursing education, similar conclusions were reached. There, the goal was to eliminate as early as possible "the differences which exist from country

¹ Review of the education and training of nurses to meet the needs of the region. Document EM/RC19/Tech.Disc./2. WHO Regional Committee for the Eastern Mediterranean, nineteenth session. Alexandria: WHO Regional Office for the Eastern Mediterranean; 1969:1.



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Training should be geared to the needs of the students and of the communities to be served.

Box 1.7.
Attitudes, knowledge and skills of midwifery personnel

1. Sufficient understanding of the basic physical and biological sciences to be able to follow the course intelligently;
2. Knowledge of the art and practice of midwifery, including:
 - a. An understanding of the public health significance of maternal health, maternal morbidity and mortality, and perinatal mortality, and the value of records;
 - b. An understanding of the psychology, physiology and pathology of child-bearing;
 - c. Sound practical skill in:
 - i. Giving prenatal care to the mother, including the nutritional and emotional aspects;
 - ii. Undertaking the normal delivery;
 - iii. Recognizing under what circumstances (prenatal, natal and postnatal) medical aid must be sought, and the value of medical examinations in the prenatal and postnatal periods;
 - iv. Carrying out simple emergency measures in case of difficulty, pending the arrival of medical aid;
 - v. Giving adequate care to the newborn, and
 - vi. Maintaining proper records;
3. Sufficient understanding of nursing art and practice to enable her to give adequate nursing care in her own field and in certain circumstances to guide the mother on home nursing procedures until more skilled aid is available;
4. Knowledge of the rules and regulations governing the practice of midwives and a high standard of professional ethics;
5. Sufficient understanding of the public health organization and of the administrative measures for safeguarding personal and community health to enable her to function effectively as a member of the public health service;
6. Sufficient understanding of the social structure in which she will work and of the social, cultural and economic factors influencing health to enable her to function effectively in the community;
7. Sufficient understanding of human motivation and behaviour to give her an insight into her own attitudes, so that she may establish good personal relationships with the families under her care;
8. Sufficient understanding of the principles and methods of teaching to enable her to give health education to individuals and groups, and to enable her to train and supervise other workers.

Source: Report of the Expert Committee on Midwifery Training.¹

to country both as regards level of health personnel recruitment and as regards the programmes in force”.¹

PROMOTING RESEARCH

Nursing research was only starting to emerge in the 1960s, and an international study of nurses’ roles, responsibilities and education had never happened before. Such global research, with global and local stakeholders involved, was the

sort of action that only WHO could make happen. The move to conduct research into nursing led WHO to strengthen its links with NGOs and academic institutions in this area. These organizations and institutions already existed – and there were already links with the International Council of Nurses, the International Confederation of Midwives and other nursing bodies, for instance, as well as with various research groups – but the need for nursing and midwifery research led to more and stronger connections.

¹ WHO Regional Committee for Africa, tenth session. Document AFR/RC10/7 Rev. 1. Accra: WHO Regional Office for Africa; 1960:16.

KEY OBSERVATIONS

- ☑ Recognition of the importance of interprofessional education for better teamwork
- ☑ Collaboration with key partners such as ICN and ICM to set standards and guidelines for education
- ☑ WHO governing bodies and regional committees demonstrate high levels of support for nursing and midwifery
- ☑ Emphasis on attracting students, quality teachers and introducing post-basic education
- ☑ Recognition of the key role of the chief nurse in national policies, standard setting, and coordination of education and services
- ☑ Need for updated and responsive curricula
- ☑ Problem of varying entry requirements into nursing and midwifery.

As expert committees discussed the role of nurses, and successive reports were published showing how essential nurses were to effective health systems, calls became louder for nurses and midwives to be more involved in leadership and decision-making about health. The research showed countries nurses’ experience with the care of patients could make a valuable contribution to policy decisions.

The need for research in WHO’s nursing programme had been recognized as early as 1950. The first Expert Committee on Nursing recommended that WHO

should undertake fundamental research to determine the real health needs of peoples and “to determine how nursing can best function to meet these needs through health teaching, participation in preventive programmes, care of the sick, and other methods”.¹ There is no record of this recommendation being followed.

If such research had been undertaken, it no doubt would have confirmed an observation made by Cora Du Bois, a cultural anthropologist who consulted for WHO in 1950, that **“the only group that had any real sense of the problem as a human one, were the nurses.”**²

The fourth Expert Committee, which met in 1958, had research in public health nursing as one of its main topics for consideration. It recognized the need “to develop a group of nurses who are capable of planning and carrying out the necessary research and of working with other researchers on team studies”. Equally urgent was “the need to develop among nurse practitioners a number of experts who will constantly explore the potentials and nature of the art of nursing”.³

The committee concluded that strong efforts should be made to develop a corps of senior nurse practitioners who

would be recognized as nurse-teacher-researchers. The tendency to consider the channel of advancement as going from practice to administration or teaching had caused many expert field nurses to leave the practice of nursing for full-time teaching or administration. As the Expert Committee commented, “This situation does not prevail in medicine, where teaching and research are considered as an integral part of practice”.⁴

WHO was called on to “undertake or sponsor inter-country research and studies of methods of evaluation of public health services”. In a separate recommendation, provoked by the committee having learned that there was interest in studies of “the synthesis of curative and preventive medicine”, it recommended that “the nursing profession be encouraged to offer to participate in such studies where they are being developed, both to incorporate the nursing phases of such a study and to use the experience nursing has accumulated in methodology of function studies”.⁵

A review of the Medical Research Programme of WHO, covering the period 1958–1963, noted that research in nursing was a “comparatively recent development”.⁶ Most of the studies conducted over the previous decades were descriptive in nature and surveyed

resources and needs in nursing, methods or techniques to be used in making observations, and research into problems of a practical, administrative or educational nature.

A scientific group, convened in 1963, identified subjects in nursing of international significance requiring research. One outcome was the preparation of a methodology for the study of current nursing practice and basic nursing education. Another was the guide *The staffing of public health and out-patient nursing services: methods of study*.⁷

The fifth Expert Committee in 1966 identified research as “one of the factors that can help to keep nursing practice in tune with community needs”. It felt that the wide range of problems confronting nursing worldwide could be subjected to systematic investigation utilizing a methodology appropriate to the individual problem and setting.⁸

Ideally, the Committee concluded, research-mindedness should be part of basic nursing education, “either through learning on a problem-solving basis or through planning” though not necessarily by carrying out small-scale studies. “Such education should be continued and extended in postbasic programmes,” the Committee added. In both cases,

¹ WHO Expert Committee on Nursing: report on the first session. Geneva: World Health Organization; 1950:21 (WHO Technical Report Series, No. 24; <http://apps.who.int/iris/handle/10665/39806#sthash.paUeu7A6.dpuf> IRIS 24, accessed 12 April 2016).

² Seymour S. Cora Du Bois: anthropologist, diplomat, agent. Lincoln (NE): University of Nebraska Press; 2015: p. 241.

³ Public health nursing: fourth report of the Expert Committee on Nursing. Geneva: World Health Organization; 1959:29 (WHO Technical Report Series, No. 167).

⁴ Public health nursing: fourth report of the Expert Committee on Nursing. Geneva: World Health Organization; 1959:29 (WHO Technical Report Series, No. 167).

⁵ Public health nursing: fourth report of the Expert Committee on Nursing. Geneva: World Health Organization; 1959:30–1 (WHO Technical Report Series, No. 167).

⁶ The Medical Research Programme of WHO 1958–1963, A17/P&B/5, 3 February 1964 page 394.

⁷ Roberts DE. The staffing of public health and out-patient nursing services: methods of study. Geneva: World Health Organization; 1963 (Public Health Papers, No. 21).

⁸ WHO Expert Committee on Nursing: fifth report. Geneva: World Health Organization; 1966:26 (WHO Technical Report Series, No. 347).

well-prepared teachers were considered necessary so that students could be guided to source good materials so that, in gaining further orientation to research, students would not be tempted to undertake impertinent or worthless enquiries.¹

ADVOCACY AND PARTNERSHIPS

A call for nurses and midwives to be involved in central health administration permeated almost all the reports referred to above. The call was associated with the importance of giving nurses and midwives the necessary leadership skills to undertake such responsibilities. While leadership qualities were clearly needed in the establishment of educational and training institutions and in the administration of nursing and midwifery activities, they were equally if not more important in the political

arena. Hence, "political awareness and active participation in the political arena are essentials in the nursing profession's efforts to influence public opinion and public policy as the profession seeks to better serve its students and its public".²

The supporting role played by a number of nongovernmental organizations (NGOs) was of particular importance in elevating nurses and midwives to leadership positions. Several international NGOs involved in nursing and midwifery activities were already well-established when WHO began its work, most notably the International Council of Nurses (ICN), the International Committee of Catholic Nurses (ICCN) and the International Confederation of Midwives (ICM). All quickly established official relations with WHO. Their physical presence as well as their active participation in the work of the Organization have helped and continue to help raise the visibility of nursing and midwifery.

¹ WHO Expert Committee on Nursing: fifth report. Geneva: World Health Organization; 1966:28 (WHO Technical Report Series, No. 347).

² Krampitz SD. Nursing power, nursing politics. In: Maggs C., editor. Nursing history: the state of the art. London: Croom Helm; 1987:102.





PART II

Primary health care (1974–2000)

A NEW APPROACH SHOWS THE NEED FOR NEW PERSONNEL

Primary health care, which gathered momentum in the 1970s to become a worldwide campaign, put the former “auxiliary” health staff in the limelight. The primary health care approach depended on a health workforce with a mix of skills, including a sufficient number of nurses and midwives working at the point of contact with people. A large part of primary health care activities required work in communities to deliver simple interventions to manage minor problems that were in danger of becoming bigger without treatment; much of it was preventive and promotive in nature. This new approach, which ensured better health for millions of people worldwide, relied on the nursing profession and required close collaboration within health-care teams, with sectors beyond the ministries of health and education, as well as with communities. In many places it led to a redefinition of the roles of doctors and nurses. There were challenges as some countries held to the medical model introduced in colonial days, and cultural attitudes that set nurses apart from the rest of the community were hard to break. Change was gradual, but it happened – thanks to the many nurses who were in the front line of primary health care.



Alma Ata Declaration
of 1979.

Promoting the development of new health services

The transition from the basic health services model to that of primary health care took several years. That a change was needed became evident following two major studies, the first¹ jointly undertaken by WHO and UNICEF, the second² an organizational study commissioned by the WHO Executive Board.

In their joint study, WHO and UNICEF provided a comprehensive assessment of their assistance to education and training programmes. Nine countries were visited; information was gathered from all countries on the status and trends of education and training programmes in the light of health manpower needs. In all the countries visited, there were serious shortages of health personnel, which in one country was described as “catastrophic”. In six of the nine countries, there were more doctors than nurses and, as the need for both was great, all the countries relied heavily on auxiliary workers of one kind or another. The shortage of health workers in some instances was exacerbated by an outflow of physicians and nurses to developed countries.

The training received by all categories of staff was judged to be inadequate.

Much of the education of health personnel was still based on western models, in some instances 50 (now 85) years old. Training was not related to the needs of communities; tropical medicine was often an optional subject, even where it was most needed. Much of the training was hospital-oriented with no attention to what was going on outside the hospital walls. Furthermore, teaching equipment was poor – especially accommodation and equipment for laboratories and practical work. There was a lack of textbooks and of simple texts for teaching in national languages.

Few countries had any health development plans, and those that did tended to plan towards hypothetical norms rather than realistic solutions. **Inadequate planning contributed to a host of deficiencies: no established posts for newly-trained staff, inadequate provision for refresher training, lack of supervision and little attention to establishing a satisfactory career structure, especially for auxiliary workers.**

Innovation was called for in educational planning, teacher training, curriculum revision, teaching methods, supervision, continuing education and the establishment of new courses to meet local needs, and there was a need for review and evaluation of all aspects of educational programmes.

The organizational study by the WHO

Executive Board, which was conducted from 1970 to the end of 1972, dealt with *Methods of promoting the development of basic health services*. The report states that in many countries **“the health services are not keeping pace with the changing populations either in quantity or quality”**. It considered that **“we are on the edge of a major crisis which we must face at once...”**³

Top priority needed to be given to solving “personnel problems”. Various proposals were made, including that the training of health personnel, including doctors, should be done in the country where the personnel will be working or, failing that, in very similar countries, and that **“the temptation to emulate the corresponding schools of the more developed countries must be resisted”**. The final point was that “as things now stand, the needs are so great and are growing at such a rate that there can be no hope of meeting them for a long time to come if we confine ourselves to using professional staff only”.⁴

Primary health care was WHO’s response to this challenge. Its key principles were enshrined in the Declaration of Alma-Ata which defined primary health care as **“essential health care based on practical, scientifically**

¹ WHO Executive Board. Report of the UNICEF/WHO joint committee on health policy on its eighteenth session. JC 18/UNICEF-WHO/71.5.

² Organizational study on methods of promoting the development of basic health services. Report of the Working Group to the fifty-first session of the WHO Executive Board. Document EBSI/WP/I. Geneva: World Health Organization; 1973:6.

³ Organizational study on methods of promoting the development of basic health services. Report of the Working Group to the fifty-first session of the WHO Executive Board. Document EBSI/WP/I. Geneva: World Health Organization; 1973:6.

⁴ Organizational study on methods of promoting the development of basic health services. Report of the Working Group to the fifty-first session of the WHO Executive Board. Document EBSI/WP/I. Geneva: World Health Organization; 1973:17.

sound and socially acceptable methods, and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every state of their development in the spirits of self-reliance and self-determination”. Primary health care was required to be an integral part of both the country’s health system and the overall social and economic development of the community. It should bring health care as close as possible to where people live and work, and should constitute the first element of a continuing health care process.¹ Primary health care was seen as the “key to health for all”, a goal agreed by the Thirtieth World Health Assembly in 1977 and which was taken to mean the “attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life” (resolution WHA30.43).

Primary health care dependent on nurses and midwives

Dr Halfdan Mahler (WHO Director-General) stated in 1975 that “if the millions of nurses in a thousand different places articulate the same ideas and convictions about primary health care,



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Dr Halfdan T. Mahler (Denmark), former Director-General of the World Health Organization, from 1973 to 1988.

and come together as one force, then they could act as a powerhouse for change”.

Just prior to primary health care being first discussed by WHO’s governing bodies (1974), an Expert Committee met on the subject of Community Health Nursing.² Participating organizations included the Christian Medical Commission, the ICN, the ICM, the International Committee of Catholic Nurses and Medico-Social Assistants, and the League of Red Cross Societies. This committee incorporated midwifery, along with maternal and child health services, as “basic components of family and community health care”.³ It also expressed a vision of the changing role of community nurses (Box II.1).

² Community health nursing. Report of an Expert Committee. Geneva: World Health Organization; 1974 (WHO Technical Report Series, No. 558).

³ Community health nursing. Report of an Expert Committee. Geneva: World Health Organization; 1974:11 (WHO Technical Report Series, No. 558).

Box II.1. The changing role of community nurses

Perhaps the most dramatic change in the roles and functions of community health nurses will be seen in the additional diagnostic and therapeutic responsibilities required of them. First, they will be expected to teach primary health workers many of the functions traditionally performed by nurses and guide these new personnel in case-finding, disease prevention, patient and family care, community programme development, health education, and curative and related functions. An even more demanding responsibility of the community nurse will be the fulfilment of roles usually ascribed to general medical practitioners. These include examining the sick and disabled, determining the source of problems presented, and treating acute conditions as well as the major prevalent diseases in the community. As the nurse becomes more competent in these and associated nursing skills, her role as teacher, supporter, and consultant of the primary health care workers will also expand.¹

¹ Community health nursing. Report of an Expert Committee. Geneva: World Health Organization; 1974:8 (WHO Technical Report Series, No. 558).

Source: Community health nursing. Report of an Expert Committee, p. 11.

The committee called for a change in the conceptual framework – one that “accepted the community itself as the major determinant of health care...”, recognized the “possibility that community health may be approached other than through an organized health system”, and envisaged the development of nursing “as a system of care rather than as a specialized occupation”.⁴

⁴ Community health nursing. Report of an Expert Committee. Geneva: World Health Organization; 1974:16–17 (WHO Technical Report Series, No. 558).

¹ Alma-Ata 1978: primary health care. Geneva: World Health Organization; 1978 (“Health for All” Series, No. 1).

Developing health manpower to meet new challenges

It was not until 1983 that WHO convened an Expert Committee to address health manpower challenges in an integrated way (see below). In the interim, as reflected in the series of GPWs that were adopted by the governing bodies, little guidance was provided concerning what is now termed human resources for health (HRH). For example, the fifth GPW (for the period 1973–1977) indicated that WHO was expected to concentrate on:

- the adjustment of education schemes, curricula and teaching methods and media to meet the local requirements, with emphasis on the team approach to the education of health workers;
- the training of auxiliary personnel;
- the training of teachers for medical and allied health sciences;
- the provision of continuing education as a part of the career structure of all health workers; and
- educational methodology and technology.

The sixth GPW (for 1978–1983) continued stressing the use of auxiliary health personnel, as follows:

- Whenever possible, attempts should be made to devise simple yet effective

health technologies that can be applied by auxiliary health personnel for people who have either no access to or need for more sophisticated health services.

- No country can afford to waste its health manpower. This implies that skills have to be developed in accordance with tasks to be performed for the solution of health problems rather than solutions sought in accordance with existing skills. Since it is most unlikely that developing countries will have adequately trained professional health manpower in sufficient numbers within a reasonable period of time, initially other solutions may have to be adopted by them, such as the training and use of auxiliary health personnel and traditional healers and midwives.¹
- Most medical and health activities within the primary health care context should, as far as possible, be carried out at the most peripheral level of the health service by the staff best trained for the purpose.

It was against this background that the Director-General, in December 1983, addressed the Expert Committee on health manpower requirements for the achievement of health for all by the year 2000 through primary health care in the following terms:

¹ Sixth general programme of work covering a specific period 1978–1983 inclusive. World Health Assembly document A29/6 Corr. 2, 30 April 1976: 14. Geneva: World Health Organization; 1976 (http://apps.who.int/iris/bitstream/10665/148681/1/WHA29_6_eng.pdf, accessed 20 May 2016).

“Health manpower development must be broad in range, encompassing the political and social obligations as well as the technical aspects of primary health care. In addition, manpower development must include the various levels of health systems where manpower plays a key role: policy-makers and planners; educators and trainers; health system and manpower managers; and communities.”²

The concept of integrated health systems and manpower development had already been introduced as an “idealized form of health systems and manpower development”, bringing together key elements as depicted in Figure II.1.³

While the mechanisms would necessarily be country-specific, the Expert Committee made clear that “in general, agencies other than health and education ministries and universities will need to be represented including among others, finance and planning agencies, social welfare, community development, agriculture, labour, communications, and public works, as well as professional and other nongovernmental and community organizations”.⁴

For manpower development, the implications of primary health care were said to be not simply for incremental

² Health manpower requirements for the achievement of health for all by the year 2000 through primary health care. Report of an Expert Committee. Geneva: World Health Organization; 1985:7 (WHO Technical Report Series, No. 717).

³ Health manpower requirements for the achievement of health for all by the year 2000 through primary health care. Report of an Expert Committee. Geneva: World Health Organization; 1985:26 (WHO Technical Report Series, No. 717).

⁴ Health manpower requirements for the achievement of health for all by the year 2000 through primary health care. Report of an Expert Committee. Geneva: World Health Organization; 1985:27 (WHO Technical Report Series, No. 717).

change or asking health workers to do a little more here or there, but to proceed with sometimes radical changes. “Primary health care, in this regard, requires active planning from below and substantial support from above. **Planning needs both extensive decentralization and input from the most peripheral parts of the system.**”¹

Table II.1 was used to illustrate the evolution of WHO’s health manpower policy objectives over the previous decades.

The 1983 Expert Committee noted that if the pattern of earlier historical periods was retained with its emphasis on doctors, “the very meaning of the health team will be distorted, thus seriously jeopardizing the successful application of the primary health care approach”.²

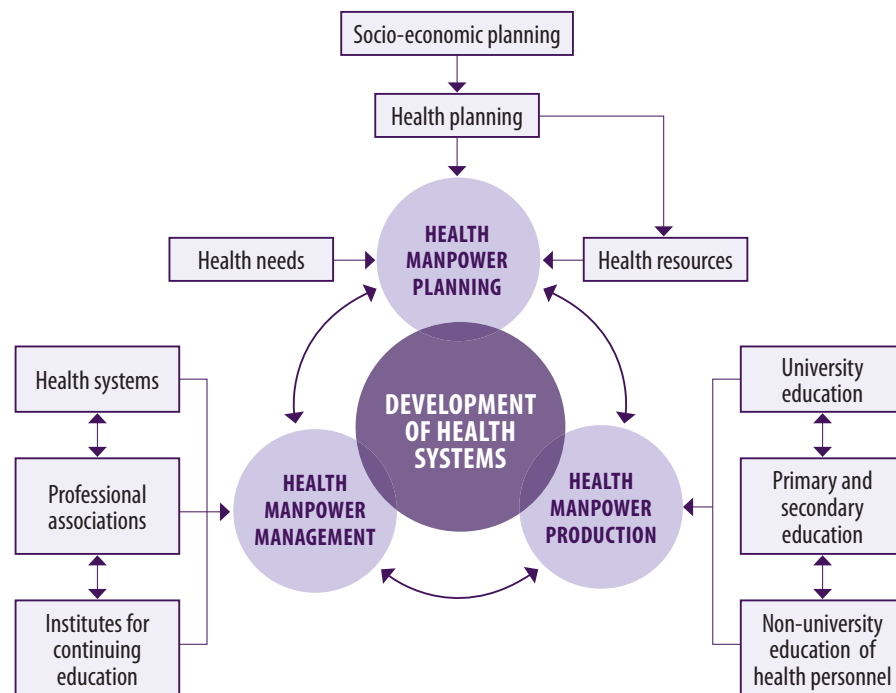
A redefinition of the roles and functions of doctors was required along with that of the nurses who were “numerically the largest group among health staff [who] provide a multiplicity of services in a wide range of settings”.³

¹ Health manpower requirements for the achievement of health for all by the year 2000 through primary health care. Report of an Expert Committee. Geneva: World Health Organization; 1985:34 (WHO Technical Report Series, No. 717).

² Health manpower requirements for the achievement of health for all by the year 2000 through primary health care. Report of an Expert Committee. Geneva: World Health Organization; 1985:45 (WHO Technical Report Series, No. 717).

³ Health manpower requirements for the achievement of health for all by the year 2000 through primary health care. Report of an Expert Committee. Geneva: World Health Organization; 1985:44 (WHO Technical Report Series, No. 717).

Figure II.1.
Health systems and manpower development (1985)



Source: Health manpower requirements for the achievement of Health for All by the Year 2000 through primary health care, p. 27.

Table II.1.
WHO’s policy objectives for health manpower development (1980)

Objectives	Period I	Period II	Period III	Period IV
	1948–1951	1952–1961	1962–1972	1973–1980
Quantity of conventional personnel	●●●	●●●	●●	●
High quality of medical and nursing education	●●	●●●	●●	
Equality of credentials cross-nationally		●●	●	
Geographical coverage in countries		●●	●●●	●●●
Efficiency of production and use of health personnel		●	●●	●●●
Planning of health manpower			●●	●●●
Relevance of health personnel		●	●●	●●●
Integration of the development of health systems and manpower			●	●●●

The appropriate degrees of importance are indicated in the various columns, from little importance (●) to very important (●●●).
Source: Health manpower requirements for the achievement of Health for All by the Year 2000 through primary health care, p. 24.

The leadership role in primary health care

In the context of health for all, the Expert Committee stated that nurses would be expected “to teach primary health care workers and traditional practitioners many of the functions traditionally performed by nurses themselves, guiding and supporting these personnel (and community leaders) in health promotion, case-finding, disease prevention, individual and family care, community programme development, health education, and curative and related functions”. A further, more demanding, responsibility for nursing and midwifery personnel would be to fulfil the roles usually ascribed to general medical practitioners, including examining the sick and disabled, determining the source of health problems, and treating acute conditions and major preventable diseases in the community.

“Nurses should be able to assume a number of leadership functions in the health team,” the Expert Committee said. **“The challenge is how to harness the potentially powerful force of the nursing group not simply for ongoing activities but for change within the health system”.**¹

¹ Health manpower requirements for the achievement of health for all by the year 2000 through primary health care. Report of an Expert Committee. Geneva: World Health Organization; 1985:45 (WHO Technical Report Series, No. 717).

Nurses assume leadership in health teams

The Expert Committee’s recommendations required a redefinition of the roles of doctors and nurses. It also called for a comprehensive approach (including health promotion, case finding, disease prevention, individual and family care, community programme development and health education, as well as curative and related functions.

In 1980, an overall analysis of nursing in countries in Latin America and the Caribbean indicated what countries needed to do to move ahead (Box II.2).² The list parallels the thinking of all the other WHO regions then and no doubt today.

Persisting challenges

Numerous obstacles continued to plague developments. Many African countries, for instance, had patterns of education and training for nurses that were introduced during the colonial period. In these countries, “where the medical model still prevails, very radical changes in education and training programmes will be necessary”.³ In the countries of the Eastern Mediterranean Region, it

² Report on nursing goals for the decade. Pan American Health Organization Directing Council document CD27/31: 17. Washington (DC): Pan American Health Organization; 1980.

³ The role of nursing and midwifery personnel in the strategy for health for all. Progress report by the Director-General. World Health Assembly document A39/7. Geneva: World Health Organization; 1986:5 (http://apps.who.int/iris/bitstream/10665/162001/1/WHA39_7_eng.pdf, accessed 20 May 2016).

was reported, “nurses have extremely limited contact with other sectors of the community and few nurses in both the developed and developing countries of the Region are familiar with the goal of health for all or even the concept of primary health care”.⁴

A general review of progress in achieving health for all revealed that progress had been slow almost everywhere. By 1986 only a few countries appeared to have taken a comprehensive look at the composition of their health teams at primary health care level, redefining and adjusting their functions and responsibilities accordingly. While some countries had made progress in reorienting and retraining existing health manpower, only a few commanded the necessary technical, financial and material resources “in this period of economic stringency”.⁵ The shortage of nursing personnel remained a major problem in almost all regions. A renewed call for support for nurses to participate in health policies and for their role at the community level was made for which “national and international nursing organizations must provide the leadership”.⁶ Pressure increased on WHO to support nursing and midwifery within the Organization as well as in the Member States.

⁴ The role of nursing and midwifery personnel in the strategy for health for all. Progress report by the Director-General. World Health Assembly document A39/7. Geneva: World Health Organization; 1986:6 (http://apps.who.int/iris/bitstream/10665/162001/1/WHA39_7_eng.pdf, accessed 20 May 2016).

⁵ Evaluation of the strategy for health for all by the year 2000. Seventh report on the world health situation. Geneva: World Health Organization; 1986:47.

⁶ Evaluation of the strategy for health for all by the year 2000. Seventh report on the world health situation. Geneva: World Health Organization; 1986:176.

Box II.2. Enhancing the future role of nurses (1980)

1. Reinforce the health infrastructures with a strong logistical support, particularly in underprivileged areas, in order to provide support for the primary care work of nursing staff and other community health assistants and agents.
2. Increase progressively the number of supervisory posts for nurses and/or to redistribute the existing ones so that the primary care agents are provided with close continuing technical and administrative support, and to make it possible to interconnect the various components of primary care and fit it in to the other levels of the health system and other sectors.
3. Create nurses' aide jobs in sufficient numbers to deliver primary health care, chiefly at the first level of care in rural areas.
4. Bring nurses into the interdisciplinary health groups responsible for planning, standardization and decision-making, to ensure adequate administration of nursing services at all levels.
5. Make the expanded functions of nursing official, in order to obtain backing and support for their work at the national and community levels and in the delivery and/or supplementing of primary care.
6. Examine the current functions of nursing staff in primary care community health programs, to evaluate the impact of their work on improving the delivery of care to the total population of the country, with particular reference to their work in rural and urban fringe areas, and to rework the functions of nurses, stressing strategies that turn out to be correct.
7. Strengthen nursing school curricula on a continuing basis, particularly in the areas of epidemiology, social sciences, community health and primary care, establishing community health as the central focus of the entire curriculum, with the goal of training nurses to work competently in the delivery of primary care.
8. Strengthen the combination of teaching and nursing services, in the basic and continuing education of nursing staff, in order to offer the students dynamic, suitable training, and at the same time contribute to improving the quality of health care.
9. Prepare and test new technologies and teaching materials to make basic nursing education more effective and to train the numbers of teaching staff required to teach and supervise nurses' aides and other community health agents and assistants.
10. Set up an interchange between the countries of the Region to share experiences on the participation of nursing staff in health services extension programs and primary care programs, the obstacles encountered, the tactics adopted to overcome them, and the progress made.

Source: Report on nursing goals for the decade. Pan American Health Organization, 1980.

In 1987, an Inter-country meeting on Nursing and midwifery was held and was attended by the chief nurses and deans of nursing from all the Member States and in 1990, the membership of the Regional Advisory Panel for Nursing was reviewed and a new panel was established. The responsibilities of the panel was to advise the WHO Regional Director on critical issues facing nursing and midwifery and propose interventions to tackle those challenges.¹

KEY OBSERVATIONS

- ✓ Catastrophic shortages of health personnel revealed in many countries
- ✓ More doctors than nurses in several country contexts
- ✓ Hospital oriented education which was not based on community needs
- ✓ Inadequacy in education planning
- ✓ Task analysis and role clarification emphasized
- ✓ Nurses viewed as key to the success of primary health care
- ✓ Multisectoral involvement essential
- ✓ Renewed call for WHO to support nursing and midwifery in WHO and Member States.
- ✓ Leadership role of nurses and midwives appreciated.

¹ Report on the Inter-country meeting on nursing in the Eastern Mediterranean Region. WHO Regional Office for the Eastern Mediterranean Region. Alexandria-Egypt. 1987

A CLEARER VISION OF NURSING AND MIDWIFERY

One of the slogans frequently used in primary health care campaigns was “health for all”, a term used in the Declaration of Alma-Ata which formally launched primary health care in 1978. WHO’s Director-General defined health for all in 1981 in the statement: “Health For All means that health is to be brought within reach of everyone in a given country.” Nurses were key to the effort to reach this goal, with the ICN adopting a plan of action for achieving it. Strong support for the “health for all goal” was expressed by WHO’s governing bodies throughout the 1980s and 1990s, while the WHO global advisory group on nursing and midwifery stressed how, through primary health care, nurses and midwives were making a real difference to the health of persons overlooked by traditional health services.

In the 1980s there were calls to encourage leadership skills among nurses and midwives to prepare them for policy-making roles. WHO and governments sponsored a number of workshops to try to hasten this goal. However, even in the 1990s there was concern that the nursing profession was still not sufficiently involved in health policy-making. There was also growing concern that, in too many places, after nurses obtained their

qualifications they faced unsatisfactory standards of employment. Many of them left their home countries to seek better working conditions abroad. Additionally, there was further concern about the suitability of the education and training provided to nurses and midwives.

WHO headquarters establishes a nursing unit

From the previous sections, it is clear that the importance of nursing and midwifery was explicitly acknowledged within WHO. Nurse consultants provided the much-needed technical support to Member States. In 1992 the World Health Assembly adopted a resolution to strengthen nursing and midwifery in support of Health for All (Resolution WHA45.5). This led to the creation of WHO’s Nursing Unit, located within the former Programme for Development of Human Resources for Health, to coordinate the relevant work of all divisions of the Organization. Activities included the development of information management systems for management of health personnel, development and provision of education and training, intercountry workshops on nursing leadership in health development and research, and funding for research projects on various aspects of nursing services. The unit received particular support for its work through

extrabudgetary funds from Denmark and Sweden. The unit was reorganized and renamed Nursing and Midwifery in 1996 as a crosscutting theme within the Health Systems Development Programme. The same WHA resolution requested the establishment of a global multidisciplinary advisory group on nursing and midwifery to advise the Director-General on all matters pertaining to nursing and midwifery services.¹

The Global Advisory Group on Nursing and Midwifery

Membership of the Global Advisory Group on Nursing and Midwifery was multidisciplinary “in order to bring a range of knowledge and experience in global health needs and health care services to bear on”.² A minimum of 50% of the members were nurses and midwives, and ad hoc members were added as needed by the Director-General. While its membership resembled that of an Expert Committee, the meetings were shorter (3 days instead of a week). Frequently there was broad attendance by WHO regional staff and representatives of NGOs and United Nations agencies. The Advisory Group’s terms of reference included active involvement in the work of the nursing and midwifery programme, namely:

¹ Lee K. Historical dictionary of the World Health Organization. Lanham (MD) and London: The Scarecrow Press; 1998.

² Global Advisory Group on Nursing and Midwifery. Geneva: World Health Organization; 1993: p. 1 (Document WHO/HRH/NUR/93.1; http://apps.who.int/iris/bitstream/10665/60751/1/WHO_HRH_NUR_93.1.pdf, accessed 13 April 2016).

- to guide the development of the Global Agenda for Nursing and Midwifery within the overall health agenda;
- to provide policy advice on how the responsiveness of health systems to peoples' health needs can be optimized through the effective use of nursing and midwifery services that are based on research as scientific evidence;
- to support the development and use of nursing and midwifery outcome indicators in relation to health gains and health status;
- to participate in resource mobilization and efforts for the effective implementation of the Global Agenda for Nursing and Midwifery;
- to collaborate in establishing mechanisms for monitoring the progress of nursing and midwifery contributions to the health agenda and to the implementation of the Global Agenda for Nursing and Midwifery.

The first Meeting of the Global Advisory Group on Nursing and Midwifery

The first meeting of the Global Advisory Group on Nursing and Midwifery took place in Geneva in 1992. The keynote



Dr Hiroshi Nakajima (Japan), former Director-General of the World Health Organization, from 1988 to 1998.

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address was delivered by the then WHO Director-General Dr Hiroshi Nakajima, with Assistant Director-General Dr J.P. Jardel also present. The high-profile attendance showed the importance WHO attached to nursing and midwifery. This first meeting called on WHO to develop **“a clear vision, with associated policies, and strategic directions for nursing/midwifery ... at headquarters, regional, and country levels of WHO”**. It also indicated that the **“workload of Regional Nursing Advisers and the Nursing Unit at HQ must receive realistic consideration, as it is currently impossible to promote all the necessary research and development**

work as well as to provide full assistance in implementing resolution WHA45.5 within each country”¹.

Each session of the Advisory Group added further advice concerning WHO's work. The second session in 1993 proposed that WHO prepare a report outlining the needs and potential benefits for donor support, which could be used as “one of the background documents in a WHO convened donors' meeting to support nursing/midwifery activities globally in the context of serving health for all”.² It also reconfirmed its recommendation that a future World Health Assembly's technical discussions should address “the role of nursing and midwifery in achieving health for all”.³ The third session in 1994 recommended that regional directors should “consider the appointment of a nursing/midwifery committee to coordinate and provide nursing/midwifery input into regional policies on health for all and primary health care, and support the committee with funding”.⁴ The fifth and sixth sessions of the Global Advisory Group were more forthright in their recommendations to the Director-General and, through him, to the regional directors.

¹ Global Advisory Group on Nursing and Midwifery. Geneva: World Health Organization; 1993: p.12 (Document WHO/HRH/NUR/93.1; http://apps.who.int/iris/bitstream/10665/60751/1/WHO_HRH_NUR_93.1.pdf, accessed 13 April 2016).

² Global Advisory Group on Nursing and Midwifery. Geneva: World Health Organization; 1993: p. 8 (Document WHO/HRH/NUR/93.1; http://apps.who.int/iris/bitstream/10665/60317/1/WHO_HRH_NUR_93.5.pdf, accessed 13 April 2016).

³ WHO, 1993. Global Advisory Group on Nursing and Midwifery: Report of the second meeting, Geneva, 8 to 10 November 1993 <http://library.ecsahc.org/items/show/2720> (accessed 13 April 2016).

⁴ Global Advisory Group on Nursing and Midwifery. Geneva: World Health Organization; 1993: p. 33 (Document WHO/HRH/NUR/93.1; http://apps.who.int/iris/bitstream/10665/60991/1/WHO_HRH_NUR_95.1.pdf, accessed 14 April 2016).

For instance, the fifth session¹ in 1997 recommended that:

- WHO should be a role model to Member States in promoting and strengthening nursing and midwifery by increasing the attention and priority accorded to integrating nursing and midwifery input to support for countries at all levels of the Organization.
- WHO should develop one integrated policy document to guide Member States on the reduction of cross-infection and drug resistance and include nursing and midwifery input in its development.
- WHO should convene a key interdisciplinary group of clinicians, educators and ministry leaders to initiate a programme of work to address the reorientation of education of health professional, including the reduction of gaps and overlaps, with the initial focus on nursing/midwifery and medicine.

The recommendations of the sixth session² in 2000 included:

- WHO should develop mechanisms to ensure the input of nursing and midwifery expertise at the earliest

possible phase in the development of policies and programmes at all levels of the organization, and should encourage countries to open up their own policy-making processes to nursing and midwifery inputs.

- WHO should establish mechanisms to inform policy-makers and the public about the impact and contributions of nursing and midwifery services in meeting the health needs of under-served populations and to advocate the use of such services when there is evidence confirming their quality and cost-effectiveness.

The World Health Assembly supported these developments by passing resolution WHA54.12 in May 2001 (Box II.3).

The above resolution was the basis for the development of the *Strategic directions for strengthening nursing and midwifery services 2002–2008*.³ These strategic directions outlined five key strategic areas:

1. Health planning, advocacy and political commitment
2. Management of health personnel for nursing and midwifery services



WHO Strategic Directions for Strengthening Nursing and Midwifery Services 2002–2008 and 2011–2015

3. Practice and health system improvement
4. Education of health personnel for nursing and midwifery services
5. Stewardship and governance.

These strategic directions were later updated as *The strategic directions for strengthening nursing and midwifery 2011–2015*. The later version had slightly modified key result areas but, in particular, partnership and collaboration were emphasized.⁴

These recommendations depended on the willingness of the Member States to follow suit but, at the end of the 20th century, as reported in the Americas,

¹ WHO, 1997. Report of the Fifth Meeting of the GAGNM. Geneva 8–10 April. Geneva, World Health Organization

² Global Advisory Group on Nursing & Midwifery. Report of the sixth meeting. Geneva: 3 World Health Organization; 2001: p. 33 (http://www.who.int/hrh/nursing_midwifery/gag_sixth_report.pdf, accessed 14 April 2016).

³ WHO Strategic Directions for Strengthening Nursing and Midwifery Services 2002–2008. http://www.who.int/hrh/nursing_midwifery/strategic_directions_en.pdf?ua=1 accessed 10 April 2017

⁴ WHO strategic directions for strengthening nursing and midwifery 2011–2015. Available at http://apps.who.int/iris/bitstream/10665/70526/1/WHO_HRH_HPN_10.1_eng.pdf accessed 10 April 2017

Box II.3.
Resolution WHA54 on strengthening nursing and midwifery (2001)

Member States were urged:

1. to further the development of their health systems and to pursue health sector reform by involving nurses and midwives in the framing, planning and implementation of health policy at all levels;
2. to review or develop and implement national action plans for health and models of education, legislation, regulation and practice for nurses and midwives, and to ensure that these adequately and appropriately reflect competencies and knowledge that enable nurses and midwives to meet the needs of the population they serve;
3. to establish comprehensive programmes for the development of human resources which support the training, recruitment and retention of a skilled and motivated nursing and midwifery workforce within health services;
4. to develop and implement policies and programmes which ensure healthy workplaces and quality of the work environment for nurses and midwives;
5. to underpin the above measures through continuing assessment of nursing and midwifery needs and by developing, reviewing regularly, and implementing national action plans for nursing and midwifery, as an integral part of national health policy;
6. to enhance the development of nursing and midwifery services that reduce risk factors and respond to health needs, on the basis of sound scientific and clinical evidence; and,
7. to prepare plans for evaluating nursing services.

The Director-General was requested:

1. to provide support to Member States in setting up mechanisms for inquiry into the global shortage of nursing and midwifery personnel, including the impact of migration, and in developing human resources plans and programmes, including ethical international recruitment;
2. to provide support to Member States in their efforts to strengthen the contribution of nurses and midwives to the health of the populations and to take the necessary measures to increase the number of WHO Collaborating Centres for Nursing and Midwifery in developing countries;
3. to ensure the involvement of nursing and midwifery experts in the integrated planning of human resources for health, including to support Member States undertaking programmes of village skilled birth attendants, by developing guidelines and training modules, as an expanded role of nurses and in particular midwives;
4. to continue to cooperate with governments to promote effective coordination between all agencies and organizations concerned with the development of nursing and midwifery;
5. to provide continuing support for the work of the Global Advisory Group on Nursing and Midwifery, and to take account of the interest and contribution of nursing and midwifery in wider aspects of the development and implementation of WHO's policy and programmes;
6. to develop and implement systems and uniform performance indicators at country, regional and global levels to monitor, measure, and report progress in achieving these goals;
7. to prepare rapidly a plan of action for the strengthening of nursing and midwifery and to provide for external evaluation at the conclusion thereof.

“nursing associations and nurses in universities were actively involved in leadership development, [but] the political will in most Member States in the Region did not yet permit the full participation of nurses in policy formulation”.¹ In Europe it was reported

that “very few countries prepare nurses for executive management and policy planning at the national level”.² In most countries in the Eastern Mediterranean Region nurses were not in senior leadership and management positions and thus were unable to

influence general health-care policy or issues such as salaries, supervision, career development, motivation, work environment and support.³ The other regional offices made similar observations.

1 Document EB89/13. Strengthening nursing and midwifery in support of health for all. Report by the Director-General. Eighty-ninth session of the Executive Board, 20–28 January 1992. Geneva: World Health Organization; 1992.

2 Document EB89/13. Strengthening nursing and midwifery in support of health for all. Report by the Director-General. Eighty-ninth session of the Executive Board, 20–28 January 1992. Geneva: World Health Organization; 1992.

3 Document EB89/13. Strengthening nursing and midwifery in support of health for all. Report by the Director-General. Eighty-ninth session of the Executive Board, 20–28 January 1992. Geneva: World Health Organization; 1992.

Developing nursing and midwifery leadership

It was already clear by the 1980s that progress would greatly depend on developing leaders among nurses and midwives, a direction pursued by WHO with the important collaboration of the ICN. It became even more evident that nurses and midwives needed to be empowered at all levels of the health system to play a leading role in health system reforms. This need has been recognized in many WHO governing body resolutions. In May 1989, for example, resolution WHA42.27 adopted by the Forty-second World Health Assembly urged Member States to “encourage and support the appointment of nursing/ midwifery personnel in senior leadership and management positions and to facilitate their participation in planning and implementing the country’s health activities”. Resolution WHA49.1, adopted in May 1996, urged Member States “to involve nurses and midwives more closely in health care reform and in the development of national health policy”.

The ICN and WHO Collaboration with Governments on the Leadership for Change initiative took place in most Regions with many countries involved. The initiative led to a large cadre of formally trained nurse leaders equipped with the skills to continue training others within their own countries.

Early regional workshops on leadership in nursing were organized, some in collaboration with the ICN and others with the International Nursing Foundation of Japan (INFJ) and the Kellogg Foundation. With funding from the Norwegian Ministry of Foreign Affairs and the W.K. Kellogg Foundation, workshops were held on nursing leadership for health and development in Namibia (national workshop), United Republic of Tanzania (national workshop), Swaziland (with participants from Lesotho, Namibia, Swaziland and Zambia), and Zimbabwe (with participants from Botswana, Tanzania and Zimbabwe).

Somewhat earlier (September 1979) a workshop cosponsored by WHO and the ICN was held in Nairobi to define the role of nurses in the planning and implementation of primary health care. The ICN congress in 1981, attended by 6000 nurses, further promoted awareness of this concept by adopting the theme “Health care for all – Challenge for nursing”. A framework for a plan of action was drawn up through which the member associations of the ICN could effectively promote and support primary health care at national and international levels. Information was gathered on how such associations would collaborate in developing and implementing their countries’ strategies for achieving health for all.

An *International encounter on leadership in nursing for health for all* was held in Tokyo, Japan, 7–11 April 1986. Attended by 30 participants invited from 20 countries from all six WHO regions, one of its objectives was to define strategies to develop and facilitate the leadership role of nursing in directing nursing education and services towards the philosophy and attainment of the goal of health for all.

The conference did not hide from the fact that the “nursing culture is heavy with subordination without influence [and] burdened with obligation without power – even in directing, heading and controlling its own education, practice, research and management”.¹ On the other hand, nurses were said to have always had a strong commitment to social causes and to have shown an acceptance of and a readiness to change. “The very nature of their work gives nurses an enormous advantage,” the conference stated. **“They provide care at all levels and in all settings which give them direct contact with the population. They are frequently the main link between individuals, the family and the rest of the health system and they form the largest sector of health workers in many countries.”**²

¹ Leadership for health for all: the challenge to nursing, a strategy for action. Geneva: World Health Organization; 1987: p. 5 (Document WHO/HMD/Nur/86.1).

² Leadership for health for all: the challenge to nursing, a strategy for action. Geneva: World Health Organization; 1987: p. 10 (Document WHO/HMD/Nur/86.1).

WHO Collaborating Centres for Nursing and Midwifery Development

An important supporting element in WHO's nursing and midwifery programme are the collaborating centres. WHO collaborating centres are institutions, such as research institutes, parts of universities or academies, which are designated by the Director-General to carry out activities in support of the



In 1986, the University of Illinois at Chicago (UIC) College of Nursing was designated as the first World Health Collaborating Centre for Nursing and Midwifery.

Organization's programmes. In line with the WHO policy and strategy for technical cooperation, a WHO collaborating centre also participates in the strengthening of country resources, in terms of information, services, research and training in support of national health development. See Box 1.8 for a summary of the functions of WHO collaborating centres.

As of 2016, 43 Collaborating Centres for Nursing and Midwifery Development were associated with WHO. The first Collaborating Centre was established in 1986 at College of Nursing of the University of Illinois, Chicago, USA. In 1988, the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development was established. The Global Network of WHO Collaborating Centres for Nursing and Midwifery Development is an independent, international, not-for-profit, voluntary organization. The First Global Network of WHO Collaborating Centers

for Nursing and Midwifery Conference 'was held in Bahrain in March 1996 under the theme "Nurses and Midwives: Making a Difference". The secretariat of the Global Network is decided on by vote and changes every four years. The first secretariat was the University of Illinois at Chicago, College of Nursing, USA; the current one is the University of Technology, Sydney, Faculty of Health, Australia. An important initiative, taken by the University of São Paulo at Ribeirão Preto, College of Nursing, Brazil, was the project *Revisiting the history of the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development* which was initiated during this collaborating centre's term as secretariat from 2008–2014. An archive was created to house the minutes of all meetings since the formation of the network and has been maintained by subsequent secretariats.

Further examples of the supporting work of NGOs and collaborating centres are provided in the sections that follow.

Box 1.8. Functions of WHO Collaborating Centres for Nursing and Midwifery Development

The functions of the WHO collaborating centres are diverse, and may include the following:

- collection, collation and dissemination of information;
- standardization of terminology and nomenclature, of technology, of diagnostic, therapeutic and prophylactic substances, and of methods and procedures;
- development and application of appropriate technology;
- provision of reference substances and other services;
- participation in collaborative research developed under the Organization's leadership, including the planning, conduct, monitoring and evaluation of research, as well as promotion of the application of the results of research;
- training, including research training; and
- the coordination of activities carried out by several institutions on a given subject.

Source: Basic documents, Forty-eighth edition. Geneva: World Health Organization; 2014.

KEY OBSERVATIONS

- ✓ The fourth and fifth sessions of the Expert Committee recommended WHO to support nursing research for practice, policy and education
- ✓ Awareness of the technical expertise of WHO collaborating centres for nursing and midwifery development in generating and contributing to nursing and midwifery research
- ✓ 1986 establishment of the first WHO Collaborating Centre for Nursing and Midwifery at the College of Nursing of the University of Illinois, Chicago, USA.
- ✓ In medicine, research was an integral part of practice unlike in nursing, which was a disadvantage.
- ✓ Establishment of the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development to enhance networking and communication.

Capacity-building for nursing and midwifery leadership in Africa

Where nurses were not given an opportunity to gain satisfactory employment after qualifying, they became “marketable products”, contributing to the increasing international mobility of health professionals. Career structures needed to be established that allowed nurses the flexibility to be innovative in their everyday work and to exercise leadership.

In intercountry workshops in Zimbabwe (November 1991) and Swaziland (April 1992), a “learning

by doing” approach was adopted in which participants were encouraged to “take leadership responsibilities in order to generate the interactive group process needed to fulfil the objectives of the workshop”.¹ In the final phase of the workshops participants worked in country teams to formulate country team action plans. The group representing Botswana concentrated on developing approaches designed to strengthen collaboration between nurses and other important elements of the Botswana’s society, including the Ministry of Local Governments and Lands, the Ministry of Home Affairs and the Ministry of Agriculture.

The Swaziland workshop explored the place of nurses in society using Figure II.1 as a conceptual model. This led to several points agreed upon by all discussion groups:

- The development of nursing, as part of the history of a country, affects the way that nurses currently practice, as do the social, economic, political and cultural expectations of that country. Most nurses are women, and the status of women in a society will impact on the status of nurses in that society.
- Many factors influence the work of nurses, both as individual practitioners and as part of a team. Clearly the organization of the health services in which a nurse is practising will

shape to some extent the nature of that practice, but in turn the health services are inevitably influenced by the demography and epidemiology of an area such as HIV and AIDS. There are pressures and influences which shape and perhaps sometimes limit or extend the work of nurses. **Effective leadership demands that nurses are aware of these influences, and are able to have a vision for themselves: to see where they are going.**

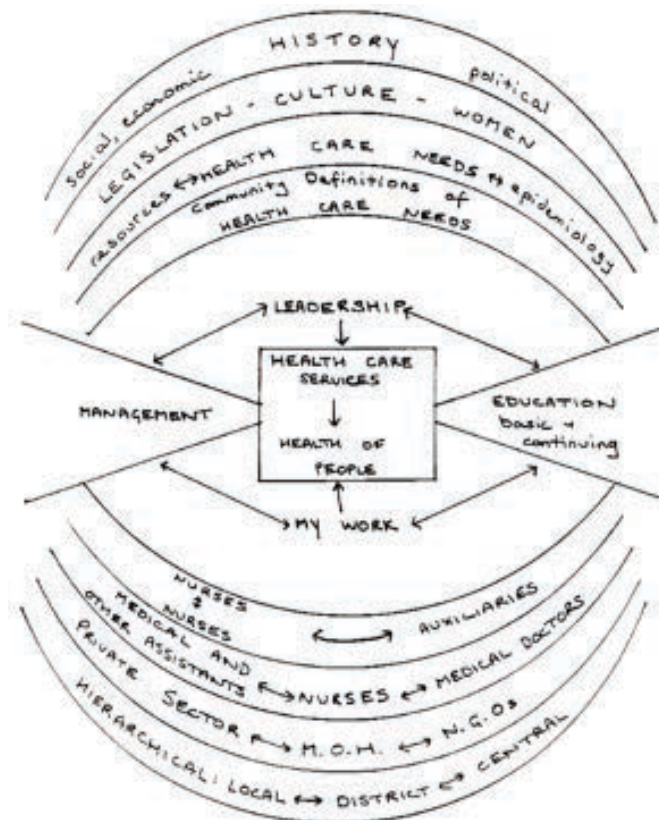
A diagram developed by the last nursing Expert Committee (1996) illustrates many of these same factors that influence both nursing and midwifery practice (Figure II.2).

Capacity-building for nursing and midwifery leadership in Europe

WHO’s European Regional Office took steps to enhance the leadership role of nurses and midwives as part of its programme related to *Health21 – Health for all in the 21st century*, which was approved by the Region’s 51 Member States in September 1998. This programme was the focus of the Seventh Meeting of Government Chief Nurses of the European Region that took place in Helsinki, Finland, in December 1999, with the aim of identifying, articulating and strengthening the nursing and midwifery contribution to *Health21*’s 21 targets and public health agenda.

¹ Report of a workshop on women in health: nursing leadership for health and development, Kadoma, Zimbabwe, 13–20 November 1991. Geneva: World Health Organization; 1992: p. 3 (Document HRH 92.10).

Figure II.2.
The broad range of factors influencing nursing and midwifery practice



A draft template for the identification and, where possible, measurement of the contribution of nursing and midwifery to the 21 targets of *Health21* was reviewed along with an exploration of how to move from the concept of the family health nurse as outlined in *Health21* to “the reality of implementation of the new role”.¹ These discussions were seen as a prelude to the Munich conference in 2000 where the *Munich Declaration – the*

point of departure was adopted.² This declaration stressed the belief that nurses and midwives have key and increasingly important roles to play in society’s efforts to tackle the public health challenges of our time, as well as in ensuring the provision of high-quality, accessible, equitable, efficient and sensitive health services which ensure continuity of care and address people’s rights and changing needs.

¹ Primary Health Care 21: “Everybody’s Business”: consensus statement of the meeting : an international meeting celebrating 20 years after Alma-Ata, Almaty, Kazakhstan, 27–28 November 1998. Copenhagen: WHO Regional Office for Europe; 1999: p. 2 (Document EUR-ICP-DLVR 06 01 02S).

² Munich Declaration—nurses and midwives: a force for health. *Intensive Crit Care Nurs.* 2000 Aug;16(4):207–8.

In November 2000, the ICN invited the Global Network of WHO Collaborating Centres for Nursing and Midwifery to a meeting on *Nursing leadership in the new millennium: envisioning the future*.³ Key trends, challenges and issues in the coming decade were analysed in society, governments, health, nursing and midwifery, and NGO governance and management. A common goal for nursing and midwifery was agreed on, namely: “global health based on cooperative nursing and midwifery leadership, and partnership, evidence and ethics in policy, workforce, and education.”

Capacity-building for nursing and midwifery leadership in Western Pacific

In 2004, WHO’s Western Pacific Regional Office established a regional leadership group for building capacity and leadership development with chief nursing and midwifery officers in the South Pacific. An Alliance of nursing and midwifery leaders was formed in 2006, with the WHO Collaborating Centre at the University of Technology Sydney acting as Secretariat since 2008. The South Pacific Chief Nursing and Midwifery Officers’ Alliance (SPCNMOA) vision is “Effective partnerships and coordinated approaches for strengthening nursing and midwifery to improve Pacific health in an equitable and sustainable manner.”

³ Meeting Report: “Nursing leadership in the new millennium: envisioning the future”, Miami, November 29 & 30, December 1, 2000

The SPCNMOA has participation from 15 countries in the region. More recently, membership has expanded to include lead regulators and educators from member countries. This allows capacity building across the region and across sectors, with members becoming more involved in global HRH debate/strategy. Since 2004 the SPCNMOA has met every two years to bring together senior leaders in regulation, education and chief nursing/midwifery officers to update, discuss and plan effective programs for the Pacific in Regulation, Education, Legislation and Service Delivery.

Reorienting education and training to support primary health care

Each of the events highlighted above recognized the central importance of training and education.

The International encounter on leadership in nursing for health for all, held in Tokyo, Japan, in 1986, called for the restructuring of educational programmes which, in turn, would require more teachers with the appropriate grounding in primary health care, supported by a curriculum fully oriented to the philosophy of primary health care. A quantum shift was needed to bring these changes about, especially among government policy-makers who resisted nursing leadership development.

An analysis by the Pan American Health Organization called for (1) strengthening

of nursing school curricula on a continuing basis, particularly in the areas of epidemiology, social sciences, community health and primary care, establishing community health as the central focus of the entire curriculum, with the goal of training nurses to work competently in the delivery of primary care, and (2) strengthening of the combination of teaching and nursing services in the basic and continuing education of nursing staff in order to offer the students dynamic, suitable training, and at the same time contribute to improving the quality of health care.

The ministers who adopted the Munich Declaration proposed the development of (1) improved initial and continuing education, and access to higher nursing and midwifery education, and (2) opportunities for nurses, midwives and physicians to learn together; to ensure more cooperative and interdisciplinary working in the interests of better patient care, and as prerequisites for action.

A guide to curriculum review for basic nursing education oriented to primary health care and community health was published in 1985. This aimed “to provide information about the concepts and processes essential in developing a basic nursing education programme oriented towards primary health care and community health; to propose a methodology for reviewing existing programmes so as to identify the changes needed; to stimulate ideas for planned progressive change in nursing education

in the direction of the health care of individuals, families, and groups in the community”.¹

The guide presented concepts and experiences calculated to make nurses more aware of the larger health needs of the community and to increase their ability to help satisfy these needs. It was addressed primarily to heads of programmes and teachers in basic nursing education programmes who were expected to be the primary users, but also to the authorities concerned with professional education and personnel responsible for manpower planning, and to administrators and supervisors of health services.

What was needed was a critical review of the existing programme followed by a planned progressive modification of the curriculum so that nursing graduates could: provide preventive, curative, and rehabilitative care to individuals, families, and groups within the community; extend primary health care to all sections of the community; train and supervise health workers in primary health care at the community level; work effectively with health teams; and collaborate with other sectors concerned with socioeconomic development.

The progress report presented to the 89th session of the Executive Board in January 1992, while indicating that nursing curricula were being reoriented

¹ A guide to curriculum review for basic nursing education. Orientation to primary health care and community health. Geneva: World Health Organization; 1985: p. 5.

to primary health care and that there was a move towards higher education, identified three major challenges. These were: (1) to educate in their clinical subject areas – in theory and practice, and in educational methodology – a sufficient number of nursing/midwifery teachers competent in primary health care; (2) to develop teaching/learning resources responsive to changing epidemiology, language and cultural needs; and (3) to develop learning facilities (e.g. schools and field practice sites).

The approaches adopted by each regional office were specific to the immediate needs of the Member States in their region. What follows is a sampling of their activities.

The WHO African Region

In the 1992 progress report prepared for the WHO Executive Board, the Regional Office for Africa reported that many countries – including Angola, Botswana, Cameroon, Congo, Guinea-Bissau, Rwanda, Senegal and Zaire (now the Democratic Republic of Congo) – were making efforts to adapt education to their needs. With the support of the Division of Family Health at WHO headquarters, in-service training modules for nursing and midwifery staff were developed and were field-tested in Botswana and the United Republic of Tanzania.

The WHO Eastern Mediterranean Region

The nursing shortage in the WHO Eastern Mediterranean Region was difficult to ascertain due a general lack of valid and reliable information about the nursing workforce in national health systems. Governments were encouraged to establish databases and registration systems for nursing personnel and consultants were made available to help them undertake a nursing manpower study, including a survey of utilization of nurses in various health-care settings.

During 1989, WHO consultants, fellowships and local training activities were made available to various Member States (e.g. Bahrain, Pakistan, Somalia and Yemen) in order to strengthen teachers' capabilities, to revise existing curricula and to develop new ones.

The regional strategy for nursing and midwifery development in the Eastern Mediterranean Region, published in 1997, was widely distributed. By the end of the decade over 60% of countries had addressed this strategy.

The WHO European Region

The WHO European Region brought together a group of experts in 1996 to map a way forward for the education of nurses and midwives in Europe. This group agreed on a draft strategy; a timetable for consultation, finalization and subsequent publication and promotion;

and a sample framework to guide each country's analysis and approach to implementation. The strategy built on the work of the WHO LEMON (Learning Materials On Nursing) project, which was originally oriented to countries of central and eastern Europe and which aimed to provide countries with a lead in preparing nursing and midwifery for excellence in practice and service delivery at a cost that each country could accommodate.

The LEMON project emerged in the early 1990s to address the problem of the lack of quality training and educational materials in local languages and the expense of translating existing literature into those languages. During the five years of the project, many countries translated the 12 chapters of the LEMON package and had them printed and published. In many countries this was the first time that nurses were introduced to the art and science of nursing, thereby serving to facilitate "a movement away from the traditional medical model and physician's role".¹

The WHO South-East Asia Region

In South-East Asia, assistance in the upgrading of teachers and managers of nurses continued through fellowships for advanced studies or specialty training in educational methods, management, or clinical nursing specialties, both within and outside the countries, in Bangladesh, India, Nepal and Sri Lanka. The baccalaureate

¹ Second workshop on monitoring of the learning materials on nursing. Report on a WHO meeting, Maribor, Slovenia, 7–10 November 1998: p. 5 (http://apps.who.int/iris/bitstream/10665/108157/1/EUR_ICP_DLVR_02_02_03.pdf, accessed 14 April 2016).

(S-I) programme in Indonesia steadily increased the strength of its full-time nursing faculty, while ensuring ongoing opportunities for faculty and staff development.

Support was given to initiatives, such as community-based team training in Nepal, and the model field practice areas in Indonesia, as well as to further development of self-learning modules as part of a distance learning initiative for upgrading the knowledge and skills

of auxiliary nursing personnel in remote areas of Indonesia. A critical appraisal of the use of distance education for nursing and other health personnel was carried out at the regional level.

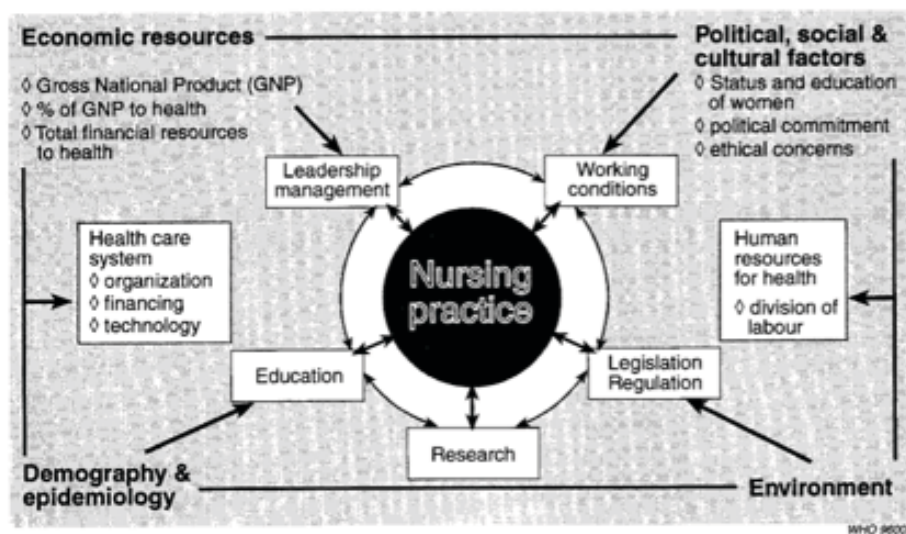
The strengthening of nursing services, especially for the development of referral systems for primary health care, was promoted through improved training of nursing personnel in Bhutan, through the development of hospital nursing guidelines and a research study on

hospital nursing services for improving the quality of nursing care in Indonesia, and through re-examination of nursing regulatory mechanisms in India. Increasing emphasis was given in other countries to strengthening nursing skills in priority specialty areas, through in-country and regional training courses.

In Myanmar, efforts were made to strengthen nursing services at central and state/division levels through the formulation of long-term development plans for nursing education and services, including a nursing procedures manual, nursing care standards, staffing patterns and job descriptions for nursing personnel.

Figure II.3.
The forcefield for nursing practice, as conceived by the WHO Expert Committee on Nursing Practice, 1996

The forcefield for nursing practice



The forcefield for nursing practice consists of all elements that influence nursing practice in whatever situation it is carried out. Economic resources, demography and epidemiology, environment, and political, social and cultural factors have an overall impact on nursing practice, not least through the health care system itself (its organization, financing and technology) and through human resources for health (particularly the division of labour). In addition, nursing practice is specifically influenced by education, leadership and management, working conditions, legislation and regulation, and research. The double arrows indicate where, through the comprehensive approach to the development of nursing practice proposed by the Expert Committee, nursing practice can – and should – have its own input into the elements that affect it.

Progress was made in improving hospital and district-level nursing services in Nepal, in the areas of nursing skills and infection control measures, through in-service education of nursing personnel in five regions, using manuals developed with WHO assistance. Support was also provided to the Division of Nursing for the development of the national programme for training of maternal and child health (MCH) workers and for systematic training of traditional birth attendants (TBAs) throughout the country.

Having successfully conducted the regional training programmes on community health nursing, critical care nursing, and midwifery education for safe motherhood in 1997, similar training programmes were organized again at four nursing and midwifery educational institutes in India, Sri Lanka and Thailand.

The programme from September 1998 to April 1999 was attended by 30 participants from the region.

The WHO Western Pacific Region

A course on curriculum development for community-oriented nursing practice was organized for 12 senior nurse educators in collaboration with the WHO Regional Office for the Western Pacific and the WHO collaborating centre at the University of the Philippines, Manila. In addition, a list of relevant materials was distributed to over 80 nursing schools in all of the Member States of the region. The development of Nurse Practitioners (similarly titled advanced practice nurses) in the western pacific region was quite significant during this time. It was aimed at addressing PHC coverage and workforce shortages in remote rural areas of Member States, islands and atolls including the Republic of Korea; Republic of Fiji; Republic of Kiribati; Republic of Vanuatu, Independent State of Samoa, Cook Islands etc.

KEY OBSERVATIONS

- ✓ The Global Advisory Group on Nursing and Midwifery established by World Health Assembly resolution WHA45.5
- ✓ Resolution WHA54.12 sets the stage for the WHO Global Action Framework on Nursing and Midwifery
- ✓ More emphasis on nursing and midwifery leadership in primary health care
- ✓ Nurses' limited practice skills noted.

EXPANDING THE ROLES OF NURSES AND MIDWIVES

As the 20th century drew to a close, the number of health areas in which nurses were involved was growing considerably. And with each new area of interest – whether family health, HIV/AIDS, home care, mental health, occupational health, emerging diseases or some other important health concern – there was an increased opportunity (or even necessity) for specialization. Nurses were active in epidemiology, family planning, in care of tuberculosis or malaria patients, and also in the conduct of research on a number of nursing-related topics. WHO's governing bodies supported this trend, though generally accompanied their words of support with clear calls for more and better education and training of nurses and midwives.

In addition to promoting leadership of nurses and midwives in the pursuit of health for all, and supporting basic training of nurses and midwives, efforts were undertaken to expand the roles of nurses and midwives in specific programmes, as called for by the Global Advisory Group on Nursing and Midwifery and the WHO Executive Board.

In 1996, the WHO Expert Committee on Nursing Practice developed a concept for analysing the environment in which nursing practice takes place, as illustrated in Figure II.3.



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A progress report presented to the 89th session of the WHO Executive Board in January 1992 urged “that the contribution of nursing care to the provision of health services ... be acknowledged and valued”, especially as nursing skills are crucial to effective and efficient health-care services in four major areas: preventive care, curative care, chronic and rehabilitative care, and high-dependency care and care of the dying.

Preventive care:¹ Although health promotion and disease prevention – through work with communities and efforts to influence individual and family lifestyles – are not the prerogative of any one profession, they are an integral part of the work of nurses and midwives. In many countries, nurses and midwives are the primary caregivers in communities, in particular to the most vulnerable populations, such as the urban poor;

¹ Document EB89/13. Strengthening nursing and midwifery in support of health for all. Report by the Director-General. Eighty-ninth session of the Executive Board, 20–28 January 1992. Geneva: World Health Organization; 1992.

those in remote rural areas, mothers and children, the elderly, and those with chronic diseases. Nurses and midwives also have a crucial role in reducing neonatal and maternal mortality and preventing birth-related complications.

Curative care:¹ As the front-line workers in many countries, community/public health nurses or nurse practitioners diagnose and treat a wide range of common health problems. Globally, however, the majority of nurses work in all levels of hospitals, where the need for care is growing. Advanced medical technology in hospitals at the tertiary level makes highly skilled nursing care crucial to the survival and recovery of the patient.

Chronic and rehabilitative care:² Increasingly nurses see themselves, besides actively meeting the professionally-defined needs of passive patients, as facilitators who enable people to participate actively in their own care and health development. This is of crucial importance in working with the chronically ill and the elderly, who must learn new ways of self-care in order to be able to manage symptoms and often complex medical regimens, involving medication, treatment, diets and exercises. Teaching and care are needed

to ensure for them and their families an optimal quality of life. Nurses also assume major responsibility in the area of mental health, from work in schools and communities to caring for acutely disturbed patients, rehabilitation of the chronically mentally ill and guidance or support to families.

High-dependency care and care of the dying:³ A growing number of severely physically and mentally impaired persons survive for many years in a state of complete dependency (e.g. infants with severe birth defects or congenital diseases who live to adulthood, or old people with dementias). This leads to a rapidly growing need for home care, support to family caregivers, and institutional care. In addition, the AIDS pandemic has multiplied the need for nursing care of the severely ill and dying. Again, families and communities need guidance and support in managing the disease and living with its consequences (e.g. cumulative grief, and the needs of family caregivers and orphans).⁴

Some of these efforts were globally driven (e.g. those concerned with human reproduction and epidemiological surveillance), while others were driven by regional initiatives such as the WHO Europe Regional Office's efforts to

expand the role of nurses in occupational health. What follows is an amalgam drawn from different sources. It is meant to be more representative than complete. Further examples are given in Part III.

Family health

A field manual for neonatal tetanus elimination was prepared in 1999 which envisaged a role for trained birth attendants to record home births, and to copy the information from their logbook into a vital events registry if one had been established for the area.⁵ Midwife supervisors were expected to identify problems with clean delivery and cord care practices and to use their contacts with the community to evaluate women's awareness of the importance of such practices, as well as to help evaluate the effectiveness of health education efforts aimed at improving their awareness.



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¹ Document EB89/13. Strengthening nursing and midwifery in support of health for all. Report by the Director-General. Eighty-ninth session of the Executive Board, 20–28 January 1992. Geneva: World Health Organization; 1992.

² Document EB89/13. Strengthening nursing and midwifery in support of health for all. Report by the Director-General. Eighty-ninth session of the Executive Board, 20–28 January 1992. Geneva: World Health Organization; 1992.

³ Document EB89/13. Strengthening nursing and midwifery in support of health for all. Report by the Director-General. Eighty-ninth session of the Executive Board, 20–28 January 1992. Geneva: World Health Organization; 1992.

⁴ Document EB89/13. Strengthening nursing and midwifery in support of health for all. Report by the Director-General. Eighty-ninth session of the Executive Board, 20–28 January 1992. Geneva: World Health Organization; 1992.

⁵ Field manual for neonatal tetanus elimination. Document WHO/V&B/99.14. Geneva: World Health Organization; 1999.

The Regional Committee for Africa examined the role of nursing and midwifery personnel in the epidemiological surveillance of patients.¹

It recommended the strengthening of their role to make up for the scarcity of doctors and epidemiologists, especially in the districts.

Self-instructional modules were developed for improving teaching on diarrhoea in medical and nursing schools, and for assessing and improving the prescribing practices of private pharmacists and drug sellers. The widely-used household survey manual on diarrhoeal diseases was revised to include questions on acute respiratory infection and breast-feeding practices. Two pilot projects in Thailand and Turkey trained midwives and nurses to provide clinical family planning services hitherto provided only by physicians. In Thailand, the pilot project showed that operating-room nurses could be trained to perform postpartum tubal ligations as competently as surgeons, and with equally low morbidity rates.

In Europe, the health policy framework for the WHO European Region introduced the family health nurse as a health worker capable of making a contribution in a multidisciplinary team of health-care professionals.²

HIV/AIDS

During 1989, an AIDS training strategy was developed for maternal and child health and family planning service providers.³ Various information booklets about AIDS and family planning were also developed.

In response to the AIDS pandemic, management of home-based care was promoted and developed. For example, in Uganda and Zambia, nurses made home visits, provided medicines, diagnosed and treated opportunistic infections, gave advice and tried to meet the needs of orphans. Public health nurses in Botswana and Zimbabwe provided integrated care, including family planning, antenatal care, child health maintenance and immunizations.

Home-based care

Home health care, particularly for the elderly, became increasingly popular in several countries in the Western Pacific Region as an economic and humane alternative to hospital care.⁴ China continued to strengthen and implement its home-based patient care system as part of the urban health care infrastructure. Japan completed a study showing how home health care has been provided by the nursing services of municipal health

authorities and by public and private hospitals and clinics.⁵ However, it became apparent that the quality of these services and their cost-effectiveness needed urgent attention as the years went by. With WHO collaboration, the Republic of Korea started a home nursing service organized by large hospitals and health centres.⁶ The public sector made increasing use of such services for the poor in urban and rural areas. A model curriculum for a home nursing practitioners' course was also developed.

The subject of home-based long-term care was addressed by a Study Group that met in December 1999. It listed the key elements of such care, as described by the Study Group, are listed in Box II.4.

Malaria control

The growing resistance of malaria parasites to antimalarial drugs called for a more careful assessment of the therapeutic efficacy of these medicines for the treatment of uncomplicated falciparum malaria. Workshops in which nurses participated were held in Indonesia in late 1998 with the aim of familiarizing participants with the WHO protocol to be used for carrying out this assessment.

¹ Forty-third Session of the WHO Regional Committee for Africa: Final Report. AFR/RC43/27.

² World Health Organization. Regional Office for Europe. The family health nurse: context, conceptual framework and curriculum. 2000 (EUR/00/5019309/13)

³ Report of the thirty-eighth session of the WHO Regional Committee for Africa, 1988.

⁴ The Work of WHO in the Western Pacific Region, 1 July 1991–30 June 1993, WPR/RC44/3 Page 30.

⁵ The Work of WHO in the Western Pacific Region, 1 July 1991–30 June 1993, WPR/RC44/3 Page 30.

⁶ The Work of WHO in the Western Pacific Region, 1 July 1991–30 June 1993, WPR/RC44/3 Page 30.

Box II.4. Elements of home-based long-term care

- Assessment, monitoring, and reassessment
- Health promotion, health protection, disease prevention postponement of disability
- Facilitation of self-care, self-help, mutual aid, and advocacy
- Health care, including medical and nursing care
- Personal care, e.g. grooming, bathing, meals
- Household assistance, e.g. cleaning, laundry, shopping
- Physical adaptation of the home to meet the needs of disabled individuals
- Referral and linkage to community resources
- Community-based rehabilitation
- Provision of supplies (basic and specialized), assistive devices and equipment (e.g. hearing aids, walking frames), and drugs
- Alternative therapies and traditional healing
- Specialized support (e.g. for incontinence, dementia and other mental problems, substance abuse)
- Respite care (at home or in a group setting)
- Palliative care, e.g. management of pain and other symptoms
- Provision of information to patient, family, and social networks
- Counselling and emotional support
- Facilitation of social interaction and development of informal networks
- Development of voluntary work and provision of volunteer opportunities to clients
- Productive activities and recreation
- Opportunities for physical activities
- Education and training of clients and of informal and formal caregivers
- Support for caregivers before, during, and after periods of caregiving
- Preparation and mobilization of society and the community for caring roles

Source: Study Group on home-based long-term care, 1999.

Emerging and reemerging infectious diseases and antimicrobial resistance

Emerging and reemerging infectious diseases and antimicrobial resistance led PAHO to develop a regional plan of action in 1995¹ to provide guidance to Member States in addressing specific problems, and in implementing regional

and subregional measures to prevent and control these diseases.² One element of the plan was for each country to develop a national team to detect and report on outbreaks. These teams were multidisciplinary and included an epidemiologist, laboratory scientist, nurse, disease/emergency specialist, armed forces health representative, and a social communicator.

The need for further research on nursing and midwifery

Nursing and research were considered together in WHO's sixth GPW (1978–1983), which stressed the need to study how health teams work and collaborate, emphasized the importance of continuing education for all types of health personnel (Box II.5).

Regional reports concerning progress in this area began to be published in the 1980s. The emphasis on research was part of wider efforts to upgrade educational standards and reorient the entire educational process for nurses. A survey of South-East Asian countries revealed that in India and Thailand a considerable number of research studies had been undertaken, the “majority of these by students in graduate-level nursing programmes to provide them with the opportunity to develop beginning research skills”.³

The importance of promoting research in nursing, and its role in the improvement of health care in general and nursing in particular, was underscored during the 15th session of the South-East Asia Regional Advisory Committee on Health Research (ACHR) in Indonesia in June 1989.⁴ One of the recommendations of this meeting related

¹ Pan American Health Organization, New, emerging, and re-emerging infectious Diseases. Washington, DC: PAHO; 2 August 1995 (Document CD38/17)

² The role of nursing and midwifery personnel in the strategy for health for all. Progress report by the Director-General. World Health Assembly document A39/7. Geneva: World Health Organization; 1986 (http://apps.who.int/iris/bitstream/10665/162001/1/WHA39_7_eng.pdf, accessed 20 May 2016).

³ Research on nursing. Agenda item 9, WHO South-East Asia Advisory Committee on Health Research, fifteenth session. Document SEA/ACHR/15/1/Rev.1. New Delhi: WHO South-East Asia Advisory Committee on Health Research; 1989:p. 5.

⁴ WHO South-East Asia Advisory Committee on Health Research. Report to the Regional Director on its fifteenth session. SEA/ACHR/15.

Box II.5. Continuing education for health personnel (1978)

An increasing number and growing diversity of professions working together in teams are required for health promotion and maintenance. These include such diverse types as epidemiologists for both communicable and noncommunicable disease control; laboratory scientists, technicians and administrators; scientists and technical manpower for drug production; environmental engineers and auxiliary environmental health personnel; food control technologists and auxiliaries; medical, nursing, other professional personnel and auxiliary personnel, with appropriate skills and attitudes for various functions within the general health services and in particular for the provision of primary health care; various clinical specialists and technicians; mental health personnel; a wide variety of scientific personnel for biomedical research; and specialists in the planning, management and evaluation of health services. It will therefore be necessary to intensify the study of health teams, including such aspects as their composition in various national and local contexts, their basic and continuing training, the promotion of collaborative teamwork between different types of health personnel of different educational levels and the implications for career structures. It is important to formulate programmes for the basic and continuing education of all types of health personnel in a coordinated manner, using appropriate educational processes, even if the subject matter to be learned varies widely from profession to profession.^a

^a Storey M, Roemer R, Mangay-Maglacas A, Piccard E. Guidelines for regulatory changes in nursing education and practice to promote primary health. Document WHO EDUC 88.194. Geneva: World Health Organization; 1988:7.

Source: Nursing beyond the year 2000. Report of a WHO Study Group. Geneva: World Health Organization; 1994 (WHO Technical Report Series, No. 842).

Box II.6. A selection of the Study Group's specific recommendations to WHO

1. Develop (with WHO collaborating centres and other institutions) collaborative research, facilitate the exchange of relevant research findings, develop strategies to utilize the findings of research in practice and policy, collect and evaluate models of nursing development, and share successful models across.
2. Encourage development of an international multidisciplinary project that:
 - a. Identifies the core competencies in health and social sciences that are common to all health professions (e.g. ethics, communication, research, consultation skills, teaching skills);
 - b. Identifies the unique competencies for each profession;
 - c. Examines the implications of these findings for the education of the different health professions.
3. Make a commitment to include nursing and midwifery care in special initiatives (e.g. safe motherhood, the sick child, urban health, sustainable development) and should monitor progress towards this goal;
4. Act as a catalyst by working with Member States and donors to include nursing and midwifery issues in relevant health systems research and to seek needed funds for such research.

Source: Nursing beyond the year 2000. Report of a WHO Study Group. Geneva: World Health Organization; 1994 (WHO Technical Report Series, No. 842).

to the use of WHO collaborating centres in nursing and the formation of national task forces/study groups as mechanisms for the development of research in nursing within the framework of health-related research in the countries. The

formation of these national groups was supported in India, Indonesia and Thailand.

A WHO Study Group on Nursing beyond the Year 2000 met in July 1993 to give

direction and advice on how best to meet the challenges of the next century, and to provide a clearer perspective on the role of nursing and midwifery in promoting health and health services beyond the year 2000. The report of the Study Group¹ discussed current global issues (population growth and demographic transition, infectious and parasitic diseases, and health needs of women and children and the concept of vulnerability), before examining trends in nursing and midwifery in terms of the role of nurses and midwives, implications for practice, implications for education, as well as implications for research (Box II.6).

Research promotion and development continued to receive priority attention in WHO collaborative programme in the region. The eighteenth session of the South-East Asia ACHR, held in April 1992, reviewed progress in implementing the regional research promotion and development programme.² After an intercountry consultation on research in nursing held in 1991, research protocols relating to the delivery of nursing and midwifery services were developed at the International Workshop on Nursing Research in Primary Health Care held the same year.

In accordance with World Health Assembly resolution WHA45.5, a subcommittee of the ACHR reviewed research-related plans and activities of

¹ Nursing beyond the year 2000. Report of a WHO Study Group. Geneva: World Health Organization; 1994 (WHO Technical Report Series, No. 842).

² Report to the Regional Director on its eighteenth Session: WHO South-East Asia Advisory Committee of Health Research, SEARO, New Delhi, 20-24 April 1992.

the Nursing Unit in 1994. This included ongoing activities in: the development of an Information System for Management of Health Personnel, and initiatives of health research relating to nursing and methodology development. After reviewing these proposals, the ACHR, at its 32nd session in October 1994, recommended that the programme should continue research on issues addressed in the Nursing Personnel Resources Survey, develop nursing research concepts grounded in the realities and cultures of developing countries, assign WHO fellowships to prepare nurses in health services research and strengthen the research competence of headquarters and regional nursing units.¹

Research and nursing formed an important part of the discussions of the 1999 meeting of the Expert Committee on Nursing Practice. It noted that some countries had established nursing practice development units that offered “opportunities to evaluate the processes and outcomes of nursing practice, the application of new skills and knowledge, the implementation of care based on research results, and innovation in nursing”. It considered that **“countries should explore the possibility of establishing one or more nursing development units”**,² for which a “wealth of literature”³ was available.

¹ Report on meeting of the global Advisory Committee on Health Research (ACHR): research policy and strategy. Report by the Director-General. Executive Board document EB95/35. Geneva: World Health Organization; 1994.

² Nursing practice. Report of a WHO Expert Committee. Geneva: World Health Organization; 1996:21 (WHO Technical Report Series, No. 860).

³ Shaw JT. Nursing development units: a way to develop nurses and nursing. London:

More research concerning nursing and midwifery care was being carried out than ever before. The reasons for this were many, but most important was the leading role played by the nursing and midwifery collaborating centres in promoting and conducting research studies. Links with academia built up gradually but today there are over 40 WHO Collaborating Centres for Nursing and Midwifery Development and the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development helps to enhance communication, information dissemination and networking.

Notable examples of successful cooperation with WHO collaborating centers include the following.

WHO developed an eye health indicator catalogue which has been used in Burkina Faso, Gabon and Zimbabwe.⁴ It also supported capacity-building in 19 countries on the application of WHO tools to evaluate needs and gaps in eye health professionals. Niger used the tool for training. Botswana was supported to include eye health as part of the standard nursing and midwifery curricula.

A simple life-saving procedure is the use of checklists, such as the one advocated in WHO’s Safe Surgery Saves Lives

initiative.⁵ Striking results had already been achieved with checklists, notably in Michigan, USA, where a state-wide initiative sought to reduce catheter-associated bloodstream infections by instituting a short checklist. Among other things, the checklist empowered nurses to ensure that doctors were following procedure. Bloodstream infections across the participating intensive care units dropped to 1.4 per 1000 days of catheter use, less than 20% of the rate before implementation, saving an estimated 1800 lives over four years.⁶

The collaborating centres demonstrated increased involvement, particularly in capacity-building (e.g. training by Jordan of nurse educators in the Syrian Arab Republic). WHO’s Regional Office for Africa provided support to the University of South Africa in publishing the first African journal for nursing and midwifery researchers in the region.⁷

Collaborative community action research projects were developed between Korean and Thai universities, while in Scotland research on the family health nurse was developed under the aegis of the WHO Regional Office for Europe.⁸

Kings Fund Centre; 1993.

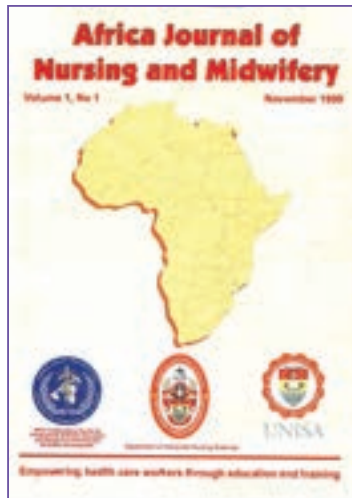
⁴ The Work of WHO in the African Region. 2014–2015 Biennial Report of the Regional Director. Available on <http://apps.who.int/iris/bitstream/0665/193406/1/9789290232926.pdf>.

⁵ World Health Organization. Surgical Safety Checklist. Available at <http://www.who.int/patientsafety/safesurgery/checklist/en/>

⁶ Pronovost P et al. An intervention to decrease catheter-related bloodstream infections in the ICU. *The New England Journal of Medicine*, 2006;355:2725–2732. doi:10.1056/NEJMoa061115 PMID:17192537

⁷ Scholarly Publishing in Africa. Opportunities and Impediments. Edited by Solani Ngoben.

⁸ The WHO Europe Family Health Nursing Pilot in Scotland. Final Report. Available at <https://www.inmo.ie/tempDocs/final%20report%20family%20health%20nurse.pdf>



Interregional initiatives (e.g. the Pan American Network for Nursing and Midwifery Collaborating Centres), and those with an emphasis on North–South collaboration (e.g. the University of Illinois with the University of Botswana, and Canada with South Africa) also expanded.

KEY OBSERVATIONS

- ✓ Nurses' and midwives' roles expand
- ✓ Practice more and more oriented to the community and emerging global health trends
- ✓ Emerging emphasis on multiprofessional collaboration and teamwork due to growing diversity of professions
- ✓ Re-emphasis on research as much more research on nursing becomes available
- ✓ Value of nurses as compared to doctors visible in the WHO programme on Integrated Management of Childhood Diseases
- ✓ Nursing and Midwifery Professionals not sufficiently involved in health policy development.

LAYING A NEW REGULATORY FOUNDATION FOR THE NURSING AND MIDWIFERY PROFESSIONS

By addressing the roles and responsibilities of nurses and midwives, and by advising on their education and considering nursing as a profession, WHO inevitably became involved in issues of employment status and professional standards. There were talks with the International Labour Organization in the 1970s, a special WHO Study Group on regulations about nursing in the 1980s, and a report about nursing/midwifery regulations to WHO's governing bodies in the early 1990s.¹ It was surprising what nurses and midwives were allowed to do, or were not allowed to do, when providing health care. The global picture was very mixed. Some countries had improved education and training standards to improve nurses' competencies and professionalism but policies and laws had not been changed to enable the nurses to use their learning in their jobs. Fortunately, however, many countries had already updated regulations to enable nurses to carry out the responsibilities they had been trained for, and in many others regulatory reform was under way.

¹ Regulatory mechanisms for nursing training and practice: meeting primary health care needs, report of a WHO Study Group [meeting held in Geneva from 9–13 December 1985].

The Joint ILO/WHO meeting on conditions of work and life of nursing personnel in November 1973 put on record some of the basic legal requirements that support the contribution of nurses and midwives to people's health.

The meeting was strongly of the opinion that **“the social and economic status of nursing personnel was far from equivalent to their importance in the community”**. **Traditionally, nursing had been associated in the minds of many people with religious orders and charity, and nurses were assumed to take vows of poverty and obedience. “This image had to be eliminated,” the meeting urged.**² Nursing should be organized as an independent profession and should speak with its own members through their freely chosen representatives, participate in all decisions relating to their professional life, including organization of work, management of nursing services, staffing pattern, conditions of employment and work, career development, observance of applicable professional standards, institution and functioning of disciplinary procedures, and application of disciplinary measures. The meeting also stressed that nurses should participate, through their organizations, in the control of the activities of temporary agencies which

² Report of the joint ILO/WHO meeting on conditions of work and life of nursing personnel. WHO Executive Board Document EB54.6. Geneva: World Health Organization; 1974: p. 3.

may affect them and in the administration of social security systems with which they may be concerned.¹

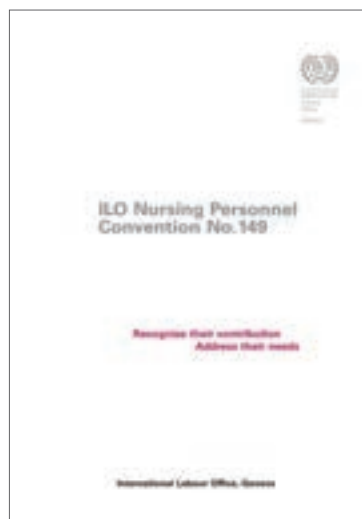
ILO/WHO joint efforts to develop standards for adequate personnel policies and working conditions for nursing continued in the years that followed. In 1977, these efforts resulted in the adoption of the ILO Nursing Personnel Convention (C. 149), and the accompanying Nursing Personnel Recommendation (R. 157) as international labour instruments.

The Convention recognizes the vital role of nursing personnel and other health workers for the health and wellbeing of populations. It sets minimum labour standards specifically designed to highlight the special conditions in which nursing is carried out. Aspects supported by the Convention include:

- adequate education and training to exercise nursing functions;
- attractive employment and working conditions, including career prospects, remuneration and social security;
- the adaptation of occupational safety and health regulations to nursing work;
- the participation of nursing personnel in the planning of nursing services;

- the consultation with nursing personnel regarding their employment and working conditions;
- dispute settlement mechanisms.²

In 2002, the ILO classified the Nursing Personnel Convention as an up-to-date instrument, thus reaffirming its relevance in the 21st century. However, the ILO noted at that time that little progress had been made in many countries towards improving working conditions in nursing and that the same concerns that prompted the need to improve working conditions in health services in the 1970s still prevailed. The health-care profession was still not attracting sufficient recruits to keep up with demand and was losing large numbers of trained personnel to areas outside the health sector.³



Building regulatory systems for nurses and midwives

In 1981, eight years after the adoption of the ILO convention, it was judged that nursing practice and education were governed by legislation that was “often archaic, determined by persons from other disciplines, detrimental to the status of the nurse, and not in tune with the needs of society. The primary health care strategy involves the reevaluation of old policies and this must certainly include nursing legislation.”⁴

WHO convened a study group in December 1985 to review regulatory mechanisms and identify facilitating or constraining factors, recommend constructive strategies and action that could be adopted by national governments and nursing regulatory bodies, and suggest guidelines for developing regulatory mechanisms to govern nursing education and practice in order to ensure that nurses receive appropriate preparation for primary health care.

An examination of the regulatory mechanisms of 81 countries found that 77 allowed nurses to give injections, oral medication and immunizations, as well as permitting them to handle trauma in emergencies, take blood pressure, do simple diagnostic tests, manage chronic diseases and treat common diseases.

¹ Report of the joint ILO/WHO meeting on conditions of work and life of nursing personnel. WHO Executive Board Document EB54.6. Geneva: World Health Organization; 1974: p. 4.

² ILO Nursing Personnel Convention No. 149. Recognize their contribution, address their needs. Geneva: International Labour Organization; 2005.

³ ILO Nursing Personnel Convention No. 149. Recognize their contribution, address their needs. Geneva: International Labour Organization; 2005:2.

⁴ Nursing in support of the goal of health for all by the year 2000. Report of a meeting, 16-20 November 1981. Document HMD/NUR/82.2. Geneva: World Health Organization; 1983:31.

Nursing practice acts were the most common source of authority. The five tasks least commonly authorized were: performing minor surgery, prescribing oral contraceptives, inserting intrauterine devices (IUDs), prescribing drugs for common ailments and diagnosing common diseases.

Despite a global trend to extend the scope of nursing practice in various ways, the Study Group concluded that many regulatory mechanisms were “weak, uncertain, or of dubious legal effect”. Their most serious shortcoming was that they did “not generally authorize reoriented nursing curricula and training, and therefore nurses are not trained for a wider role in primary health care”.¹

The study group felt that the “most important provisions on the licensing of nurses are those relating to the approval of nursing schools and to curriculum requirements”. The regulation of nursing education included: (1) approval of schools, hospitals, and other sources of academic and clinical training; (2) establishment of admissions requirements for nursing schools (e.g. minimum age, number of years of previous schooling); (3) establishment of the duration and content of the curriculum and the kind of clinical training required; and (4) preparation, administration and supervision of the

examinations needed in order to qualify as a nurse.

The study group found that the various functions involved in the process of regulating nursing education could be exercised “either in a way as to promote primary health care affirmatively or, more frequently, in a traditional manner that instead prepares nurses for patient care in hospitals under the direction of physicians”.²

Nigeria and Senegal provided examples of countries that had enacted legislation to bring nursing curricula into line with the needs of primary health care. Senegal's Decree No. 77-017 providing for a new type of education oriented to national needs extended the length of studies from two years to three. Nigeria's Nurses Decree of 1970 provided for the establishment of the Nursing Council of Nigeria with power to approve educational programmes and to authorize the trial and recognition of innovations in training and examination. Under this law and Decree No. 89 of 1979, the Nursing Council approved a new curriculum oriented to prevention, community nursing, collaboration between nursing schools and the nursing service, and the preparation of nurses for broad functions in providing care, teaching, planning, evaluation, supervision and coordination.

Regulatory mechanisms can be reoriented, the study group concluded, only if the content of the basic nursing curriculum is changed to incorporate the concept of primary health care, to provide nurses with training in midwifery (and, in those countries where traditional birth attendants and auxiliary midwives practise midwifery, to ensure their competence in this area), and to provide financial and other resources to support the reorientation of educational programmes for nurses.

As a follow-up to the study group, WHO's *Guidelines for regulatory changes in nursing education and practice to promote primary health care*³ was published in 1988. Numerous examples of laws were provided pertaining to general provisions in nursing practice acts and the powers of nursing boards and councils, nursing education, nursing functions, rural service, continuing education and career structure.

The report prepared for the 89th session of the WHO Executive Board in 1991 provided a summary by WHO region of the degree to which countries had adopted or amended legislation and regulations to facilitate the involvement of nursing and midwifery personnel in all aspects of primary health care, and the degree to which such legislation was part of other legislation related to education, social and health issues (Box II.7).

¹ Regulatory mechanisms for nursing training and practice: meeting primary health care needs: report of a WHO Study Group. Geneva: World Health Organization; 1986:17 (WHO Technical Report Series, No. 738).

² Regulatory mechanisms for nursing training and practice: meeting primary health care needs: report of a WHO Study Group. Geneva: World Health Organization; 1986:22 (WHO Technical Report Series, No. 738).

³ Storey M, Roemer R, Mangay-Maglacas A, Piccard E. Guidelines for regulatory changes in nursing education and practice to promote primary health. Document WHO EDUC 88.194. Geneva: World Health Organization; 1988

Much of the information gathered was from collaboration on the part of ICN, with over 80 countries in five WHO regions on nursing regulations and legislation. New laws were being drafted at the time in some 25 countries. The information in Box II.7 describes activities almost entirely initiated and guided by ICN.

KEY OBSERVATIONS

- ✓ In 1977 ILO Convention recognizes the vital role of nursing personnel
- ✓ WHO strives to review Member States' regulatory mechanisms and facilitate development of strategies.

Box II.7.

National legislation and regulations on nurses/midwives in primary health care (1991)

African Region. Most of the English-speaking countries were in the process of drafting or amending legislation relating to nursing. These included Ethiopia, where nurses had developed a code of ethics, and a revised Nursing Act was in process. Gambia, Ghana, Lesotho, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe were all at different stages of reviewing and revising their nursing legislation. Kenya had produced a manual on nursing practice standards for general and specialist nurses, and in Nigeria nurses were involved in efforts to implement the newly-passed Nursing Act. Malawi was just beginning to define areas in which its legislation needed to be strengthened. In the French- and Portuguese-speaking countries specific nursing legislation still had to be prepared.

Region of the Americas. Most of the countries had reviewed the status of their nursing legislation and were revising existing legislation or preparing new legislation. This included 17 countries in Latin America and eight countries in the Caribbean. For example, Argentina had drafted a new nursing practice law, and Costa Rica was focusing on incorporating law and ethics into the nursing curriculum. Bahamas had developed definitions for practice, in particular for the work of registered nurses in primary health care. Canada was working on ways to regulate the development of specialties, and the USA was in the process of defining and regulating the links between professional nurses and auxiliary nursing personnel.

South-East Asia Region. Bangladesh, India, Myanmar and Thailand had long-established national nursing councils and nursing Acts to define and regulate nursing and nursing education. There was not yet an established national body with the authority to regulate and control the nursing profession in other countries. Few countries had a requirement for the renewal of registration or licensing. This lack of control bodies and regulatory mechanisms was being tackled: Nepal was in the process of establishing a national nursing council, Indonesia and Thailand were considering the institutionalization of national quality control mechanisms for education programmes and their graduates, Myanmar had recently revised its nursing/midwifery law, and India and Indonesia were in the process of revising theirs.

European Region. In some Member States, well-established legislation regulating nursing education and practice was the basis for continued work on standards and quality assurance, as was the case in the Nordic countries and the United Kingdom. In other parts of the region the development of adequate regulation was impeded by a failure to recognize its importance in strengthening the quality of nursing care. Lithuania, Poland, Romania and the USSR reported that they were taking steps to change the legal definition of the scope of nursing practice and education to include the functions needed in primary health care. Bulgaria, Czechoslovakia and Hungary were moving in the same direction.

Eastern Mediterranean Region. The many efforts to reorient nursing programmes and teacher training had not yet resulted in the expected impact on health services because they had not been matched by changes in policies, laws and values governing health workers and the health services infrastructure. Only two countries – Bahrain and Egypt – had instituted regulatory mechanisms to facilitate nursing and midwifery practice. Others either did not have legislation regulating nursing practice, or the legislation was outdated.

The Regional Office hosted a meeting of the Regional Advisory Panel on Nursing during 1995, and developed regional standards for nursing education which could be used as guidelines by countries to develop their national standards.

Western Pacific Region. Philippines passed a new law to allow for the extended role of nurses. Several countries, such as Australia, Cook Islands, Fiji, Japan, New Zealand, Republic of Korea, Samoa and Tonga, gave particular attention to revising existing laws regulating practice. Recognizing specialty areas, upgrading the educational system, and developing standards and competency measures were some of the major concerns. Several countries and areas such as China, Guam and the Northern Mariana Islands had recognized the need to develop additional legislation for nursing education and practice.

Source: Strengthening midwifery personnel in support of the strategy for health for all. Document EB89/13. WHO Executive Board, 89th session, January 1991.





PART III

More recent developments (2000–2015)

FROM THE MILLENNIUM DEVELOPMENT GOALS TO THE SUSTAINABLE DEVELOPMENT GOALS

There is no doubt that the number of trained nurses and midwives in the twenty-first century is far greater than it was when WHO first invested in this area of work in the 1940s and 1950s. Yet despite continued investment in education and training, the number of nurses and midwives in most countries is still far from what is needed. WHO estimates that countries with fewer than 44.5 health-care professionals (counting only physicians, nurses and midwives) per 10 000 population will be unlikely to achieve adequate coverage rates for the key primary health-care interventions identified as tracers for services required for universal health coverage and the attainment of the health targets of the Sustainable Development Goals. There remain huge disparities both between and within countries.¹ The SDGs follow the MDGs of the period 2000–2015, with a call to action to people and leaders across the world to ensure a life of dignity for all. The health workforce underpins the proposed health goal, with a target (3c) to “substantially increase health financing and the recruitment, development, training and retention of the health workforce”. Nursing and midwifery workforce are a major component of the health workforce.

Concurrently, health problems have not gone away and the cost of providing health care – especially in hospitals and specialist institutions – has increased considerably. Universal health coverage is a noble goal, but it is also an essential one for assuring equity and justice and for supporting efforts towards global health security. Nurses and midwives will remain key players in the delivery of health services.

¹ The Millennium Development Goals. What are they? New York (NY): United Nations (<http://www.unmillenniumproject.org/goals/>, accessed 15 April 2016).

Increasing attention to the health workforce discourse

The first decade of this century has seen an unprecedented level of attention to health workforce issues. The adoption by the UN General Assembly of the Millennium Development Goals focused the attention of the international community on priority health challenges, but this was soon followed a recognition of the inadequacy of the health workforce to attain the MDG targets. The Joint Learning Initiative of 2002¹ and the WHO World Health Report of 2006² contributed to raising attention and momentum to the shortage, maldistribution, quality and performance challenges affecting health workers globally, including the nursing and midwifery workforce. Significant advocacy and normative initiatives during this period included the launch of the Global Health Workforce Alliance (2006);³ the first Global Forum on Human Resources for Health in 2008, resulting in the Kampala Declaration and Agenda for Global Health;⁴ and the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel by the World Health Assembly in 2010.⁵

¹ The Joint Learning Initiative, Harvard University Press, "Overcoming the Crisis: Report of the Joint Learning Initiative 2004", Available from: http://www.healthgap.org/camp/hcw_docs/JLI_Human_Resources_for_Health.pdf

² World Health Organization. World Health Report 2006 "Working together for health", Available from: <http://www.who.int/whr/2006/en/index.html>

³ Global Health Workforce Alliance. Alliance vision and mission: Available from http://www.who.int/workforcealliance/about/vision_mission/en/index.html

⁴ GHWA: The Kampala Declaration and Agenda for Global Action, 2008. Available from: http://www.who.int/workforcealliance/knowledge/resources/kampala_declaration/en/index.html

⁵ World Health Organization (2010). WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva, Switzerland. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf

Thirty years after Alma Ata, WHO's continued commitment to primary health care was further articulated in the *World health report 2008* which addressed the theme "Primary health care – now more than ever". The widespread and growing demand from Member States for WHO to direct its attention to primary health care was said to show a "growing appetite among policy-makers for knowledge related to how health systems can become more equitable, inclusive and fair". It also reflected a "shift towards the need for more comprehensive thinking about the performance of the health system as a whole".⁶

The 2008 report outlined four sets of reforms that were needed to bring about the changes needed. These were:

- **universal coverage reforms** that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection;
- **service delivery reforms** that reorganize health services around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world, while producing better outcomes;

⁶ The World Health Report 2008 – primary health care (now more than ever). Geneva: World Health Organization; 2008:viii.

- **public policy reforms** that secure healthier communities by integrating public health actions with primary care, by pursuing healthy public policies across sectors and by strengthening national and transnational public health interventions; and
- **leadership reforms** that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership indicated by the complexity of contemporary health systems.

Although the language used had changed over the years, there was a striking similarity between the reforms called for in 2008 and those in earlier WHO nursing history, as described in Parts I and II.

For these reforms to be realized, health authorities must generate the knowledge needed to monitor progress, identify technical and political obstacles, and provide the elements for corrections where necessary.⁷

⁷ The World Health Report 2008 – primary health care (now more than ever). Geneva: World Health Organization; 2008:108.

The commitment of the health workforce and the participation of people must be mobilized in support of these reforms. More specifically, the report argued:

- Significant investment is needed to empower health staff – from nurses to policy-makers – with the wherewithal to learn, adapt, be team players, and to combine biomedical and social perspectives, equity sensitivity and patient-centredness.¹
- Civil society can be a powerful ally for primary health care reforms. Civil society groups can make the difference between a well-intentioned but short-lived attempt, and successful and sustained reform, and between a purely technical initiative and one that is endorsed by the political world and enjoys social consensus.²

A strategic vision for the new century

The broader health workforce and health systems policy areas highlighted above were integral to both the 11th General Programme of Work (2006–2014) and the 12th General Programme of Work (2014–2019).

The 11th General Programme of Work set out a global health agenda for all

¹ The World Health Report 2008 – primary health care (now more than ever). Geneva: World Health Organization; 2008:110.

² The World Health Report 2008 – primary health care (now more than ever). Geneva: World Health Organization; 2008:111.



Nurses in a hospital in rural Ghana.
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stakeholders, highlighting a number of priority areas, namely: investing in health to reduce poverty; building individual and global health security; promoting universal coverage, gender equality and health-related human rights; tackling the determinants of health; strengthening health systems and equitable access; harnessing knowledge, science and technology; and strengthening governance, leadership and accountability.

The 11th General Programme of Work also set out six core functions for WHO to focus on. These were: providing leadership on matters critical to health and engaging in partnerships where joint action is needed; shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; setting norms and standards, and promoting and monitoring their

implementation; articulating ethical and evidence-based policy options; providing technical support, catalysing change and building sustainable institutional capacity; and monitoring the health situation and assessing health trends.

The 12th General Programme of Work was prepared as part of an extensive programme of reform in WHO that began in 2010. It aimed to provide a high-level strategic vision and was one of the main elements of the WHO programmatic reform.³ At a meeting in February 2012 Member States agreed that WHO's work would be organized according to a limited number of categories, of which five were programmatic: communicable diseases; noncommunicable diseases; promoting health through the life-course; health systems; and preparedness, surveillance and response.⁴

Concern for the state of human resources for health (HRH) was expressed in both the 11th and 12th General Programmes of Work. WHO said it would focus more attention and action on ensuring that countries have a health workforce appropriate to their needs and to “keep this concern in the forefront of national and international policy”.⁵ Nursing practice has been shown to be adaptable to population

³ Twelfth General Programme of Work (GPW) 2014–2019 and the Programme Budget (PB) 2014–2015. Geneva: World Health Organization; 2013 (<http://apps.who.int/iris/bitstream/10665/166304/1/CE152-INF2-e.pdf?ua=1>, accessed 15 April 2016).

⁴ Draft twelfth general programme of work. Document A66/6, Agenda item 12.2. Sixty-sixth World Health Assembly, May 2013 (http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_6-en.pdf, accessed 15 April 2016).

⁵ Eleventh General Programme of Work, 2006–2015. Document A59/25, Fifty-ninth World Health Assembly, Geneva, 22–27 May 2006:24.

and patient health needs and it has been particularly successful in delivering services to the most vulnerable and hard-to-reach populations.

At the same time, midwifery practice has the potential to provide 87% of the essential care needed for sexual, reproductive, maternal and newborn health services.¹

It is against this background that WHO's nursing and midwifery programme has contributed to reform efforts.

Leadership and governance roles for nurses and midwives

Much was learned in the 30 years following the Alma-Ata Declaration that has direct relevance to the roles of nurses and midwives in achieving health-care goals. It is now recognized that the speed of transition from traditional caregivers to professional care was underestimated. Where strategies for extending primary health care coverage proposed lay workers as substitutes to professionals rather than as complements to them, the care provided was often perceived to be poor. This pushed patients towards commercial care which was perceived to be of better quality. This in turn diverted attention from the

challenge of building integrated primary health care teams.²

On the other hand, it was judged that proponents of primary health care were right about the importance of cultural and relational competence, which was the key advantage of community health workers. **Citizens of developing countries, like those elsewhere, do not seek technical competence alone; they also want health-care providers to be understanding, respectful and trustworthy. They want health care to be organized in line with their needs, respectful of their beliefs and sensitive to their situation in life.**³

The health workforce is critical to primary health care reforms. Significant investment is needed to empower health staff with the competences to learn, adapt, be team players, and to combine biomedical and social perspectives with sensitivity to equity and patient-centeredness.

Expanding the numbers of well-trained nurses and midwives was an area of sustained focus. Resolution WHA59.27, adopted by the Fifty-ninth World Health Assembly in 2006, urged Member States to confirm their commitment to strengthening nursing and midwifery by “actively involving nurses and midwives

in the development of their health systems and in the framing, planning and implementation of health policy at all levels, including ensuring that nursing and midwifery is represented at all appropriate governmental levels, and have real influence”. In 2011, resolution WHA64.7 urged Member States to put their commitment to strengthening nursing and midwifery into action by **“engaging actively the expertise of nurses and midwives in the planning, development, implementation and evaluation of health and health system policy and programming”**. The need to urge Member States to take action on a commitment which they had previously confirmed is revealing in itself.

Despite repeated expressions of political will on the part of governments, progress has been slower than hoped. Even in the European Region, where the Ministers of Health in their Munich Declaration identified “key and increasingly important roles for nurses and midwives to play to contribute to decision-making at all policy levels”, significant variations between Member States on goal achievement were said to persist.⁴ In order to improve on this situation, and in particular for nurses and midwives to “contribute to and influence the debate on improving health and the quality of health care in Europe”, 26 national nursing and midwifery associations and

¹ UNFPA ICM, WHO: “The state of the world’s midwifery 2014: A universal pathway. A women’s right to health”. 2014, New York: United Nations Population Fund.

² The World Health Report 2008 – primary health care (now more than ever). Geneva: World Health Organization; 2008:16.

³ Epstein H. The strange politics of saving the children. The New York Review of Books, 5 November 2015:p. 62.

⁴ WHO Nursing and Midwifery Progress Report 2008–2012. Geneva: World Health Organization; 2013:74.

WHO's Regional Office for Europe formed the European Forum of National Nursing and Midwifery Associations (EFNNMA) in 1997. EFNNMA serves as a link between international and national policy-makers and the 6 million nurses and midwives in the WHO European Region. Serving as “the voice of nursing and midwifery within WHO European Region”, EFNNMA works in partnership with WHO and other key stakeholders with the aim of influencing health policy, and improving the quality of health services and the health of people across the 53 Member States of the region.¹

At the global level, the Global Forum for the Government Chief Nurses and Midwives (GCNMOs) was established in 2004. Meeting every two years, this forum has allowed senior nursing and midwifery officials to address major concerns; in 2010, at its fourth session, the forum focused on such leadership issues as how to “confidently inform World Health Assembly policy and decisions” and how to ensure success in “strengthening health systems within the context of primary health care”.²

In 2010, the forum issued a *Government Chief Nursing and Midwifery Officer's Position Statement on Primary Health Care* that expressed its commitment “to work collectively and at the country level to



European Forum for National Nursing and Midwifery Associations (EFNNMA), 2016.

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support the World Health Assembly Resolution WHA62.12 on primary health care and health system strengthening, and World Health Assembly Resolution 59.27 on strengthening nursing and midwifery, “to scale up collaboration with key stakeholders and effectively lead and facilitate this necessary transformation”.³

Noting that “nurses and midwives have historically embraced and continue to endorse community-based interprofessional collaborative practice”

as an essential element of primary health care”, the forum said that policy commitment and leadership within WHO and Member States should be examined to ensure there was capacity to further primary health care renewal. This included:

- WHO nursing and midwifery focal points should be created to collaborate with Government Chief Nursing and Midwifery Officers (GCNMOs) at country level.
- Member States should have a focal nursing and midwifery directorate at national level.

¹ European Forum of National Nursing and Midwifery Associations (website). Lisbon (http://efnma.ohttp://efnma.org/publ/info/mission#.VyH04HrtMIA rg/meeting/info/2#.VmGIQLGFP_9, accessed 20 May 2016).

² Report of the forum for the government chief nurses and midwives, 12–13 May 2010, Geneva, Switzerland. Geneva: World Health Organization; 2011:4 (http://apps.who.int/iris/bitstream/10665/70622/1/WHO_HRH_HPN_11.1_eng.pdf, accessed 15 April 2016).

³ Report of the forum for the government chief nurses and midwives, 12–13 May 2010, Geneva, Switzerland. Geneva: World Health Organization; 2011:33 (http://apps.who.int/iris/bitstream/10665/70622/1/WHO_HRH_HPN_11.1_eng.pdf, accessed 15 April 2016).



Global Chief Nursing and Midwifery Officers Meeting, 2014.

- GCNMOs should be placed within national ministries with accompanying structural, resource and policy accountabilities at a level of decision-making to lead primary health care renewal effectively.
 - GCNMOs should be engaged at all levels of policy-making to drive “health in all policies” as part of primary health care renewal.
 - GCNMOs should influence and create policy to shift resources towards primary health care.
 - GCNMOs should create opportunities for nursing and midwifery to be involved in all levels of decision-making, including decisions related to external funders’ resource allocation, where applicable.
- GCNMOs should be responsible for leveraging the education, regulation and practice of nursing and midwifery towards the implementation of safe and effective people-centred primary health care.
- In the 2014 Global Forum, the government chief nursing and midwifery officers committed their support to the global agenda on universal health coverage in three key areas: leadership and management, education and training, and strengthening of collaborative partnerships. These leaders are instrumental in moving forward WHO’s agenda. The recommendations from the 2014 Global Forum were the foundation for the development of the *Global*

*strategic directions for strengthening nursing and midwifery 2016–2020.*¹

The Eastern Mediterranean Regional Office has promoted several regional tools² to strengthen capacity for health workforce governance and planning, such as a guide to accreditation of health professions programmes, and tools to optimize staff workload in health facilities and to make workforce projections. Initiatives to strengthen nursing and midwifery training include support to several countries in developing their national strategic plans. The leadership and management training programme, developed by ICN with WHO support, continues in several countries.

Updating and upgrading education and training

Strengthening nursing and midwifery education and training has been the mainstay of WHO’s nursing and midwifery programme from its very inception. Member States have faced innumerable obstacles in developing a health workforce best suited for their health needs. Strong economic incentives for the best trained health workers to migrate to countries offering better employment opportunities have undermined many national efforts. Other negative factors include inadequate investment and the low priority given

¹ WHO global strategic directions for strengthening nursing and midwifery 2016–2020. Available at http://www.who.int/hrh/nursing_midwifery/global-strategic-midwifery2016-2020.pdf

² The work of WHO in the Eastern Mediterranean Region. Annual report of the Regional Director 2012, 2013, 2014, 2015. WHO Eastern Mediterranean Regional Office, Cairo, Egypt

to nursing education; lack of capacity in nursing schools in terms of the availability of trainers as well as infrastructure; the need to further update nursing curricula in order to bridge the service-education gap; the limited institutional capacity to offer post-basic training programmes; and inadequate emphasis on continuous professional development programmes, as reported by the Regional Office for the Eastern Mediterranean in 2013.¹ To date, a framework for nurse specialization in mental health has been developed and will be critical in addressing the need for improved mental health in the region.

The WHO Regional Office for Africa in 2013 developed a regulatory framework for professional nurses and midwives because of inadequate regulations for nursing and midwifery education and practice. Three prototype curricula for nursing and midwifery training programmes have been developed – general nursing, direct-entry midwifery and nurse-midwife programmes.

Fellowships and study tours continued to be one of the key methods for strengthening human resource capacity in Member States, as indicated in Table III.1.

Fellowships and study tours were used to help Bhutan develop a post-basic bachelor degree programme in nursing and midwifery, which was launched in June 2012. To increase its

workforce, Bhutan sent students to study for bachelor degrees in nursing and midwifery in India and Thailand. Working with the Royal Institute of Health Sciences in Bhutan, WHO assisted in the development of the curriculum, building managerial and teaching capacity, and strengthening library and teaching aids. A Regional (South-East Asia) Network on Health Professional Education Reforms was formed in 2012 with a start-up grant from the China Medical Board. Five countries (Bangladesh, China, India, Thailand and Viet Nam) initially formed the network which subsequently became the Asia-Pacific Network on

Health Professional Education Reforms (ANHER), with additional countries of the Asia-Pacific area as members. A common protocol and tools have been developed and are being used to survey national and institutional levels of medical, nursing and public health education, as well as to assess final-year graduates on their attitudes, competencies and readiness to serve in rural health services. It is envisaged that this will serve as a platform to enable national health professional education systems to be more responsive to the health needs of the population, reflecting demographic, epidemiological and economic changes.

Table III.1.
Nursing and midwifery fellowships and study tours, by country, 2012–2013,
WHO Regional Office for South-East Asia

Member State	Fellowships awarded	Study tours awarded
Bangladesh	49	17
Bhutan	8	30
Democratic People's Republic of Korea	111	82
India	1	7
Indonesia	8	6
Maldives	25	9
Myanmar	101	54
Nepal	14	96
Sri Lanka	62	32
Thailand	10	4
Timor-Leste	11	25
Total	400	362

¹ The work of WHO in the Eastern Mediterranean Region: Annual report of the Regional Director 1 January–31 December 2013. Cairo: WHO Regional Office for the Eastern Mediterranean; 2014: p. 13.

Need for evidence for HRH Development

In order to obtain up-to-date and accurate information concerning the health workforce, countries and regions were encouraged to develop HRH observatories that would take stock of all factors relating to the development of an effective health workforce. Observatories were expected to be a “cooperative initiative among relevant stakeholders”, and to be based on networking and stakeholder involvement and ownership. It was said that they should be “the key element for scaling up health interventions to achieve national goals and health-related targets of the Millennium Development Goals”.¹

HRH observatories aim to provide an accurate and timely picture of their workforce. Progress in developing them serves as an indicator of how well countries are prepared to face the human resource needs of the future.

An assessment of human resources for health programme implementation in 15 Latin American countries, carried out in 2015 by PAHO and the Institute of Social Medicine at the State University of Rio de Janeiro, identified numerous obstacles that have blocked the development of

functioning HRH observatories. Although the 15 countries differed in their political, social, economic and geographical contexts, the HRH initiatives showed that the actions of these countries have been directed to strengthening national health systems and oriented towards primary health care with universal and equitable coverage. Beyond that, however, many of the challenges faced in the implementation of human resource programmes were the same in all countries; these included “the difficulty of training HRH personnel, the lack of political will and financial support, weak HRH information systems, fragile/weak HRH governance, and difficulties in hiring and retaining health professionals in the public sector and in their allocation in remote and rural areas”.²

Many of these difficulties are related to the fact that health systems in the Americas are characterized by fragmentation and segmentation that constitute barriers to expanding coverage and reducing inefficiency.³ In the Americas, only Canada and the USA possessed a public health framework that enabled them to understand the competency gap in order to facilitate implementation of the primary health care strategy and health workers’ performance of essential public health functions.

Moreover, few countries had competency frameworks that made it possible for them to document critical gaps.⁴

WHO’s Regional Office for Africa convened a regional consultation in Pretoria, South Africa, in October 2011 on scaling up the health workforce for improved service delivery. The 145 participants reached consensus on the need to have a regional road map that defined actions for scaling up health workforce capacity.



Road map for scaling up HRH in the WHO African region

The challenges facing the African Member States are uneven. They pose a strategic threat to the development of national and regional health systems and to the well-being of populations in the African Region. Major and pressing HRH challenges identified are: weak HRH leadership and governance capacity; weak

¹ Assessment of human resources for health programme implementation in 15 Latin American and Caribbean countries. *Human Resources for Health*. 2015;13:24. doi: 10.1186/s12960-015-0016-4 (<http://www.human-resources-health.com/content/13/1/24>, accessed 15 April 2016)

² Assessment of human resources for health programme implementation in 15 Latin American and Caribbean countries. *Human Resources for Health*. 2015;13:24. doi: 10.1186/s12960-015-0016-4 (<http://www.human-resources-health.com/content/13/1/24>, accessed 15 April 2016).

³ Report of the forum for the government chief nurses and midwives, 12–13 May 2010, Geneva, Switzerland. Geneva: World Health Organization; 2011:33 (http://apps.who.int/iris/bitstream/10665/70622/1/WHO_HRH_HPN_11.1_eng.pdf, accessed 15 April 2016).

⁴ Report of the forum for the government chief nurses and midwives, 12–13 May 2010, Geneva, Switzerland. Geneva: World Health Organization; 2011:33 (http://apps.who.int/iris/bitstream/10665/70622/1/WHO_HRH_HPN_11.1_eng.pdf, accessed 15 April 2016).

training capacity; inadequate utilization, retention and performance of the available health workforce; insufficient information and evidence base; weak regulatory capacity; uncoordinated partnerships and weak policy dialogue. Of the 46 countries in the region, 36 had a critical shortage of HRH in 2006. The road map adopted by the Regional Committee for Africa built on a number of national, subregional, regional and global efforts. It had the following six strategic areas for achieving its objectives:

- 1 Strengthening health workforce leadership and governance capacity.
- 2 Strengthening HRH regulatory capacity.
- 3 Scaling up education and training of health workers.
- 4 Optimizing the utilization, retention and performance of the active health workforce.
- 5 Improving health workforce information and generation of evidence for decision making.
- 6 Strengthening health workforce dialogue and partnership.

Each of these strategic areas has a set of identified priority interventions. For implementation, specific steps and actions have been developed for regional, subregional and especially country levels. The road map has a number of indicators and milestones for achievement up to 2025. Implementation of the road map requires the commitment and collaboration of all stakeholders and

partners under the leadership of national governments.

Many European countries face growing shortages of health professionals and imbalances in their distribution, and these shortages are projected to increase over the next 20 years. International recruitment may solve the shortages in some countries, but may exacerbate shortages in others – particularly developing countries. The migration of health workers has become a prominent public policy concern and an issue of special attention for WHO, which has urged its Member States to develop strategies to mitigate its adverse effects.

The WHO Regional Committee for Europe discussed the issue in 2007 and adopted a resolution calling on the Regional Office to give high priority to monitoring the situation and facilitating the development of an ethical framework for the international recruitment of health workers into and within the European Region. In response, the Regional Office started a dialogue on international migration between source and destination countries. It continued to assess migration flows in countries, using two frameworks: one for country case studies and the other for monitoring migration. The Regional Office for Europe published a report on these flows in five Member States in September 2006. It also conducted a number of policy dialogues on human resources for health in countries,

in collaboration with the European Observatory on Health Systems and Policies.

The Regional Office for Europe has worked with many counterparts in this field – in particular the OECD, the International Organization for Migration (IOM), and the International Labour Organization (ILO).

IMPROVING SERVICE DELIVERY

WHO's nursing and midwifery programme used the 11th General Programme of Work as the framework for exploring how to scale up capacity of nursing and midwifery services to contribute to the Millennium Development Goals (MDGs) which were adopted by the United Nations General Assembly in September 2000.¹

In its 2005 World Health Report "Make every mother and child count", WHO stressed the importance of scaling up the number of skilled midwives and midwifery services to provide quality maternal, newborn and child health services in a bid to address the range of disparities and widening gaps in morbidity and mortality between settings and countries.²

¹ Scaling-up the capacity of nursing and midwifery services to contribute to the Millennium Development Goals. The 2008–2009 Global Programme of Work. Summary of implementation. Document WHO/HRH/HPN/10.7. Geneva: World Health Organization; 2011.

² The World Health Report: 2005: make every mother and child count.

In January 2011, the WHO Executive Board adopted a resolution on strengthening nursing and midwifery in recognition of “the crucial contribution of the nursing and midwifery professions to strengthening health systems” and for “increasing access to comprehensive health services for the people they serve”. The resolution was subsequently adopted by the Sixty-fourth World Health Assembly in May 2011 (resolution WHA64.7).

KEY OBSERVATIONS

- ✔ Leading role of nurses and midwives re-emphasized
- ✔ Progress on moving the agenda for nursing and midwifery requires political will
- ✔ Increasing need for nurses and midwives at policy level.

Providers of essential care

The World Bank (in 1993) noted that most essential clinical and public health services could be delivered cost-effectively by nurses and midwives.

In many countries nurses, midwives and allied health personnel are the main providers of health care, particularly in rural and remote areas where vulnerable populations reside. Nurses and midwives work in many rural health centres, they visit patients at home, give vaccinations

and provide care for patients with HIV/AIDS, malaria, tuberculosis and other infectious diseases. Nurses also supervise home-based care in a number of regions, offer health education, promote contraceptive advice, and give guidance on nutrition and sanitation. In a number of countries mental health nurses provide a variety of mental health services, including prevention and management of stress, conflict resolution, and group and family therapy.

The list of roles that nurses and midwives fulfill is long. Initiatives to assist them are also increasing. As examples two major initiatives are briefly described below – one global programme that aims to strengthen both the numbers and the education of nurses and midwives worldwide, and one regional initiative that prepares midwives for essential roles in emergencies and disasters in Asia and the Pacific.

Maternal and child health

The Global Strategy for Women’s, Children’s Health, initiated by United Nations Secretary-General Ban Ki-moon in 2010, is a collaborative effort by six agencies (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank). Many of its activities have helped strengthen nursing and midwifery support to MCH services. For example, Sierra Leone, which had only 100 qualified midwives serving a total population of around 6 million, opened a second

midwifery school in the northern town of Makemi with the support of H4+. H4+ agencies help sponsor 50 students every year (plus another 50 at the midwifery school in Freetown), paying all their fees and living expenses.¹

In Zambia, H4+ supported the training of 31 midwives. In addition, 20 retired midwives and nurses were trained in emergency obstetric and neonatal care to provide back-up for existing staff when necessary. In Cameroon, 38 midwifery school teachers received additional training and 10 midwifery schools received support in the form of equipment.

At the 2010 G8 meeting in Muskoka, Canada, the French government committed to spend 500 million Euros over five years to accelerate the achievement of the Millennium Development Goals (MDGs 4 and 5) by improving the health of women and children and promoting human rights. Through the French Muskoka initiative, WHO and other multilateral partners of France, such as UNWOMEN, UNICEF and UNFPA, support the development and implementation of health workforce strategies to improve the maternal and child health situation in the countries supported. A major part of this initiative has been to support the assessment and planning of midwifery practices in four African francophone countries - Democratic Republic of Congo, Guinea, Mali and Togo.



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7th Asia Pacific Emergency and Disaster Nursing Network (APEDNN) meeting.

Emergencies and disaster response

In response to the increasing numbers of people affected by emergencies and disasters, the Asia Pacific Emergency and Disaster Nursing Network (APEDNN) was formed during the Joint Asia Pacific Informal Meeting of Health Emergency Partners and Nursing Stakeholders in Bangkok, Thailand, in October 2007. The network's mission is to promote nursing's ability to reduce the impact of emergencies and disasters on the health of communities. The network aims to:

- establish a system for ongoing interaction among members to strengthen collaboration and mentoring;
- collaborate with others in establishing the research agenda for emergency and disaster nursing;

- develop and share tools, materials and training programmes in emergency and disaster nursing education, services and research;
- identify best practice standards and develop evidence-based guidelines for emergency and disaster nursing practice;
- work with organizations (including ICN, WHO and other leading stakeholders) to implement and validate emergency and disaster nursing competencies;
- implement mechanisms for timely and effective sharing of information and other resources on an ongoing basis, including in times of crisis;
- disseminate information on the work of the network to inform and influence the development of emergency and disaster management policy and resource allocation.

The main output of these meetings was a checklist for the use of nurses in any phase of a disaster. The APEDNN continues to support activities on emergencies and disasters.

The work of the APEDNN has also resulted in many outputs including an emergency and disaster curricular blueprint; capacity-building at national and subnational levels; research training, cross-border research projects and publications; a compilation of case studies of nurses and midwives in disasters/emergencies; a monitoring and evaluation tool to assess progress and identify gaps in emergency and disaster risk reduction, preparation and response.

Nurses played a key role in controlling the spread of disease and in addressing the health needs of displaced people after the devastating floods in Mozambique in 2000. Responsibilities of the nurses included conducting a rapid needs assessment, coordinating with departments of health, providing education on the prevention and treatment of malaria, cholera and diarrhoea, and distributing water purification tablets.



Global strategic
directions for
strengthening
nursing and midwifery
2016-2020



Global strategic
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PART IV

WHO's *Global strategic directions for strengthening nursing and midwifery 2016–2020*

SETTING THE SCENE FOR NURSING AND MIDWIFERY DEVELOPMENT

The Global strategic directions for strengthening nursing and midwifery 2016–2020 are based on various current strategic documents and frameworks. These include the SDGs, UHC, the Global strategy on human resources for health: Workforce 2030 and the recommendations of the High-Level Commission on Health Employment and Economic Growth. The Global strategy on human resources for health: Workforce 2030¹ proposes several interventions that are key in developing the health workforce including nursing. The report of the High-Level Commission on Health Employment and Economic Growth² makes ten recommendations in relation to job creation, gender equality and rights, health service delivery and organization, technology, crises and humanitarian settings, financing and fiscal space, partnership and cooperation, international migration, data, information and accountability; the Commission report concludes that investing in education and job creation in the health and social sectors will make a critical positive contribution to inclusive economic growth. Nursing and midwifery professions are well placed to effectively contribute both to the economic growth of a country and improvement of population health.

¹ Global strategy on human resources for health: Workforce 2030, World Health Organization 2016.

² Report of the High-Level Commission on Health Employment and Economic Growth, World Health Organization 2016.

UN and WHO Member States have committed to the Sustainable Development Goals,¹ the Global Strategy on Human Resources for Health: Workforce 2030,² the Global Strategy on Women's, Children's and Adolescents' Health,³ and the recommendations of the UN High Level Commission on Health Employment and Economic Growth.⁴ These frameworks provide the strategic roadmap for ensuring that investments in the health workforce result in a triple return of improved health outcomes, global health

security, and economic growth through the creation of qualified employment opportunities in the health sector.

The nursing and midwifery workforce is central to the attainment of all these broader strategic goals. WHO continues to act on its strong commitment to strengthening nursing and midwifery services. WHO's *Global strategic directions for strengthening nursing and midwifery 2016–2020* were published in May 2016, and include four objectives:

- 1 Ensuring an educated, competent and motivated nursing and midwifery workforce within effective and responsive health systems at all levels and in different settings
- 2 Optimizing policy development, effective leadership, management and governance
- 3 Working together to maximize the capacities and potentials of nurses and midwives through intra- and inter-professional collaborative partnerships, education and continuing professional development
- 4 Mobilizing political will to invest in building effective evidence-based nursing and midwifery workforce development.

Its development also involved many partners such as ICN, ICM, WFME, ILO and UNICEF.

The previous *Strategic directions for nursing and midwifery* (2002–2008 and 2011–2015) provided policy-makers, practitioners and other stakeholders at all levels of the health-care system with a flexible framework for broad-based, collaborative action to build capacity for nursing and midwifery development.



Launch of the SDNM 2016–2020.

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¹ United Nations (2016). Sustainable Development Goals. <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>

² WHO. (2016). Global strategy on human resources for health: workforce 2030. Geneva, Switzerland. Retrieved from http://www.who.int/hrh/resources/pub_globstrathrh-2030/en/

³ The Partnership for Maternal, Newborn, and Child Health. Global strategy for women's, children's, and adolescents' health. www.who.int/pmnch/activities/advocacy/globalstrategy/en/

⁴ WHO. Working for health and growth: Investing in the health workforce. Geneva: High-Level Commission on Health Employment and Economic Growth. World Health Organization; 2016.



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Global Chief Nursing and Midwifery Officers Meeting, 2016.



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“What is critical [for nursing and midwifery] in the future is to embrace and adopt collaborative strategies with other members of the multidisciplinary health care team. This is key to the delivery of evidence-based, quality care.”

Marie-Paule Kieny, former Assistant Director-General, WHO

The *Global strategic directions for strengthening nursing and midwifery 2016–2020* was launched by Princess Muna Al Hussein of Jordan, WHO Patron for Nursing and Midwifery in the Eastern Mediterranean Region during the seventh Global Forum for Government Chief Nursing and Midwifery Officers which took place in Geneva, Switzerland, on 18–19 May 2016. The 70-strong meeting issued a statement on the future of nursing and midwifery workforce in the context of the Sustainable Development Goals and universal health coverage. The Forum called for strengthened governance and accountability in order to ensure that the overall processes of planning and coordination of nursing and midwifery development are efficient

and are focused on priorities. In addition, the need to maximize the capacity and realize the full potential of the nursing and midwifery workforce was stressed in a call for proper coordination of the education, deployment, management and retention of nurses and midwives in order to ensure an appropriate balance of local competencies and mix of skills. Members of the Forum further emphasized that government and decision-makers' support, commitment and investments are vital for successful strengthening of nursing and midwifery services.

Recent global consensus on the United Nations' Sustainable Development Goals and on the principle of universal health coverage indicates that the focus of nursing and midwifery will continue to evolve. The application of the principle of universal health coverage requires that nursing and midwifery play a central role in the delivery of health interventions.

The demands on health systems are changing – as populations age, urbanization spreads, new infectious diseases emerge, old diseases become resistant to antibiotics, and economic development fosters lifestyles that encourage noncommunicable diseases. In this fast-evolving environment, nurses and midwives, who have already led so many changes over the years, will have key roles in the future in transforming the way health actions are organized and how health care is delivered.

The development of global norms and standards has been one of the core functions of WHO since the Organization was first established. It was early recognized that, in order to apply those norms and achieve those

standards, countries – and their health workers – needed guidelines and tools to assist them. Consequently, WHO at both headquarters and regional levels has generated a large number of publications – many of which have been adapted to

meet specific national needs and to fit local contexts – to enable nurses and midwives to do their jobs better and to take on new and more important roles.

During the seven decades of its existence, WHO has made significant contributions to the roles and achievements of nurses and midwives. A few of these achievements are listed in Table IV.1.

Of the 42 million health workers in the world (2013 data), it is estimated that 19.7 million are nurses and midwives. It is further projected that by 2030 the health workforce need will grow to 71.8 million, of which 37.2 million will be nurses and midwives. At the same time, health conditions are increasing and are becoming more complex – including noncommunicable, communicable, emerging and re-emerging diseases. This will result in even more demands for nursing and midwifery services.

The series of strategic directions for strengthening nursing and midwifery shape WHO's contemporary nursing and midwifery agenda. Regional offices are also making strides in putting in place their respective strategic directions. The regional guidelines for implementing the strategic directions in the African Region aim to accelerate action at country level.¹ The guidelines also provide both a framework for WHO action to support

Table IV.1.
WHO contributions to the role and achievements of nurses and midwives

Area	Achievements
Primary health care and people-centred care	<ul style="list-style-type: none"> • Primary health care and models of care led by nurses and midwives in communities and families; women-centred care and the midwifery model of care • Meeting the needs of people with disabilities, chronic conditions and NCDs, including the needs of those who require palliative care • Core competencies in primary health care are being addressed • Capacity-building in areas of emergency and disaster response, infection control, mental health and substance abuse • More involvement in community health services • Nurse-led multidisciplinary and multi-professional team-growing
Workforce policy and practice	<ul style="list-style-type: none"> • National strategic plans for nursing and midwifery • Greater commitment to regulation, legislation and accreditation • Regulation, education and practice standards • More commitment to establishing reliable nursing and midwifery databases
Education	<ul style="list-style-type: none"> • Adoption of competency-based training at pre-service, continuing education and faculty levels • Progress toward advanced nursing and midwifery practice
Career development	<ul style="list-style-type: none"> • Gradual improvement in developing upgrade and bridging programmes • Leadership, skill development and presence in leadership positions
Workforce management	<ul style="list-style-type: none"> • Agreements reached on the need to increase recruitment, retention, motivation and participation supported by global initiatives on retention • Implementation of better technology and communication platforms for nursing and midwifery workforce capacity-building and the dissemination of good and best practices
Partnerships	<ul style="list-style-type: none"> • Moves towards strengthening collaboration with donor partners and NGOs in order to address challenges • Much more synergy between WHO Collaborating Centres for Nursing and Midwifery Development and other stakeholders such as ICN and ICM • Enhanced faculty development and fellowships awarded through North-North and North-South partnership collaboration

Source: Adapted from WHO progress report on nursing and midwifery. Geneva: World Health Organization; 2013:117–118 (http://www.who.int/hrh/nursing_midwifery/progress_report/en/, accessed 20 July 2016).

¹ WHO Guidelines for Implementing Strategic Directions for Strengthening Nursing and Midwifery Services in the African Region 2007–2017. Brazzaville: World Health Organization Regional Office for Africa; 2007.

countries in improving the quality of nursing and midwifery services, and a guide for action at national and local levels. Possible priority actions have been proposed to countries to facilitate strengthening of nursing and midwifery services at national and local levels. These guidelines will be updated in the view of the new *Global strategic directions for strengthening nursing and midwifery 2016–2020*.

The Regional Office for the Americas is also in the process of developing a regional strategic direction for nursing. In the Eastern Mediterranean region, a “framework for action” to strengthen nursing and midwifery is an update of the earlier regional strategic directions. The new *Framework for action: Strengthening Nursing and Midwifery in the Eastern Mediterranean Region 2015–2025*¹ sets out the following vision:

“Progressing towards the Sustainable Development Goals and the Universal Health Coverage, nurses and midwives, as part of the multidisciplinary healthcare team, contribute to improved health outcomes and the well-being of the society.”

The *European strategic directions for strengthening nursing and midwifery towards Health 2020 goals*² and *Nurses*

*and midwives: a vital resource for health. European compendium of good practices in nursing and midwifery towards Health 2020 goals*³ were both launched at the WHO Regional Committee meeting in Vilnius, Lithuania.



A Strategic Action Plan for Nursing and Midwifery Development in the Western Pacific Region was developed in 2008.⁴

In moving the WHO nursing and midwifery agenda forward, efforts will have to be directed towards ensuring an educated and competent nursing and midwifery workforce. This should take into account appropriate skill mixes and educational levels. For instance, advanced nurse practice will depend on country needs and bridging programmes for career advancement while maintaining quality and competence. There will

need to be optimization of policy development, leadership and governance, maximization of the potential of the nursing and midwifery workforce with other professionals, and mobilization of political will to invest in nursing and midwifery. Nursing and midwifery interventions will have to utilize principles that demonstrate ethical actions, relevance, ownership, quality, people-centred services, and interprofessional education and collaborative practice. International, regional, national and local partnerships will be key in moving the agenda forward.

As a concrete example of its inclusive partnership approach, WHO, in collaboration with the United Kingdom's All-Party Parliamentary Group on Global Health, convened in April 2017 a policy dialogue meeting on the nursing workforce. The meeting provided the platform to discuss the creation of a global nursing campaign as a vehicle to drive the development and advancement of nursing worldwide. As a result of this event, preparations were started to launch the “Nursing Now!” campaign, which aims to raise the profile of nursing globally, make it more central to health policy and ensure that nurses can use their skills, education and training to their full capacity in order to:

¹ Framework for action: Strengthening Nursing and Midwifery in the Eastern Mediterranean Region 2015–2025. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2015. Eastern Mediterranean Health Journal. 2015;21(9):698–701 (http://applications.emro.who.int/emhj/v21/09/EMHJ_2015_21_9_698_701.pdf?ua=1&ua=1, accessed 15 August 2016).

² European strategic directions for strengthening nursing and midwifery towards Health 2020 goals. Copenhagen: World Health Organization Regional Office for Europe; 2015.

³ Nurses and midwives: a vital resource for health. European compendium of good practices in nursing and midwifery towards Health 2020 goals. Copenhagen: World Health Organization Regional Office for Europe; 2015.

⁴ Strategic Action Plan for Nursing and Midwifery Development in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2008.

- improve health and well-being and, in particular, enable the achievement of Universal Health Coverage;
- support the empowerment of women globally, by creating more opportunities for employment and influence and raising their status within the workforce;
- develop local economies through employment within health, health services and associated areas.

In the context of these developments and new opportunities, WHO collaborating centres for nursing and

midwifery development will continue to provide WHO with expertise to shape the nursing and midwifery agenda to meet future health challenges worldwide.

This history has indicated the growing relevance of WHO Collaborating Centres for Nursing and Midwifery Development to the strengthening of WHO's work and the work of vast numbers of nurses and midwives worldwide over the years. Boxes IV.1 to IV.6 highlight the continuing efforts of just a few of these collaborating centres, beginning with the very first one in

Chicago that was designated in 1986.

At the time of finalizing this report, in October 2017, WHO Director-General Dr Tedros Adhanom Ghebreyesus announced the appointment of Cook Islands' Elizabeth Iro as WHO's Chief Nursing Officer. This appointment fulfils a commitment he made during his transition to the Director-General role to appoint a nurse to his senior team, and signals the recognition by WHO that nurses are central to achieving universal health coverage and the Sustainable Development Goals.

Box IV.1.**The WHO Collaborating Centre for Nursing and Midwifery Development, Chicago, USA**

The year 2016 marks the 30th anniversary of the designation of the College of Nursing of the University of Illinois at Chicago (UIC) as the first WHO Collaborating Centre for International Nursing Development in Primary Health Care. In August 1986, during a formal inauguration ceremony at the university, the then Dean of the College of Nursing described the designation as “. . . very exciting, not only because it is a singular honor which has never before been conferred on any other College of Nursing, but also because it is a reflection of WHO’s trust and confidence in the College’s commitment to international nursing development.”

The designation ceremony was immediately followed by a three-day conference on “Leadership in nursing for Health for All: echoing in the area of the Americas”. The conference included some of the world’s foremost leaders in nursing and health, including WHO’s Senior Nurse Scientist and Deputy Director-General; the Director of the Pan American Health Organization, and the USA’s Chief Nursing Officer and Deputy Surgeon-General. During her remarks at the conference, the Dean of the College of Nursing stated that “we cannot achieve WHO’s goal of Health for All . . . without focusing the full potential, capabilities, and technical expertise of nurses throughout the world. By accepting the responsibility for leadership and for innovation, we also accept the challenge to reach that goal.”

The UIC College of Nursing was elected as the first Secretariat of the Global Network of WHO Collaborating Centres for Nursing Development (now called the Global Network of WHO Collaborating Centres for Nursing and Midwifery) and served in this role until 1994. The designation of UIC designation has been continuously maintained since 1986, with the most recent redesignation covering the period 2015–2019.

The WHO Collaborating Centre at UIC serves as a resource to nurses around the world. Collaborating Centre staff continually work with WHO to promote technical cooperation among countries, to develop and share educational materials, to disseminate information, and to initiate collaborative nursing research projects of regional and international significance. Global Health Leadership at the College of Nursing promotes diversity and participation both domestically and internationally, with a focus on primary health care nursing. The College of Nursing has identified the following Global Health Leadership objectives:

1. To enhance the abilities of nurses worldwide to advance Health for All goals both globally and in their home communities, and to advance the UN Millennium Development Goals.
2. To provide educational experiences for nurses from countries outside the USA that enables them to develop sound, culturally sensitive nursing resources in their home countries.
3. To provide opportunities for all students in the College of Nursing to acquire a global perspective on matters of health and nursing.
4. To prepare nurses for interdisciplinary leadership in global health.
5. To facilitate faculty international outreach and collaboration on professional matters of common interest, including research, service and educational programs.
6. To support/prepare/guide faculty to function in a global health environment.

Source: Report of the Expert Committee on Midwifery.

Box IV.2.

The WHO Collaborating Centre for Nursing and Midwifery Development, Manama, Bahrain

In August 1990, the Nursing Division of the College of Health Sciences, Ministry of Health, Bahrain, was designated as the first WHO Collaborating Centre for Nursing Development in the WHO Eastern Mediterranean Region. In June 1992, the centre became a full member of the Global Network of WHO Collaborating Centres for Nursing and Midwifery.

The first Global Network of WHO Collaborating Centres for Nursing and Midwifery Conference was held in Bahrain in March 1996 where the theme was ‘Nurses and Midwives: Making a Difference.’

The centre is now located at the University of Bahrain after the College of Health Sciences was moved from the Ministry of Health to the University of Bahrain. Since its designation as a WHO collaborating centre, it has been active in moving forward the nursing agenda in the region. The centre has played a vital role in the Technical Nursing Committee of the countries of the WHO Eastern Mediterranean Region in general and of the Gulf Cooperation Council in particular. Over the years since its designation, the Bahrain collaborating centre has received WHO fellows in different fields of nursing and midwifery from other Member States of the Eastern Mediterranean Region. The centre has contributed to the development of the health workforce in the region.

The Centre contributed to the development of the first Strategic Directions for Strengthening Nursing and Midwifery Services 2002 to 2008. It was endorsed by the following partners: ICN, ICM, ILO, UNICEF, UNFPA, Global Network of WHO Collaborating Centres, International Federation of Nurse Anaesthetists, International Society of Nurses in Cancer Care and the Sigma Theta Tau International Honor Society of Nursing.

Box IV.3.

The WHO Collaborating Centre for Nursing and Midwifery Development, Gaborone, Botswana

The University of Botswana School of Nursing (formerly the Department of Nursing Education) was designated a WHO Collaborating Centre for Nursing and Midwifery Development in 1990. It was the first WHO Collaborating Centre to be designated in sub-Saharan Africa. All academic staff of the School of Nursing are members of the centre.

The collaborating centre’s purpose is threefold: to undertake collaborative research to generate evidence for improved access to quality community home-based care for vulnerable groups; to build partnerships and networks with community organizations that provide services to clients with maternal health, child health and mental health needs and challenges; and to develop capacity-building programmes for frontline community home-based care providers and family caregivers to improve the quality of home-based care services.

The centre has forged partnerships with a range of international, national and local organizations – such as the Botswana Retired Nurses Society and the Botswana Family Welfare Association. Partnerships with schools of nursing in the USA have resulted in student exchanges, a visiting scholar programme, a community health nursing course by videoconferencing, joint publications and other collaborative activities. Undergraduate students from the USA come to Botswana for their clinical experience in community health nursing, while students from Botswana have been able to take courses in the American partner universities.

The collaborating centre has adopted a small village about 20km from the capital as a site for clinical teaching for nursing and midwifery, has held workshops on home-based care for nurses working in the primary care settings, and has provided basic training to community volunteers who assist community home-based nurses and family caregivers with routine tasks such as the bathing and feeding of patients. Thanks to grants from the University of South Africa and the University of Kwazulu Natal, the centre is mentoring new schools of nursing in Kenya and Rwanda.

While the collaborating centre is constantly active, the lack of full-time personnel (i.e. the centre’s staff all have responsibilities in the school of nursing) limits its scope. For instance, the director of the collaborating centre is also the full-time head of the nursing school with administrative and teaching responsibilities.

Box IV.4.**The WHO Collaborating Centre for Research and Training for Nursing Development in Primary Health Care, Seoul, Republic of Korea**

Designated as a WHO Collaborating Centre in 1988, the Yonsei University College of Nursing was the first nursing-related collaborating centre in the Republic of Korea and one of the earliest Korean collaborating centres across all disciplines. The Yonsei centre served as Secretariat of the Global Network for WHO Collaborating Centres in Nursing and Midwifery from 1994 to 1998 and convened the second Global Network executive and general meetings as well as the international conference in 1998. The centre also hosted the Asia Pacific Emergency and Disaster Nursing Network meeting in 2011, which aimed to strengthen nurses' competence in disaster preparedness.

The Yonsei collaborating centre has pioneered a number of firsts for Korean nursing at several levels (e.g. the first masters programme in nursing, first PhD programme, first advanced practice nursing programme and others). The centre is also well-recognized for its active international collaboration and training for nursing development in primary health care. It has led the way in promoting the nurses' role as primary health providers in rural communities where physicians are lacking, as well as conducting numerous training and capacity-building activities for nurses and nursing.

The Yonsei University College of Nursing celebrated its 110th anniversary in September 2016 and looks forward to more concerted work and collaboration in advancing the Sustainable Development Goals and further contributing to nursing development.



© Yonsei University College of Nursing

110th anniversary of the Yonsei University College of Nursing.

Box IV.5.**The WHO Collaborating Centre for Nursing and Midwifery Development, Chiang Mai, Thailand**

The Faculty of Nursing of Chiang Mai University first conducted regional and international training sessions on behalf of WHO in 1997 and the relationship was formalized in September 2003 when the faculty was designated as a WHO Collaborating Centre for Nursing and Midwifery Development. The centre focuses on improving nursing and midwifery education and service as well as promoting the uptake of evidence-based practice through systematic reviews and the development of evidence-based guidelines.

The centre's terms of reference, which were updated as of October 2015, require it to serve as a resource centre for nursing policy formulation, planning, administration, management and nursing outcomes; to build capacity of nurses and midwives in systematic reviews and evidence-based practice guidelines and disseminate the products nationally and internationally; to develop the capacity of nurses and midwives in the areas of education and service; and to conduct meetings and/or develop documents related to maternal, newborn and child health nursing, midwifery, infection control or healthy ageing.

In the almost 20 years since it began collaboration with WHO, the nursing faculty has played a strong role in building nursing and midwifery capacity and has become nationally and internationally recognized. Some graduates of its programmes have become leaders in the international area. The collaborating centre has conducted 29 regional and international training courses for 119 WHO fellows. It has also hosted 12 regional and international workshops, training-of-trainers courses and consultation meetings for a total of 540 nurses and other health professionals such as doctors, epidemiologists, staff from ministries of health and public health specialists.

The main challenge for the collaborating centre has been to balance the core teaching and research duties of the Faculty of Nursing with the services provided through the collaborating centre. The WHO collaborating centre has no dedicated staff, but rather relies on full-time faculty and staff who have other responsibilities at the Faculty of Nursing.

Collaboration with WHO has played a strong role in helping the centre to develop its own capacity in addition to providing services to others. The collaborating centre will continue to improve nursing and midwifery by providing technical assistance and helping to develop the capacity of health professionals, so that they in turn can develop capacity within their own countries. As many of the countries in the WHO South-East Asia Region are still in the early stages of developing graduate and postgraduate nursing and midwifery programmes, the centre can help to upgrade the credentials of nurses and promote the consistent use of evidence-based guidelines in the region.

Box IV.6.

The WHO Collaborating Centre for Nursing, Midwifery and Health Development, Sydney, Australia

The WHO Collaborating Centre for Nursing, Midwifery and Health Development at the University of Technology Sydney (UTS) was first designated in 2008 was redesignated in 2012 and again in 2016 until 2020. The centre is located in the Faculty of Health and operates independently.¹ The centre collaborates with regional and global partners in a range of institutions; it is overseen by a management committee at the university while its strategic vision and international work is overseen by an advisory group with members from NGOs, other universities and government organizations.

The centre's areas of focus include: improving health system outcomes by building capacity, strengthening cross-sectoral relationships to support improved service provision, supporting national and international development of the nursing and midwifery workforce, and strengthening maternal and child health-care standards and services. In practical terms the UTS collaborating centre provides project management, technical advice, research, policy analysis, consultancy, advocacy, training and short courses, monitoring and evaluation and capacity-building. Since 2009, 106 persons from 15 different countries have participated in the centre's leadership and capacity-building projects. It also facilitates the collection of nursing and midwifery data from Pacific island countries for WHO's Western Pacific Regional Office. The centre acts as secretariat for the South Pacific Chief Nursing and Midwifery Officers' Alliance, and (2014–2018) for the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development.

Challenges faced by the Sydney collaborating centre include: working with nursing and midwifery professionals to achieve universal health coverage; supporting colleagues to obtain recognition of the key role that nurses and midwives play, particularly in relation to Sustainable Development Goals; and the need for more data on health, nursing and midwifery resources to align research and evidence to inform models of care and workforce solutions. Since the Pacific islands are particularly vulnerable to climate-related disasters, improving planning and more effective health responses in times of natural disaster is a growing part of the centre's work.

The centre aims to contribute to the future of nursing and midwifery through strengthening and promotion of nursing and midwifery leadership, education, practice and research towards the social goal of "Health for All" through primary health care.

¹ See: <http://www.uts.edu.au/research-and-teaching/our-research/who-collaborating-centre> (accessed 2 August 2016).

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WHO Collaborating Centre for Nursing, Midwifery and Health Development at the University of Technology Sydney (UTS), Australia.

CONCLUSIONS

The historical account laid out in this document demonstrates that the importance of nursing and midwifery has always been recognized, but not necessarily in a consistent manner. The seven decades covered in this historical narrative witnessed a gradual shift away from single-theme principles (e.g. disease eradication campaigns serving as the opening wedge to the development of rural health services, or the importance of a regional health structure providing coverage to all rural areas) to much broader ones, such as the concepts of universal health coverage and good health as a lever for sustainable development. The Global Strategy on Human Resources for Health: Workforce 2030 acknowledges the critical contribution of the nursing and midwifery scope of practice to address population needs. Effective use of limited resources and implementation of evidence-based workforce policies in ensuring appropriate regulation, skills mix, working conditions, continuous professional development and career pathways are critical to realize this capacity.


The prospect of a successful future for nursing and midwifery is intricately linked to a balanced and sustained increase of the socio-economic empowerment and recognition of the status of women in the workplace. Member States and other partners' commitments to ensure women's full and equal participation and leadership in the economy, as well as women's right to work and rights at work, is vital for achieving sustainable development, as underscored by the United Nations Commission on the Status of Women and the High Level Commission on Health Employment and Economic Growth. The five-year action plan of the Commission on Health Employment and Economic Growth, "working for health", is grounded on compelling scientific evidence, socioeconomic arguments and renewed impetus created by the aforementioned and other relevant multi-stakeholder commitments.

Concrete investments in the education and deployment of nursing and midwifery personnel is also needed. Evidence from the State of the World's Midwifery 2014 accorded midwifery a "best-buy" status in primary health care. This resulted from a value-for-money assessment conducted in Bangladesh which showed a 16-fold return on investment when compared with the impact of child immunization. Similarly, the Global Strategic Directions for Strengthening Nursing and Midwifery 2016–2020 highlights the versatility and cost-effectiveness of nurses and midwives in delivering key services if adequately supported and well regulated.

Long term planning is necessary to make available human resources for health more responsive to local needs. Changing local and national political scenes, as well as changing global policies, have affected countries' and international organizations' ability to realize consistent long-term reforms. More detailed research is needed to help tease out the most important factors operating both positively and negatively to affect nursing and midwifery especially at country level.


Finally, greater political will by health planners and decision makers is needed to shape and implement policies and programmes that inculcate a leadership culture into nursing and midwifery health service delivery. Nurses and midwives must increasingly join in at the policy and decision-making table if their voices are to be heard. WHO together with partners will continue to use relevant existing and new initiatives to assist countries in implementing the policy advocacy measures to instil greater leadership for nursing and midwifery.

PERSPECTIVES ON THE FUTURE OF NURSING AND MIDWIFERY




Today nurses are more creative and better trained around the world than ever before. As I now have experienced hospitalization and home health care myself, I realize that their role in research and care is more important than ever.

Theresa Rope Elizabeth Miller, Regional Nurse Advisor, WHO Western Pacific Region, 1985–1995.




Evidence is incontrovertible that nurses and midwives play a multitude of vital and pivotal roles in enacting health improvements in promotion of universal health coverage and sustainable development goals. The maximal utilization of nursing and midwifery experts within WHO and in full partnership with WHO will support inter-professional technical planning across areas of work and ensure a future of high quality people-centered, integrated care.

Kathleen L. Fritsch, Regional Nurse Adviser, WHO Western Pacific Region, 2000–2013.




I believe that nursing knowledge, holistic and humane, must be integrated in all of the WHO programmes promoting health in countries. The WHO Nursing Unit must keep its role as coordinating and promoting this objective.

Dr Miriam Hirschfeld, Chief Scientist for Nursing, WHO Headquarters, 1989–1997.




Nursing and midwifery in WHO should advocate for increasing investment in the nursing and midwifery workforce as an important member of the health team for strengthening the health systems' response, particularly for achieving universal health coverage and equity in health. Moreover, it is essential to further strengthen the integration of nursing and midwifery services to all WHO programmes. Presence of nurse-midwife technical expert(s) at WHO headquarters and regional offices is crucial to lead, facilitate and support nursing and midwifery development at the national, regional and global levels.

Dr Duangvadee Sungkhobol, Regional Nursing Officer, WHO South-East Asia Region, 1991-1998; Regional Adviser for Nursing and Midwifery, WHO South-East Asia Region, 1999-2005.




Looking back, I am happy to say that the work accomplished under my leadership has contributed to strengthen our integration and enhance our relationships with the general public, advocating for nursing and midwifery and their contribution to people's health. After a journey of more than 25 years together, we are really proud of our history of collaboration and partnerships! Thank you very much for your trust and especially for the strong bonds of friendship we have built together in strengthening the contribution of nursing and midwifery to global health!

Dr Isabel Amélia Costa Mendes, Coordinator, Deputy Director and Director of the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development 2008-2014.




I see a great need for nursing and midwifery within WHO at all levels, but especially at the country and regional ones. However what I see is erosion of posts and decreasing attention to the needs of a profession that is vital to the health of any nation.

Judith A Oulton, Chief Executive Officer, International Council for Nurses, 1996-2008.




The development of higher degrees in nursing and midwifery to drive the scholarship and leadership in nursing and midwifery needs to be accelerated, the development of evidence based, competency-based nursing and midwifery curricula and the development of regulatory bodies in all countries in the WHO African Region.

Prof Busisiwe Ncama, Director, WHO Collaborating Centre for Nursing and Midwifery, University of KwaZulu-Natal, South Africa, 2011-present; Associate professor, Dean and Head of School, School of Nursing and Public Health, 2012-current.




Being part of the global network of WHO collaborating centres has opened the doors for increased engagement with nursing and midwifery leadership in every region: the opportunity to share successful models of expanded roles for nursing and midwifery, to respond to escalating humanitarian crises as a central cadre, and to unite to promote this leadership at the highest levels of WHO, regional and country levels. This is nursing and midwifery's time – the doors can be pushed open for our learned wisdom and collective experience to move forward, tackling health inequities, and pushing for the justice of everyone's human right to the highest level of health attainable.

Dr Jennifer Dohrn, Director of the WHO Collaborating Centre for Advanced Practice Nursing, Columbia University, Faculty of Nursing.




Nurses and midwives should strive for leadership roles in WHO to enhance nursing and midwifery contributions to global health.

Dr Eric Chan, Coordinator, Health Profession, Nursing and Midwifery, WHO Department of Human Resources and Health, July–December 2010.




Nurses and professional nursing must be ready for the challenges. We must not cling to cherished ways and passé functioning when that stance interferes with our goal of health for the people of the world. We must be collaborators, and yes leaders, but we must not think we can be insular. We must join the new ways and new advances and we must continue to lead in this new environment.

Dr Rita M Carty, Secretary General of the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development, 2000–2004.




I think WHO will continue to reinforce nursing and midwifery to be a priority over the coming years. It will support Member States in strengthening nursing and midwifery to improve the health of the people by leading and supporting the countries to implement the global strategic directions and the regional frameworks for actions to develop nursing and midwifery services further in support of the sustainable development goals.

Dr Fariba Al-Darazi, Regional Adviser for Nursing, Midwifery and Allied Health Personnel, 2000–2015; Coordinator, Health Workforce Development, 2013–2015, WHO Eastern Mediterranean Region.




I see a promising and great future for nurses in WHO as far as nurses can see the opportunities and take advantage of several situations to promote their inclusion in several WHO posts. The special, wide and complex education that nurses receive everywhere, and their progressing capacity to participate in policy and strategic development of health services and practice, allow them to be at a singular advantage to obtain posts and collaborate with WHO at different levels.

Dr Silvina Malvárez, Regional Advisor of Nursing and Health Personnel Development, Pan American Health Organization, 2002–2013.



Future nurses and midwives will continue to contribute to protecting the health of women and children. They will protect the right to health of all, especially in difficult situations, by being equipped with the most cost-effective technology at local level, working in teams and in partnership with others. They will contribute to strengthening nursing and midwifery services as key components of country health systems in order to ensure health security and peace. Their work will be based on evidence, as reflected in policies, strategies and plans at national and global levels, and they will advocate for equity, justice and a safe environment for all. To meet WHO's constitutional mandate, a strong nursing and midwifery presence in the organization is crucial and will be much needed in future.

Dr Naeema Al Gasseer, Senior Scientist for Nursing and Midwifery, WHO Headquarters, 1999–2003.



I foresee that, in order for nursing and midwifery in WHO to maintain or increase international influence, the representative, rather than being a coordinator in WHO's Geneva headquarters, should have the status and power of a nursing director with independent decision-making capacities and with active participation in the selection and training of the regional advisors. With the recent structure of nursing in WHO, I see the risk that the nursing and midwifery development in each region will depend on the power and judgment of the regional advisor and that the link with WHO headquarters will gradually be weakened and the influence of this visionary leader will be reduced. The collaborating centres will not have the privilege and opportunity to receive feedback, be empowered and have access to sharing ideas with the chief nursing officer directly to improve the potential contribution of these centres.

Dr Ilta Lange, Director, WHO Headquarters, 2003–2012.

ANNEXES

ANNEX 1. LIST OF PARTICIPANTS

Meeting on the History of Nursing and Midwifery

Château de Penthes, Geneva

15-16 September 2015

AFRICA

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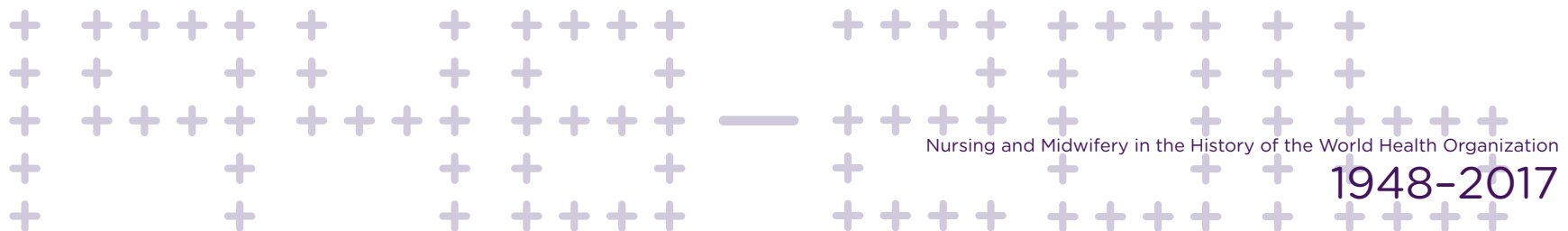
Tomas ALLEN, Library and Information Networks for Knowledge, World Health Organization, Geneva, Switzerland

Jing WANG CAVALLANTI, Technical Officer, Global Health Histories, WHO Press, World Health Organization, Geneva, Switzerland

ANNEX 2. WORLD HEALTH ASSEMBLY (1949–2015) RESOLUTIONS ON NURSING AND MIDWIFERY

Table 1.
Key decisions of the World Health Assembly (1949–2015)

Year	Resolution
2011	WHA64.7 Strengthening nursing and midwifery
2006	WHA59.27 Strengthening nursing and midwifery
2001	WHA54.12 Strengthening nursing and midwifery
1996	WHA49.1 Strengthening nursing and midwifery
1992	WHA45.5 Strengthening nursing and midwifery in support of strategies for health for all
1989	WHA42.27 Strengthening nursing/midwifery in support of the strategy for health for all
1983	WHA36.11 The role of nursing/midwifery personnel in the strategy for health for all
1977	WHA30.48 The role of nursing/midwifery personnel in primary health care teams
1950	WHA 3.67 Increasing and improving the supply and use of nurses
1949	WHA 2.77 Expert Committee on Nursing



Nursing and Midwifery in the History of the World Health Organization

1948-2017



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