commonwealth nurse

Journal of the Commonwealth Nurses Federation
Issue 44 June 2011

20th CNF BIENNIAL CONFERENCE MALTA

BOARD AND OFFICERS

Elected Officers

Susie Kong (Singapore)
President

Satish Chawla (India)
Vice President

Ioannis Leontiou
Cyprus
Europe Region

Alice Asare-Allotey
Ghana
West Africa Region

Arvind Kulkarni
India
South Asia Region

Ramziah Bt Ahmad
Malaysia
Pacific Region

Donald Epaalat
Kenya
East, Central and
Southern Africa Region

Marion Howard
Barbados
Atlantic Region

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

Commonwealth Nurses Federation
c/o Royal College of Nursing
20 Cavendish Square W1G 0RN London UK
Tel: + 44 (0) 20 7647 3593
Fax: + 44 (0) 20 7647 3413
Email: cnf@commonwealthnurses.org
Website: http://www.commonwealthnurses.org

ISSN 2047-170X

Published by the Commonwealth Nurses Federation
Printed by Art Avenue, Selangor, Malaysia

Printed with the support of the Commonwealth Foundation

Commonwealth Foundation

Appointed Officers

Jill Iliffe
Executive Secretary

Angela Neuhaus
Honorary Treasurer

from the PRESIDENT

Susie Kong
CNF President

The Commonwealth Nurses Federation held a very successful 20th Biennial Conference and Meeting in Malta 29-30 April 2011. I want to thank the Malta Union of Midwives and Nurses for their wonderful hospitality and the opportunity to visit their beautiful country.

The Conference theme, *Nurses and midwives: meeting the challenges of the 21st Century* was appropriately chosen and timely. Attaining the Millennium Development Goals and developing a sustainable workforce are challenges nurses have to face daily in their work and the views presented by the speakers on these critical issues were well received by participants. Some of the presentations are on the CNF website and I encourage you to view them.

During the Biennial Meeting, members had fruitful discussions and deliberations on amendments to the CNF Constitution. There were a couple of significant changes endorsed which may be of interest to those who were unable to attend the meeting. The proposed changes have been circulated for comment and the new Constitution will be forwarded to all members 1 August 2011 and uploaded to the CNF website. The Board also decided to organise an *Inaugural Commonwealth Nurses Conference* in London, 10-11 March 2012 in conjunction with Commonwealth Week celebrations. I hope to see you in London.

Another amendment was the re-organisation of the Pacific and South Asia Regions. It was proposed that since Malaysia and Singapore are geographically located in Asia and are culturally aligned, it is logical for these countries to be incorporated within the South Asia Region and the region be renamed the Asia Region. We will keep you informed when the process is finalised.

The CNF is celebrating its 38th anniversary this year and although it has come a long way, I feel that the CNF could still improve its visibility as an organisation to the wider community.

During this biennium, I would like to see the CNF and its member countries work together to create a stronger identity. The CNF will continue to focus on organising in-country educational projects in partnership with national nurses associations.

It would be great if each member country could organise a fund-raising or fun activity in the name of the CNF. In organising the event, try to involve local leaders and other professional organisations, to help promote and raise awareness of the CNF to the wider community of nurses and midwives. After you have conducted the event, please let us know so we can highlight the event in our monthly e-News and share your success with others.

Thank you for your continued encouragement and support. I look forward to meeting you in London at our Inaugural Conference. The announcement and call for papers has been widely circulated. For more information, please see the back page of this issue of the Commonwealth Nurse or alternatively you can visit: http://www.commonwealthnurses.org.

CNF CELEBRATES 20TH BIENNIAL

The Malta Union of Midwives and Nurses (MUMN) were hosts to the 20th CNF Biennial Meeting and Conference 29-30 April in St Julian's, Malta. Over 100 members from 18 countries gathered to hear world renowned speakers and to discuss and debate issues relevant to nurses and midwives across the Commonwealth.

The Conference was officially opened by Malta's Minister for Health, Elderly and Community Care, Dr Joseph Cassar, supported by the President of MUMN, Mr Paul Pace and President of CNF, Miss Susie Kong.

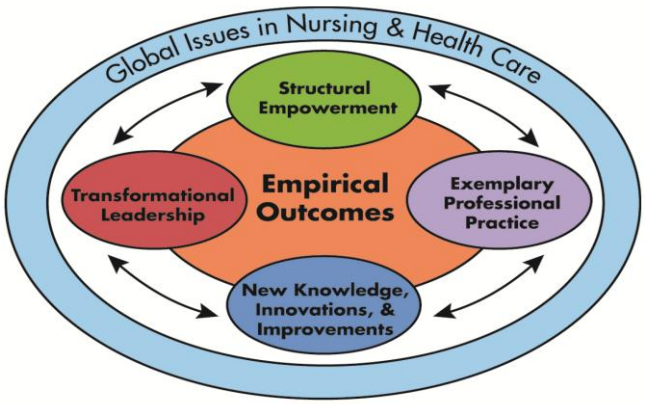
Delegates were entertained with traditional cultural dances depicting scenes from everyday life in Malta.

Ms Lee Thomas, National Secretary of the Australian Nursing Federation discussed the benefits and dangers of task shifting; Ms Christine Hancock from C3 Collaborating for Health outlined what nurses and midwives need to do to stay healthy particularly in relation to preventing non-communicable disease; and Professor James Buchan from Queen Margaret University, Edinburgh shared with delegates the process for developing a country plan for a sustainable health workforce.

Dr Stephanie Ferguson, Associate Professor from Virginia Commonwealth University School of Nursing described strategies that nurses and midwives can follow to achieve the health MDGs in their country; Ms Dorothy Matebeni, President of the Democratic Nursing Organisation of South Africa addressed inequalities in providing universal access to health care; and Ms Rachel Bard, CEO of the Canadian Nurses Association explored the nurses' role in primary health care.

Key note speaker to the Biennial was Dr Karen Drenkard, Executive Director of the American Nurse Credentialling Centre. Dr Drenkard addressed delegates about transforming nursing and the building blocks required to be successful. These building blocks were described as:

* Transformational leadership,
* New knowledge, innovation and improvement,
* Exemplary professional practice, and
* Structured empowerment.



Globally, Dr Drenkard noted, developing countries face seemingly insurmountable obstacles including the migration of their nursing and midwifery workforce to other countries and a lack of resources to deal with the health challenges their countries face: having 90% of the global health burden but only 10% of global health resources. Developed countries also have challenges. Health budgets have been cut as a result of the global financial crisis, with nurses and midwives being the most effected and struggling with governments choosing to invest in less costly health workers. All countries are battling with poverty and unequal distribution of resources; chronic disease; ageing populations; and the challenges of technological innovation.

Transforming nursing, Dr Drenkard explained, involved taking positive steps to push forward in nursing and midwifery, and:

* Expanding nursing and midwifery education,
* Staying at the forefront of research,
* Assuming leadership roles,
* Advocating for good health, equality and justice, and
* Maintaining excellence in nursing and midwifery regulation and practice.

The American Nurse Credentialing Centre also sponsored the 20th CNF Biennial Dinner.

ANCC
AMERICAN NURSES CREDENTIALING CENTER

Delegates were privileged to hear from Mr Philemon Ngomu Nyangi, executive Director of the Southern African Network of Nurses and Midwives about the extensive program of work being undertaken by that organisation.

MR PHILEMON NYANGI WITH AFRICAN COLLEAGUES

Prior to the Biennial, the CNF Board met when changes to the CNF Constitution and the CNF's strategic plan 2011-2015 were discussed.

THE BENEFITS AND DANGERS OF TASK SHIFTING

Lee Thomas
National Secretary
Australian Nursing Federation

Global shortages of nurses and midwives; migration of qualified nurses and midwives from low-resource countries to wealthy countries; increased incidence of chronic diseases; epidemics of infectious diseases; falling behind on meeting the Millennium Development Goals; ongoing impact of the global financial crisis; slashing of health budgets by governments; world population growth; and ageing populations in many countries: makes a gloomy picture doesn't it? But these factors are largely the drivers of the emergence of 'task shifting'.

What does that phrase mean in the context of health care? To some people the words 'task shifting' generates that their role is under threat! For others though, 'task shifting' may mean liberation within their role, and an opening up of opportunities. So let us explore the dangers and benefits of 'task shifting', as it relates to nursing and midwifery.

The World Health Organisation defines 'task shifting' as: *A process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications,* and *extending the scope of practice of existing [groups] of health workers to allow for the rational redistribution of lesser qualified health care staff taking on activities that have been the exclusive role of higher skilled staff.*

That is, assistants in nursing, personal care workers, health care workers, community health workers, or whatever title you give them in your country, undertaking care activities which have been traditionally performed by registered nurses or midwives. 'Task shifting' from registered nurses and midwives to other workers undertaking what we know as nursing care, is occurring in almost every country across the globe – so this affects us all.

Let me give you an example from Australia to illustrate points I will be making in this paper. Unlike some countries, Australia has registered nurses and midwives and enrolled nurses. All of these must be registered in order to practice.

In addition there is legislation which dictates who can and who cannot manage medicines. Until recent years, enrolled nurses were not legally able to administer medicines. This has now changed and so within the regulation there is sanctioned 'task shifting' of aspects of medicines management from registered nurses and midwives to enrolled nurses.

In aged care settings in Australia, assistants in nursing have moved from doing largely domestic tasks to now undertaking nursing care activities. Because this category of worker is not regulated and the legislation is silent regarding them being able to handle medicines, slowly but surely they have become more involved in the administration of medicines. They are using pre-packaged medication containers under the guise of assisting residents to self-administer. In reality, these workers are now administering medicines. This type of 'task shifting' has occurred without any regulatory or legislative support structures and places the elderly people in our aged care facilities in a vulnerable position.

So this leads me into dealing with possible dangers of 'task shifting':

- decreased quality of care,
- incorrect treatment,
- inability to deal with adverse reactions to medicines or complications of a condition,
- failure to recognise deterioration of a person's health status,
- lack of knowledge to understand health care needs and/or how to deal with family or friends appropriately, or
- an increase in the professional and/or legal responsibility for qualified staff when care is delivered by health care workers under their supervision.

In other words, there is RISK involved in 'task shifting'. Many would argue that the risks are too great; that we should be investing more in producing qualified nurses and midwives and not letting others take over aspects of our role. However, we do not live in Utopia and as a comment from a Ugandan colleague succinctly puts it: *"…task shifting would not be necessary if we had enough nurses and doctors, but we should work in the world as it is, rather than the world we would wish!"*

The reality is that our populations are growing, health care needs are increasing, and we simply cannot keep pace with producing and retaining sufficient numbers of educated nurses and midwives to meet these needs.

So, what do we do? Could there be benefits of 'task shifting'?

In some countries, 'task shifting' occurs in fairly specific areas of practice, for example with traditional birth attendants, or to cope with the sheer magnitude of crippling infectious diseases such as HIV and AIDS. 'Task shifting' can actually allow for more efficient use of human resources by:

- relieving nurses and midwives of aspects of care so that they can concentrate on complex clinical activities and care planning, and by
- enabling qualified nurses and midwives to oversight and co-ordinate the care of a greater number of people.

Other benefits may include:

- shorter pre-service training leading to speedier release of workers into the health care workforce, and
- the ability for a greater number of people to remain living in their own homes with the support of community health workers.

There is clearly the bottom line argument that says the alternative to transferring of tasks is that there would be NO health service for those people in need. In the International Council of Nurses statement (2008) on 'task shifting' Dr Bill Holzemer from the US is quoted as saying: *"If done well, task shifting will provide more care for more people"*. But, he cautions that it requires *"timely access to a sufficient number of qualified health professionals"…, and "major investment in health training and services".*

The World Health Organisation, in a 2006 publication, indicated support for 'task shifting' as a strategy for improving health care workforce capacity, but declared that it: *"…must be implemented within systems that contain checks and balances that are sufficient to protect both health workers and the people receiving health care."*

I think what we are seeing in many countries is a surging ahead in implementing 'task shifting' as a quick fix to the health care workforce shortages, without there being a great deal of thought to care outcomes. The WHO document I just quoted also noted that: *"…task shifting must be implemented such that it improves the overall quality of care. It should not and must not be associated with second-rate services."* 'Task shifting':

- is being supported by the WHO,
- is being rapidly implemented in many countries (resourced and under-resourced alike),
- can have benefits for nurses and midwives, but,
- clearly poses risks for the public.

Nurses and midwives, as educated and regulated health professionals, have a central concern for the health outcomes of the community. Nurses and midwives have a mandate to protect communities from second-rate and incompetent care delivery.

So, what can and should we be doing to make sure standards are maintained? 'Task shifting' can be supported as part of a strategy to improve access to health care for all people. BUT, nursing and midwifery must take a leadership role in lobbying for policy development at the national level on this issue. Failure to act will see a continuation of a uncoordinated approach to solving workforce shortages putting people at risk of incompetent care. Nursing and midwifery needs to adopt a position which requires 'task shifting' to occur within a professional practice framework.

Just as the practice of nurses and midwives is governed by standards for education, competence, scope of practice and codes of conduct and ethics, so too must this apply to all groups of direct care workers. Nurses and midwives are regulated in most countries. The purpose of that regulation is to protect the public through practice frameworks which minimise the risk of adverse outcomes of care delivery. The logical conclusion has to be that all health care workers should be regulated.

My proposal to you is that the nursing and midwifery professions in every country should be:

- embracing health and aged care workers as part of the nursing and midwifery family,
- supporting 'task shifting' and insisting that it occur within a supportive legislative and regulatory structure,
- lobbying for a process of licensing or regulation and a professional practice framework for health and aged care workers, just as registered and enrolled nurses and midwives have.

This professional practice framework includes standards for minimum education; competence; identified scopes of practice; codes and guidelines including codes of ethics and professional conduct; a decision-making framework for clinical practice, and requirements for continuing professional development.

We owe it to our communities to lead the change which will give greater access to health and aged care services to all people. And we also owe it to our communities to be able to guarantee them that the people providing that care are competent to do so. In concluding I want to leave you with this challenge. As the nursing and midwifery professions expand their scope of practice to include advanced practice roles such as nurse practitioner, so too we need to be mindful of passing the mantle of care to other workers undertaking nursing care. And just as we want support and recognition from medical and other health professional colleagues with our expanded scope of practice, we must be able to develop supportive structures for those to whom we must inevitably 'task shift' aspects of our nursing and midwifery roles.

20th CNF BIENNIAL COUNTRY DELEGATIONS

AUSTRALIA

BARBADOS

INDIA

BAHAMAS

BERMUDA

BOTSWANA

CYPRUS

GHANA

GRENADA

JAMAICA

KENYA

MALAYSIA

20th CNF BIENNIAL COUNTRY DELEGATIONS

SOUTH AFRICA

UNITED KINGDOM

CANADA

SINGAPORE

NEW ZEALAND

MALTA: hosts to the 20th CNF Biennial Meeting and Conference

PRIMARY HEALTH CARE
The nurses' role

Rachel Bard
Chief Executive Officer
Canadian Nurses Association

The nursing profession in Canada is striving to meet ever rising professional demands and excessive workloads. This is exacerbated by increasing patient acuity, higher patient volumes, and the growing complexity of treatment. A primary health care policy encourages a shift in health resources from acute care to primary care as a strategy to create efficiency gains, improve patient access, and contribute to more positive patient experiences and outcomes.

In 1978, the World Health Organization adopted the primary health care (PHC) approach as the basis for effective delivery of health services as outlined in the Declaration of Alma Ata (WHO, 1978): *"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination … It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*

Based on the world-wide experience since Alma Ata, WHO (2008) has more recently identified key sets of reforms necessary to implement effective PHC systems:

* universal coverage reforms: to improve accessibility and health equity;
* service delivery reforms: to make health systems people-centred by making them more responsive and producing better outcomes;
* public policy reforms: to promote and protect the health of communities through healthy public policies across sectors;
* leadership reforms: to make health authorities more reliable, participatory and accountable; and
* participation reforms: to support community representation and active participation in the development of PHC policy and funding arrangements.

Primary health care is both a philosophy of health care and a model for providing services that support health. Effective primary health care includes:

* a focus on health promotion and illness prevention;
* takes a holistic approach, which factors in the various determinants of health as well as socio-economic and environmental influences on population health;
* is patient-,family-, and community-centred;
* includes the active participation of the public in identifying needs and preferences; and
* relies on meaningful collaborative relationships with community agencies to facilitate client access and referrals to health services.

Over the course of the last three decades, CNA has focused its primary health care work on five core principles:

* ACCESSIBILITY: A continuing and organized supply of essential health services is available to all people with no unreasonable geographic or financial barriers.

* PUBLIC PARTICIPATION: Individuals and communities have the right and responsibility to be active partners in making decisions about their health care and the health of their communities.

* HEALTH PROMOTION: The process of enabling people to increase control over and to improve their health.

* APPROPRIATE TECHNOLOGY: This includes models of care, service delivery, procedures and equipment that are socially acceptable and affordable.

* INTERSECTORAL COOPERATION: Commitment from all sectors (government, community and health) is essential for meaningful action on health determinants.

As we seek to make the health system more responsive to the needs of Canadians, it is important that nurses and midwives integrate primary health care principles *throughout* the continuum of care. Strategies to advance a PHC orientation address a number of common themes such as; accessibility; quality improvement through evidence-based practice; electronic health records, chronic disease prevention and self-management; continuity of care; providing the right care at the right time; and, human resource strategies to ensure an appropriate supply of family physicians, nurses and nurse practitioners.

Unfortunately, the application of the primary health care principles and practices is uneven and inconsistent across Canada. The Commonwealth Fund International Health Policy Survey (2010) reported that Canadians used emergency departments more than respondents from 10 other countries. Equitable access remains a significant issue for vulnerable and marginalized groups. Residents of poor neighborhoods are significantly more likely to be hospitalized with ambulatory care sensitive conditions than residents of affluent neighborhoods, as are residents of rural areas when compared with residents of urban areas.

Nurses and midwives have a role to play in supporting primary health care. What issues affect the ability of your clients to access your services (hours, transportation, disability, cultural, economic factors)? What are the effects of social, economic and environmental factors on the health of your clients? Do you take these factors into account when you develop your interventions? Do you work as a valued team member with health professionals from other disciplines? Are the skills of different health professionals used in the most effective way to support your clients? Does the community you work with have input into the programs you offer, or in the way in which they are delivered?

Research has shown the benefits of a strong primary health care system in improving health outcomes for patients, as well as in reducing overall health care costs (Starfield et al. *and* Delaune and Everett). As the research base increases, so does the weight of evidence showing that nurse-driven innovations are making a positive, measurable impact on client and system outcomes; nurses and midwives are involved in early intervention, early disease detection and comprehensive health screening and actively involved in supporting the health of patients - not just those with diseases or episodic conditions. We know that primary health care teams produce better health outcomes; improve access to services; result in more efficient use of resources; and provide greater satisfaction for both patients and providers.

As we break down divisions *within nursing* and barriers *between professions*, we achieve a more symbiotic relationship with the patient; we adopt a more holistic therapeutic approach; and gain a reinforcement of each other's effectiveness. There are many benefits that can be realized. For patients and families it means more time with a health professional for education, guidance and counselling and access to more health care providers with complementary strengths and perspectives. For primary care physicians it means support with complex and time-consuming patients and another health care professional to problem solve through collaborative teamwork.

For registered nurses it means enhanced career satisfaction due to greater independence, quality of team interactions and ability to achieve work-life balance and more time for patient education, support, advocacy and counselling. For the health care system it means improved and more timely access to care and improved patient outcomes, which decreases costs to the health system in the future as well as potentially reducing emergency department visits and hospital admissions.

As professionals, it is the role of nurses and midwives to encourage governments to fund new initiatives, presenting them with the evidence that these innovations not only work, but can also lead to cost savings down the road - a strong motivator in these times of fiscal restraint. We can also promote an understanding of the various roles nurses and midwives can play in primary health care. Efforts to achieve primary health care reform have increasingly encouraged physicians to work in multidisciplinary teams however while the central role of registered nurses and nurse practitioners to PHC interventions is increasingly articulated, some physicians and medical associations have been reluctant to embrace the promising potential for interprofessional practice.

In summary, primary health reform involves shifting paradigms toward a paradigm that moves:

* from illness to health;
* from treatment to health promotion and disease prevention;
* from cure to prevention, care and cure;
* from episodic care to continuous care;
* from problem-based care to comprehensive care;
* from individual practitioners to teams of practitioners;
* from the health sector working in isolation to intersectoral collaboration;
* from professional dominance to community participation; and,
* from the passive reception of services to shared responsibility (Starfield).

The CNA has produced a Primary Care Toolkit, a web-based resource for nurses who are building collaborative teams in primary care settings. The Toolkit provides information on the benefits of RNs working in primary care; recruitment materials; financial and patient volume considerations; information on how to build a collaborative team, and guidelines, flow sheets, medical directives and educational resources for patient teaching on a variety of chronic diseases (http://www.cna-aiic.ca/CNA/practice/family/default_e.aspx).

As nurses, we must continue to champion social justice, health equity and the determinants of health, in advocating for whole-of-government approaches to ensuring health in all policies.

LEADERSHIP WORKSHOP IN SRI LANKA

22-23 May 2011

The CNF and the Sri Lanka Nurses Association recently hosted a very successful leadership workshop in Colombo Sri Lanka with 58 nurses and midwives attending. The workshop covered leadership theories and models, advocacy and lobbying, strategic thinking and planning, and working with the media. The workshop consisted of formal presentations; group work; and individual self-reflection activities and provided participants with an opportunity to refine their leadership skills, problem solve and develop media strategies. The workshop was funded by the Commonwealth Foundation.

A POSITIVE PARTNERSHIP

The Nurses Association of the Republic of the Seychelles (NARS) and the Seychelles Ministry of Health partnered with the CNF to conduct one leadership workshop and two safety workshops in the Seychelles. Forty five nurses attended the leadership workshop with 33 and 34 nurses attending the safety workshops. The workshops were a great success.

COMMONWEALTH HEALTH MINISTERS' MEETING

pre-CHMM Partners' Forum

Preventing NCDs: children and young people

Commonwealth Health Ministers met in Geneva on Sunday 15 May prior to the World Health Assembly. The theme for the 2011 CHMM was *non communicable diseases*. Non-communicable diseases (NCDs) are now the leading cause of death in almost every country in the world and are diseases to which young people are particularly vulnerable. These diseases include diabetes, cardio-vascular disease, cancer and chronic respiratory disease which together contribute to an estimated 35 million deaths per year globally, 80% of which are within low and middle income countries (WHO 2005). The prevalence of NCDs and their risk factors for young people are rising in almost every country, with immediate and long term consequences for health. This rise is largely a result of urbanisation which has exposed young people to the key risk factors for NCDs which include tobacco use, excessive alcohol intake, sedentary lifestyles and unhealthy diets.

On Saturday 14 May a pre-CHMM Partners' Forum, titled: *Preventing NCDs - children and young people* was held. High profile international speakers presented and led the discussion about strategies to prevent NCDs in children and young people. Copies of the presentations are available on the CNF website: http://commonwealthnurses.org.

The Commonwealth Health Ministers' meeting was followed by the 64th World Health Assembly at which an important resolution in relation to nursing and midwifery was passed by member states. **CNF member associations are encouraged to take the opportunity provided by the resolution to lobby their governments to strengthen nursing and midwifery in their country**. View the resolution at: http://apps.who.int/gb/ebwha/pdf_files/EB128/B128_R11-en.pdf

WORLD HEALTH STATISTICS 2011

The World Health Organization has released *World Health Statistics 2011,* which contains the WHO's annual compilation of health related data for its 193 Member States, and includes a summary of the progress made toward achieving the health MDGs and associated targets.

The publication has essential information for nursing and midwifery associations as they lobby their government to enhance nursing and midwifery care. For example, maternal and infant mortality data and density figures for nursing and midwifery personnel are provided. The data for selected Commonwealth countries are listed below. The full report can be found at: http://www.who.int/whosis/whostat/2011/en/

Country	A	B	C
Australia	8	4	95.9
Bangladesh	340	41	2.7
Barbados	64	10	48.6
Botswana	190	43	28.4
Brunei Darussalam	21	5	48.8
Cameroon	600	95	16.0
Canada	12	5	100.5
Cyprus	10	3	39.8
Fiji	26	5	19.8
Gambia	400	78	5.7
Ghana	350	47	10.5
Guyana	270	29	22.9
India	230	50	13.0
Jamaica	89	26	16.5
Kenya	530	55	11.8
Lesotho	530	61	6.2
Malawi	510	69	2.8
Malaysia	31	6	27.3
Maldives	37	11	44.5
Malta	8	6	66.3
Mozambique	550	96	3.1
Namibia	180	34	27.8
New Zealand	14	4	108.7
Nigeria	840	86	16.1
Pakistan	260	70	5.6
Papua New Guinea	250	52	5.1
Rwanda	540	70	4.5
Sierra Leone	970	123	1.7
Singapore	9	2	59.0
Solomon Islands	100	30	14.5
South Africa	410	43	40.8
Sri Lanka	39	13	19.3
Swaziland	420	52	63.0
Trinidad and Tobago	55	31	35.6
Uganda	430	79	13.1
United Kingdom	12	5	103.0
United Republic Tanzania	790	68	2.4
Zambia	470	86	7.1
Zimbabwe	790	56	7.2

A: Maternal mortality per 100,000 live births
B: Infant mortality rate - probability of dying before 1 year per 1,000 live births
C: Nursing and midwifery personnel - density per 10,000 population

RAMPHAL COMMISSION FINAL MEETING

The final meeting of the Ramphal Commission on Migration and Development was held at Oxford University July 2011. The Commission's work over the past eighteen months titled: *People on the move: managing migration in today's Commonwealth* has focused on encouraging Commonwealth governments to take the lead in establishing managed migration programs, developing partnerships and sharing expertise. The Commission has already released two of its three reports and at the Oxford meeting, approved draft recommendations to put to the Commonwealth Heads of Government meeting in Perth Australia in October 2011. Copies of the first two reports are available on the Ramphal Commission website: http://www.ramphalcentre.org.

CNF member associations are encouraged to take the recommendations to their governments and seek a commitment for them to be endorsed at the Perth meeting of CHOGM.

The Commission concluded that, in the light of its studies on migration and development advised by three eminent academics, migration is a structural and growing feature of our globalised community. At a time when international processes appear to have stalled, there is a unique opportunity for Commonwealth leadership, reflecting shared principles. Migration has made a huge contribution to human wealth and progress. The Commonwealth, which is the field of the Commission's concern, has been built on migration and has a recognised capacity in reaching consensus for action. Accordingly the Commission recommends Commonwealth Heads of Government to:

1 Concentrate on better managing an inevitable process, which offers many more opportunities than risks, and move the balance of public debate and national policy from the policing of migration to its management.

2 Adopt "development-friendly" migration strategies, which enable countries of origin, countries of destination and migrants themselves to share equitably the benefits of success. These would include reduction of the cost of remittances, more coherence between remittances and development policies, dual nationality, portable pensions and circular migration.

3 Position the Commonwealth as a laboratory for best practice, stimulating cooperation between sending and receiving countries, building on bilateral, multilateral and Commonwealth-wide schemes, and contributing to international processes.

4 Implement a Commonwealth programme to strengthen the migration management capacity of their officials, with improved training and sharing of data collection.

5 Develop strategies to address negative public perceptions, recognising the role of media, political leaders and civil society, and challenge misinformation and xenophobia on the basis of accurate evidence and Commonwealth principles.

6 Prevent discrimination against migrants, based on gender, age, ethnicity, religion and all other grounds, and carry out their obligations under international conventions and national constitutions.

7 Share best practice relating to diasporas, interacting regularly with their organisations, and understanding their priorities, remittance and investment choices; and create incentives for diaspora communities to invest their financial resources and expertise in the urgent need to provide food security and rural development in countries of origin.

8 Factor the importance of international migration into all development planning and particularly into national strategies for the environment, agriculture and nutrition.

9 Request the Commonwealth Secretariat to implement a considered work programme to support these recommendations. Governments with the capacity to do so should be encouraged to take a lead in implementing these recommendations in their regions.

10 Review progress at the 2013 Commonwealth Heads of Government Meeting.

The Jubilee Time Capsule wants your stories!

The Jubilee Time Capsule is the Royal Commonwealth Society's (RCS's) innovative way of celebrating Her Majesty, The Queen's Diamond Jubilee. It is a unique online archive that aims to tell the people's history of the last 60 years through a range of media and will be presented to Her Majesty as part of the Diamond Jubilee celebrations.

Launched on the 14th March this year, the Jubilee Time Capsule is the RCS's most ambitious public engagement project to date and with entries being submitted from the length and breadth of the Commonwealth, an exciting and vibrant history of the past six decades is starting to emerge.

Amongst the wealth of content that is being submitted to the Time Capsule the RCS is beginning to see some themes emerging and one emerging theme that we are keen to foster is that of medicine, nursing, midwifery and health care.

The changes in health care over the past 60 years have been immense, but the care of health staff has been constant through-out. The RCS is keen to receive entries from Commonwealth nurses and midwives; to hear their experiences of the profession.

Sir Alexander Fleming
BBC interview 1947

We have already received a number of submissions on the theme of health care. One such submission is an interview with Valerie McDonald-Ennis, who talks about her days as a student midwife in Margate in the 1970s. Another submission is an entry from the BBC archives about the death of the renowned pharmacologist Sir Alexander Fleming. A third entry is from Lara Clauss, whose mother was a nurse in Pretoria South Africa. Lara's story is about her mother's small act of defiance in taking down the 'Slegs Blankes' or 'Whites Only' sign above the nurses changing room in 1992.

Valerie McDonald-Ennis, Midwife

No story is too big or too small for the Time Capsule; we want to hear about personal moments that were important to you, as well as the big events that have changed the world of health care. Perhaps you remember the day you qualified as a nurse, or you remember the development of IVF in the late 1970s? Whatever your story we want to hear it!

To submit a story to the Jubilee Time Capsule, simply visit http://www.jubileetimecapsule.org. Your contribution can be made up of photos, video, writing and audio, the more creative the better! If you have any questions please email jubilee@thercs.org or contact Verity on +44 (0)20 7766 9227.

We look forward to receiving your submissions and to developing the nursing, midwifery and health care theme within the JTC as we create this exciting digital legacy for The Queen and the Commonwealth.

Conference 2012
COMMONWEALTH NURSES FEDERATION

Inaugural Commonwealth Nurses Conference

Call for Abstracts

Our health: our common wealth

Saturday 10 and Sunday 11 March 2012, The Commonwealth Club, London UK

Conference theme

This inaugural conference will be based around key themes and will provide an opportunity for nurses and midwives to showcase and share their contribution to improving the health and wellbeing of citizens of the Commonwealth. The conference is being held on the eve of Commonwealth Week 12–18 March 2012; so come and join the celebrations and fun on Commonwealth Day Monday 12 March 2012 and the other Commonwealth Week events.

Abstracts should address the key themes which are:

- meeting the health MDGs
- the regulation of nursing and midwifery
- using information technology to improve care
- the health effects of climate change
- developing a healthy workforce and healthy systems of work
- innovation and excellence in clinical practice

Abstract submission

Email your abstracts (of no more than 300 words) to the Commonwealth Nurses Federation at **cnf@commonwealthnurses.org** by **31 October 2011**.

CNF
Commonwealth Nurses Federation