

# **Moving on from Munich**

A Reference Guide

to the implementation of the

Declaration on Nurses and Midwives: a Force for Health

Edited version

NURSING - trends  
MIDWIFERY - trends  
PROGRAM DEVELOPMENT  
DECISION MAKING  
POLICY MAKING  
EDUCATION, NURSING  
MIDWIFERY - education  
LEGISLATION, NURSING  
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WHO Regional Office for Europe, Copenhagen

### **The purpose of this guide**

- To enable countries to carry out a review of the current position, and help them to assess what kind of further progress is now possible.
- To identify any changes required *inter alia* in their legislation, education and training strategies and employment policies.
- To anticipate any problems that might arise.
- To envisage the long-term outcome of the implementation process.

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## Introduction

The Second WHO Ministerial Conference on Nursing and Midwifery in Europe, held in Munich in June 2000, provided the point of departure in strengthening the contribution of nurses and midwives towards achieving the goal of better health for all that the Regional Committee and the individual Member States have set themselves. It is now timely to develop strategies to ensure that, throughout the WHO European Region, nurses and midwives will be in a position to contribute to their full potential in the development of health policy and in the provision of a wide range of health services.

The Munich Declaration charts the course for governments, health and education authorities and institutions, the nursing and midwifery professions, WHO and other partners to follow. Implementation of the Declaration requires political will, professional commitment and dialogue – internationally, nationally and locally – between all those who have a part to play. Internationally there has to be continued cooperation, especially between Member States, the International Council of Nurses, the International Confederation of Midwives and WHO. Within countries, nurses and midwives and their national associations have to work with policy-makers, administrators and educators at all levels.

Progress will be built on experience, and especially by reflecting on and thereby learning from that experience. The learning process must involve all the interested parties, in government and the regulatory bodies, in the professions, in the funding bodies, in the educational institutions and elsewhere.

The guiding principle in policy-making offered by modern systems thinking is to keep in view and pursue the whole vision. In this case, it is the vision captured in the Declaration of better health and the contribution of nurses and midwives. Each component, whether legislation, education, service development or workforce planning and employment policy, interacts with the others.

A selective approach would be ineffective and in fact irrational. At the same time, implementation in practice is necessarily pragmatic, often incremental, and achieved by patiently negotiated agreements between the stakeholders, but with the vision providing the constant point of reference when deciding what action to take.

This guide presents a distillation of the full range of issues that now need to be addressed.

## The Munich Declaration – the point of departure

1. Ministers identified their overall health policy objective as: “to tackle the public health challenges of our time, as well as 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”.
2. Ministers affirmed that to contribute to the fulfilment of that objective, nurses and midwives should work to their full potential as independent and interdependent professionals; that the necessary legislative and regulatory frameworks should be in place; and that obstacles, such as those relating to gender and status issues, must be addressed.
3. Ministers identified key and increasingly important roles for nurses and midwives to play:
  - to contribute to decision-making at all policy levels (development and implementation);
  - to be active in public health and community development; and
  - to provide family-focused community nursing and midwifery services.
4. Ministers proposed in consequence of these roles the development of:
  - knowledge and evidence for practice through research and information dissemination;
  - improved initial and continuing education, and access to higher nursing and midwifery education;
  - 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:
    - partnerships with all ministries and other bodies within countries and internationally; and
    - workforce planning strategies and employment policies to ensure adequate numbers of educated, trained and rationally deployed nurses and midwives, who would enjoy fair rewards and recognition (incentives) and opportunities for career advancement.
5. Ministers requested the WHO Regional Director for Europe to provide:
  - strategic guidance in the implementation of the Declaration;
  - help to Member States in developing coordination mechanisms for partnerships with national and international agencies to strengthen nursing and midwifery; and
  - regular reports to the Regional Committee; and
  - a first meeting in 2002 to review the implementation of the Declaration.

## **An action agenda for Ministers and Government Chief Nurses<sup>1</sup>**

1. Consider how best to formulate the political argument for implementation in terms that reflect and respond to the country's economic, social and health situation. (Paragraphs 1–27)
2. Develop a strategy to alert political leaders at all levels, the professions and the public to the key messages of the Declaration, and the urgency of the action on the Declaration that will now be taken in the country. Establish a suitable mechanism for a continuing dialogue with national associations of nurses and midwives. (Paragraphs 28–32)
3. Carry out an analysis of the use currently made of the nursing and midwifery workforce, where they are deployed and the tasks they carry out. Compare the findings with the proposals in the Declaration and determine the degree of change needed. Review all relevant legislation and regulation and determine what amendments or new provisions are needed to support nurses and midwives in their envisaged roles as independent and interdependent professionals. (Paragraphs 33–39)
4. Appoint a Government Chief Nurse and a supporting structure of professional officers in the health ministry and at other administrative levels in the health sector, and establish a consultation mechanism with the national associations of nurses and midwives to ensure that full use is made of their knowledge and experience in policy-making. (Paragraphs 40–45)
5. Review the present scope and level of involvement of nurses and midwives in public health action and consider what steps could be taken to strengthen their impact. (Paragraphs 46–56)
6. Review the present use made of nurses and midwives in community based-and family care and determine how their role could be strengthened to raise the quality of care and make better use of all resources. (Paragraphs 57–67)
7. Determine what action is needed to encourage the continuing development and adoption of evidence-based practice in nursing and midwifery, and to strengthen the knowledge base of practice through research and development programmes. (Paragraphs 68–69)
8. Review present educational and professional development programmes. Decide what new programmes should be established or existing programmes reoriented and strengthened, in order to prepare nurses and midwives to function as independent and interdependent professionals and in the roles identified for them, and to create opportunities for joint learning with physicians and others. Establish the necessary intersectoral machinery to implement the national educational and professional development strategy. (Paragraphs 70–99)
9. Review present workforce planning strategies and employment policies. Amend these as necessary to ensure that they support the objectives of the Declaration. (Paragraphs 100–115)
10. Identify the need for WHO support to strengthen implementation efforts. (Paragraphs 116–123)

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<sup>1</sup> This checklist makes no assumptions about progress already achieved or how actions would be implemented in keeping with the country's legal and governmental practices. It should be interpreted accordingly.

11. Institute a tracking process to ensure that the momentum and sense of direction of the Declaration are maintained and to identify where further action may be required.  
(Paragraphs 124–130)

## Political significance of the Munich Declaration

1. One in every 145 citizens in Europe is a nurse or midwife. Nursing and midwifery as professions and vocations draw on a history and culture with three fundamental themes: a focus on preserving and restoring good health, advocacy for the wellbeing of those in need, and service to society. As the single largest category of health workers in Europe, nurses and midwives are a significant potential political and social force and resource for public health.
2. The majority of nurses and midwives work in hospitals and, on all reasonable assumptions about future developments, will continue to do so. Moreover, their role will become more specialized with the continuing advances in scientific knowledge and technology. But a growing number of nurses and midwives are working in community settings, providing family care<sup>2</sup> and supporting, guiding and enabling people to find ways to meet their own health needs.
3. The need for all forms of public health action, including the provision of high-quality institutional and community-based health services, is growing steadily. It is a necessary response to such macro trends as the aging of the population, biomedical and other technical advances, environmental and other hazards to health, and re-emerging diseases.
4. Historically the strength of informal support systems in families and communities has been critically important, since much of health care has been provided in these settings. But as a consequence of migration patterns changes in family structure and other trends, in many places the informal system is weakening. At the same time, budgetary constraints on the professional services have coincided with increasing needs, while advances in technology can sometimes seem to be distancing those services from the people they are intended to help.
5. The pressure is on governments and the health care and social services to find ever more effective and efficient ways of helping those who find themselves in difficulties. Sustaining the primary health care vision, first articulated in the Declaration of Alma-Ata<sup>3</sup> and reaffirmed by the World Health Assembly in the World Health Declaration 1998, is most important at this time, as all countries face the challenge to develop services to meet both increased need and growing public expectations, and to contain their social sector costs (see Box 1).
6. Primary health care, with nurses and midwives working with physicians and others at the core, should be the means of bringing health care closer to local populations. Midwives and nurses could play a key role in advancing the primary health care agenda, whether it is in their day-to-day work with families, taking on a public health advocacy and action role, or becoming more involved at policy levels. Much will depend on their ability in future to appreciate for themselves and then to assert their proper worth.

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<sup>2</sup> The term “family” is to be taken to signify not just the nuclear or three-generation family but also other forms of personal partnerships, and people living together in households and other micro-social settings.

<sup>3</sup> *Alma-Ata 1978: primary health care*. Geneva, World Health Organization, 1978 (“Health for All” Series, No. 1).

### **Box. 1. Selected extracts from the Declaration of Alma-Ata**

- Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments should be the attainment by all peoples of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.
- Primary health care:
  1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities based on the application of the relevant results of social, biomedical and health services research and public health experience;
  2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
  3. includes at least: education concerning prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care and family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
  4. involves health and all related sectors and aspects of national and community development;
  5. requires and promotes community and individual self-reliance and participation in planning, organization, and operation of primary health care, making use of available resources; and develops through appropriate education the ability of communities to participate;
  6. is sustained by integrated, mutually-supportive referral systems, leading to progressive improvement of comprehensive health care for all, giving priority to those most in need;
  7. relies, at local and referral levels, on health workers, including physicians, nurses and midwives, trained socially and technically to work as a team and respond to health needs.

7. As the macroeconomic social and other trends continue, it will be seen with greater clarity that the nursing and midwifery workforce represents not only so many willing hands but a priceless intellectual capital asset of the health system.<sup>4</sup> It is in the nature of their work

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<sup>4</sup> The term “intellectual capital” is being increasingly used in the business world and elsewhere to describe the skills and use of technologies and the accumulated knowledge, especially their normally unarticulated “tacit knowledge”, of all those involved in an organization. Tacit knowledge is the cumulative learning that comes

and their approach to it that they have unmatched knowledge of people as they are, in sickness and in health. Making the best use of this asset, especially their tacit knowledge born of daily experience, will be a major challenge in what is now being referred to as “knowledge management”.

8. For political leaders, recognizing the overall economic and other benefits of maximizing the potential of nursing and midwifery will be an essential step in shaping an affordable health system. As the backbone of health care systems, nurses and midwives are not only highly appreciated by the users of their services and by the general public; they can also be a most cost-effective resource for delivering high-quality services.
9. Applying a holistic approach to assessing people’s circumstances, their past life experiences and future life chances, and focusing on their capacity for independent living and the prevention of ill health and disability, nurses and midwives instinctively develop what economists would recognize as a “cost-effective” approach to meeting the individual’s or family’s changing needs. It should make more costly services unnecessary or at least lead to a reduced need for them.
10. For these reasons, and responding to the intent of the Munich Declaration,<sup>5</sup> it is now timely to develop strategies<sup>6</sup> to ensure that throughout the Region nurses and midwives will be in a position to contribute to their full potential: in the development of health policy, in public health action, and in the provision of a wide range of health services.
11. These strategies will be building on foundations already laid. As long ago as 1977 European Community directives defined a basic, mutually recognized level of education for nurses. Convention 149 and Recommendation 157 of the International Labour Organization, concerning employment and working conditions for nurses, were adopted the same year. While for many years now the Regional Office’s programme on nursing and midwifery has sought to mobilize governments and nurses and midwives through technical support to countries and the dissemination of information, research findings and guidance material.
12. The European Conference on Nursing and Midwifery held in Vienna in 1988 proposed changes in nursing education and practice, greater emphasis on primary health care and involving nurses in health policy development.<sup>7</sup> Progress has been made. Learning embraces theory and practice, and theoretical education increasingly takes place in institutions of higher education. There have been new educational programmes with an orientation towards primary health care as well as care in hospitals. And in a number of countries there are now more nurses and midwives in leadership and policy positions (see Box 2).

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directly from, and is applied to, day-to-day practice. The level of performance of an organization or service is determined to a significant degree by its use of its intellectual capital.

<sup>5</sup> Copies of the Declaration and Conference documents are available from the Regional Office in Copenhagen.

<sup>6</sup> *Nurses and midwives for health: a WHO European strategy for nursing and midwifery education*. Copenhagen, WHO Regional Office for Europe, 2000 (document EUR/00/5019309/15).

<sup>7</sup> Copies of the Declaration and Conference documents are available from the Regional Office in Copenhagen.

## Box 2. Nurse as Minister of Health

In the spring of 2001, the Minister of Health and Social Security in Iceland resigned her position in order to pursue other interests. The Minister was by profession a nurse and a member of a political party with 10–20% support of the electorate and a partner in a coalition government. She had held the office for six years.

As Minister of Health, she had invaluable insights into the health care system through her nursing background. She had links to nurses in almost every health care institution in the country. By the very nature of their work, nurses are in constant contact with the public. They were able to bring their observations to the attention of the Minister to a much greater extent than before.

The Minister's term of six years in office was longer than any former Health Minister in Iceland, and also longer than any of the ministers in other European countries who were her contemporaries with the same portfolio.

13. In 1996, the European Forum of National Nursing and Midwifery Associations and WHO<sup>8</sup> was established to address common issues, thereby complementing the roles of the International Council of Nurses and the International Confederation of Midwives.
14. All these developments have been essential steps towards maximizing the potential of nurses and midwives and harnessing their contribution towards the goal of better health for all. The underlying message from the Munich Conference is that much more needs to be done.
15. Through the Declaration, Ministers have given the future of nursing and midwifery both new political emphasis and a visionary European dimension. Not all countries are at the same starting line. In the past they have not all been able to develop their nursing and midwifery services at the same rate and with the same drive for improvement. It is evident that some countries may require a longer time-scale than others to achieve a full realization of the intent of the Declaration. That is much less important than the common opportunity now given to nurses and midwives in all Member States to strive for the same high professional standards that will be expected of them.
16. The ultimate aim is to achieve better health. Neither investment in education and professional development nor strengthening and expanding the roles of the nurse and midwife is a goal in itself. Any strategic change should be judged by how it improves service and quality in practice.
17. For their part, nurses and midwives must understand that the more demanding their role and the stronger the foundations of their expertise, the greater their personal accountability.<sup>9</sup> It could also require them to disengage from what is familiar and habitual: such as giving up what might be called the psychological protection of institutions, the feelings of certainty associated with hospitals and clinics – their structures of house rules, daily routines and management hierarchies – for more autonomous or self-directed roles.

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<sup>8</sup> Documentation is available on request from the Regional Office in Copenhagen.

<sup>9</sup> CLARK, J. *Accountability in nursing*. Background paper for the Second Ministerial Conference on Nursing and Midwifery in Europe, Munich, 2000. Copenhagen, WHO Regional Office for Europe, 2000 (document EUR/00/5019309/8).

18. In future they must engage more purposefully with the worlds of political and business leaders, who have a different perspective from theirs. They are essentially concerned with making the best use of resources to deliver a product. These leaders need to be persuaded of the value *in their terms* that nurses and midwives represent. If nurses and midwives are to exploit to the full their intellectual capital in order to create better health for all, they must learn to recast their unique knowledge in vocabulary appropriate to the political and business arena, and talk to strategists and policy-makers in their own language.

## **Nurses and midwives in a time of transition**

19. To a large degree, nursing and midwifery reflect the status of women in society. Their knowledge and skills have not always been recognized or valued. In some societies the image of the nurse as the physician's handmaiden still lingers. In many countries and for historical reasons, physicians are still formally responsible for activities at the community and family levels that are more properly the domain of nurses and midwives. In looking at the European experience, one sees a continuum of roles and functions, ranging from those who only assist others in their work to those who function in the spirit of Alma-Ata as full professional partners in teams serving the community.

20. The opportunity and the ability to exert influence at work and in social and political settings is significantly dependant on a good education. The lack of influence could be in part explained by historical and cultural factors, such as the conscious discrimination against girls and young women in terms of opportunities for secondary and tertiary education.

21. At the same time, since the number of women physicians is large and increasing in many countries, gender should not be taken as a sufficient or even persuasive reason to explain any continuing imbalance in the influence of physicians and nurses and midwives. Arguably, the assumption that some policy-makers and others seem to make, that the views and experiences of physicians and men will be more important and valid than those of nurses and women, is no more than cultural baggage that is now ready to be jettisoned.

22. In some countries, Ministers consult physicians' associations regularly; they consult nursing and midwifery associations less consistently and often only in times of crisis. The twin tasks of consensus building on policy and lifting morale in the health sector will be much better served if all professions enjoy the same high level of ministerial confidence.

23. It follows that opportunities for regular and continuing consultation on key health issues and health sector developments should be the norm with all the principal professional stakeholders as well as with service-user interests. One particular manifestation would be a standard practice of including nurses and midwives on relevant government committees and other such policy-making mechanisms.

24. Persisting gender and occupational discrimination demands vigorous action at all levels of society and particularly in all health organizations. At the same time, if it is accepted that nurses and midwives and physicians need to become more politically involved in advancing primary health care, as suggested above, it is equally true that they should join together in this endeavour.

25. The general public can be expected to be more receptive to a common appeal rather than to separate parallel messages from each profession reflecting its own particular perspective. The subsequent greater visibility and public understanding of primary health

care will be to their joint advantage. This could come in the form of political recognition and support for their work in the community, increased resource allocations, and more active responses from actors in other sectors.

26. Once having come together in this way, they could go on to search for a mutually satisfying resolution of any more difficult issues of gender respect and relative power and influence, and in turn reap the benefits of shared learning.
27. All these trends, pressures and real opportunities to improve the health of people and the quality of the services they receive call for a united strategic response. It should address the need for new policies where indicated, the organization and financing of services and other health actions and, not least, the development and use of human resources. Hence the political urgency of action to implement the Munich Declaration.

### **Implementation: the nature of the task**

28. In their commitment to implementation, countries will have their own sense of priorities. It might be expected that Member States that have not yet clarified the roles of nurses and midwives in ways consistent with the vision of the Declaration, and consequently do not yet have appropriate legislation and regulation in place, would address these first. Where specifically designed programmes of higher education and professional development do not currently exist, Member States would see the need to put them in place as soon as possible.
29. But whatever the identified priority, as stressed at the beginning of this guide it is essential to see implementation in systems terms (see Box 3). The commitments in the Declaration are closely related and the relationship between some quite complex, such as between the proposed roles, workforce planning, and education strategies. Implementing some actions may take time, such as those that involve reaching agreements between different ministries (for example, with regard to professional education or legislation to regulate nursing and midwifery).

#### **Box 3. “First things first” – systems thinking**

Any strategy for change will only be as good as its inherent logic and cohesion. A strategy for maximizing the potential and harnessing the contribution of nurses and midwives needs a systems approach, linking:

- a clear and shared understanding of the roles the professions are expected to play,
- the proper legislative framework for the professions in place and the means for implementation;
- the requisite educational programmes to fit them for those roles, including the preparation of nurse and midwife educators who will be involved in the planning and provision of those programmes;
- well functioning partnership relationships between the professions, representatives of user interests and the general public, the responsible health and education authorities, funding bodies and education institutions; and
- workforce planning strategies and employment policies in place that are framed by population needs and expectations, and designed to sustain the motivation of health workers.

30. In determining what rate of change is possible, regard must also be had for the capacity of the health and education sectors, their organizations and institutions and of the nursing and midwifery professions themselves to absorb change. It is particularly important to avoid any change that is perceived by those whom it affects as change for change's sake.
31. This means it is essential to prepare the ground properly. So, for example, the legislative issues can only be addressed after clarity has been established and agreement reached about the professional roles that are to be regulated. New laws will be effective only if the professional and organizational culture has been prepared first.
32. One means of ensuring cohesion and maintaining momentum would be to set up a country group to implement the Declaration. Its membership would be drawn from the various stakeholders and should be representative of them. It would be responsible for disseminating information throughout the nursing and midwifery workforce and for building up support. It would liaise with key government and other decision-makers, whose actions will determine the scope and scale of progress that would be achieved. It would also be a point of contact for the Regional Office in tracking implementation.

### **The need for reviewing and amending legislation and professional regulation**

33. As the Declaration makes clear, the rational way forward, in terms of making best use of human resources to meet the population's health needs, is to empower nurses and midwives to work according to their competencies independently and interdependently with other professions. This should generate in them a strong motivation for lifelong learning, commitment to the continuous development of the knowledge base for practice, and a full awareness of their responsibility and professional accountability.
34. The premise is that legislative and regulatory support is necessary to maximize the contribution of the nurse and midwife. As envisaged in the Declaration, the first step would be to examine legal and regulatory barriers to full participation of nurses and midwives, and consider how these might be removed. The law should not place unnecessary barriers in the way of delivering valuable care services to people. The law should serve affirmatively to promote the provision of health services and public action, and enhance the role of nurses and midwives in meeting the population's health needs.
35. Professional regulation should encompass standards for education, practice, service and ethical behaviour; the processes by which nurses are held accountable; and the titles and definitions that identify nurses and midwives and the professional scope of their practice.
36. It may be that any review of legislation and regulation of the professions should extend to laws relating to health services and health protection and promotion. This should establish whether any revisions would be appropriate to specify or clarify roles and responsibilities and rights to practice for nurses and midwives.
37. In particular, nurses and midwives in primary health care practice require an appropriate and enabling framework, which includes clear definitions of their competencies. This is to facilitate their working in partnership with members of other professions. They will not, and are not meant to, replace family physicians. But in future, activities involving two or more professions should be carried out with a conscious and, ideally, formal recognition

of the interdependence of those responsible.<sup>10</sup> This means cooperation on a professionally equal footing between especially (but not only) nurses, midwives, physicians, psychologists, therapists and social workers.<sup>11</sup>

38. In respect of legislation that in effect addresses the interface of health and higher education, there should be clarification of the qualifications required of teachers of nursing and midwifery. The implication of the Declaration is that nurses and midwives with relevant academic and teaching qualifications should be responsible for schools of nursing and midwifery; and that nurses and midwives with those qualifications should be eligible for academic appointments in those schools.
39. The law on employment, including health and safety at work, may also need to be reviewed to see whether all necessary provisions are in place to facilitate good management practice and the creation of a working environment for the nursing and midwifery workforce, to enable them to use their knowledge and skills to the benefit of patients and clients.

### **Participation in decision-making at all policy levels**

40. Public policy is perhaps the most significant single determinant of health, since action on all other determinants flows from the policy decisions taken. Ensuring that cogent nursing and midwifery contributions are made at the policy level is a critical issue.
41. Three steps are essential. First, a nursing and midwifery presence at the highest policy level should be established by the appointment of a Government Chief Nurse and a supportive structure of nursing and midwifery officers in the ministry of health. Second, responsible professional officers should be appointed in health authorities at all levels. Third, there should be formal consultation procedures involving professional associations, which would be expected to offer technically sound advice and be guided by the public interest.
42. This is not a matter of mere formalities or a routine consultation process that must be seen to be observed. Policy-makers need the perspective that nurses and midwives bring to the process. They have unmatched insights that come from close and continuing contact with the public, from whom their patients and clients are drawn. No other professionals come to the table with the same understanding and feeling for people's living conditions, their health in its various dimensions, and how well they cope (and are helped to cope) with sickness and disability.
43. Government Chief Nurses must be seen as key contributors to the policy process in ensuring better health and health care. Their role, and that of their equivalents at all policy and decision-making levels, is *both* to support nursing and midwifery development within the frame of national and subnational health policy *and* to provide a nursing and midwifery perspective in the broad sweep of public policy development.

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<sup>10</sup> In some countries, relationships between nurses and midwives would benefit from a more collegial approach, and more systematic collaboration to ensure the best possible use of all resources for the benefit of parents and children. Good collaboration between nurses and midwives is also essential in primary care and hospital settings, based on mutual acknowledgment of and respect for their different roles and skills.

<sup>11</sup> Care at childbirth provides a sensitive pointer in this regard. In some countries, it has been alleged, the law regulating midwives' independent practice is being subverted. Legislative changes may be indicated in these countries: to ensure continuity of midwifery-led care before, during and after childbirth; to establish the autonomous role of midwives (not subordinates to obstetricians) in the primary health care team; and to enable appropriate financing of midwifery and nursing services provided in private practice.

44. One quite specific strategy is for decision-making bodies in the health system to adopt the principle of “parallel participation”, establishing a nurse or midwife position (whichever is appropriate) wherever there is a medical position concerned with decision-making and professional advice.
45. This should be set up in such a way as to recognize and make clear that the professions will provide complementary, mutually supportive contributions. Policy advice from all professional sources needs to be integrated to ensure coherence and that all policy decisions are based on sound technical judgement.

## **The role of nurses and midwives in public health**

46. A population enjoying good health should be seen as one of the pillars that support a stable and just society. At the same time, economic, social, environmental and other forces in every country mean that health systems are changing continually, radically and rapidly. The interaction between health and overall development is symbiotic, and all health professionals should understand the nature of their work in this societal context. This has implications not only for how health workers should be educated and trained in future but how they engage with the broader society.

## **Serving people across the lifespan**

47. The challenge of public health action is *both* to provide care and treatment *and*, through health protection and promotion, to create the conditions for healthy living. It is to enable people – families, individuals and their lay carers (who are often family members) – to cope, to make better decisions for themselves and to attain their highest health potential, as well as to prevent and mitigate the effects of disability and handicap.
48. The importance of the contribution of nursing and midwifery to public health action is self-evident. Their services, provided in such a wide variety of settings, together span the life cycle from conception through to care of the dying. People’s need for their support and services is highest not only during episodes of sickness but often also in critical transitional phases and life events such as pregnancy, birth, adolescence, entry into the workforce, becoming unemployed, retirement and migration.
49. The work of nurses and midwives brings them into contact with all sections of the community, including socially weak groups, the homeless, refugees and people with mental health problems. Empathy and respect for everyone are of the essence of best professional practice. Nurses and midwives work *with* their patients and clients, and act as advocates and guides through the maze of health and social services.
50. Given their standing and credibility among the general public, nurses and midwives can use their personal influence and contacts to improve the uptake of different services offered to the public, such as healthy nutrition, healthy pregnancy and smoking cessation programmes. They can give appropriately framed advice on health matters, both opportunistically, as in clinical settings, and through organized programmes aimed at population groups.

## Engaging with the community

51. Public health action requires the involvement of many community stakeholders. By taking up the public health agenda and gaining support in the community, nurses and midwives can be very influential in securing the commitment of political leaders to action on inequities in health and to community empowerment. This will be essential for sustaining their own efforts.
52. Once they have acquired the necessary political and negotiating skills, they should also be in a position to influence resource allocation decisions so that resources of all kinds are directed to real community needs; and to promote approaches to service development and provision that involve wide, active participation (see Box 4).

### Box 4. Involving service users

The midwives of New Zealand opened their Association to their clients some years ago. Representatives of women's organizations have a seat and voice within the Association. Their involvement enables them to have the opportunity to:

- influence midwifery policies
- give their opinions about their needs in the field of pregnancy and childbirth
- offer advice and promote changes in midwifery practice.

53. To be effective over time, nurses and midwives need to develop their network of "partnerships for health" at all levels. These partnerships will not be created by the efforts of nurses and midwives alone; they require a response and commitment by others, from both agencies and professions as well as nongovernmental organizations. But nurses and midwives can reach out to people, moving across sectors and between settings and making links with different cultural and ethnic communities and groups.
54. It will demand that nurses and midwives invest time and effort in building relationships and developing participatory approaches with service users – clients, patients, community groups and others. It will also mean not only engaging other health care personnel and making and maintaining contacts in the wider social sector of housing, welfare and education, but reaching out to the economic sectors of trade and industry as well.
55. This should give nurses and midwives opportunities to become involved in health protection and promotion policy-making. The obvious entry points for influencing policy include community development activities (where necessary acting as advocate on behalf of individuals, families and communities) and any formal mechanisms set up for intersectoral<sup>12</sup> and inter-organizational collaboration in which they have a seat.
56. It would also strengthen their involvement in workplace health. This would mean not only the monitoring and control of occupational health hazards as normally understood, but advocating and contributing to the creation of conditions for healthy living wherever

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<sup>12</sup> The term intersectoral refers to contact or collaboration between actors in two or more delineated areas of public service (e.g. health, education, social security) or economic activity (e.g. agriculture, manufacturing, tourism).

people work. Their concern is to protect and promote people's health, whether they are teachers and children in schools, employees in offices, shops and factories and other locations, or health care professionals in hospitals and clinics.

## **Community nursing and midwifery and family care**

57. Midwives and nurses who work in community-based services already provide a broad spectrum of services for the population (for example in maternal and child health care), which range from psychosocial interventions and the creation of social support networks to antenatal care and breastfeeding programmes.
58. Since community-based nursing straddles health and the other social services, nurses should be centrally involved in the development and implementation of a range of policies and programmes related to the care and support of older people. Nurses are well placed to support the shift from institutional to home-based care, and to facilitate cooperation between various levels of care.
59. There is significant potential to be realized by applying their holistic approach to address the unmet needs that currently exist in many mental health systems. Their presence in different settings (including workplaces, schools and community centres) means that they can be involved in identifying populations at risk, screening and early detection, providing therapeutic services, liaising with other services, mobilizing and targeting support to vulnerable people.
60. The further development of the contribution of nurses and midwives to ensuring high quality in the provision of all types of care and treatment will depend in part on steps being taken, where necessary, to clarify their roles, functions and responsibilities.
61. In many cases they need to be more closely involved in the resource management process in the health services, in setting standards of care based on models and methods of good practice, and in assessing care and treatment outcomes. In fact these steps should be taken as necessary consequences of Member States' commitments to establish sustainable health care systems based on the principles of the Ljubljana Charter.<sup>13</sup>
62. User demand for quality care and other pressures for change are opportunities to counter the dominance of the technocratic disease management model of care, which at the extreme treats patients not as people but as cases. But this also requires commitment from all nurses and midwives to a shift from reliance on hospitals to the continuing development of integrated health care with a two-way referral mechanism between hospitals and community-based services.
63. This has signalled the need to strengthen community-based nursing and midwifery. A wide range of patient- and client-centred care models and methods has been developed and brought together in the portfolio of innovative practice compiled by the Regional Office.<sup>14</sup>

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<sup>13</sup> *The Ljubljana charter: setting the principles for health care reform for better health of people [CD-ROM]*. Copenhagen, WHO Regional Office for Europe, 1999.

<sup>14</sup> *Portfolio of innovative practice in primary health care nursing and midwifery*. Copenhagen, WHO Regional Office for Europe, 1999 (document EU/00/5019309/16).

64. This issue is important in many parts of the European Region. There is a felt need for a nurse and midwife who can combine functions and:
- help individuals and families cope with disease, disability and stress;
  - provide counselling on risks related to lifestyle and behaviour;
  - contribute to the diagnosis and treatment of health problems, and provide palliative care; and
  - act as an interface between the family, the community and the health care system, in particular cooperating with hospital staff to ensure continuity of care.
65. Family health nursing and midwifery incorporates many important principles of professional practice, such as rendering personalized care and giving emotional support in the form of personal contact. These have proved to be especially effective in, for example, facilitating childbirth and enabling family carers to cope with their burdens.
66. The actual context in which these services are being built up will determine what actions are appropriate and feasible. No single model fits all, but there is value in following a guiding policy framework for developing nursing and midwifery services. It is anticipated that such a framework could be distilled from the findings of the WHO Family Health Nurse Multinational Study.<sup>15</sup> Countries can adapt international guidance to their own realities and specific conditions to develop services that are *both* culturally sensitive and socially acceptable *and* financially sustainable.
67. Several countries already employ community midwives and public health nurses who work as generalists within a primary health care framework. In these countries the added value of the family health approach could be a sharper focus on public health objectives and community development and improved coordination of services. It may well be that use could be made of the “new” family health nurse and midwife to complement, streamline or integrate existing activities.

## Education and professional development

### Promoting evidence-based practice

68. When reviewing and promoting models or methods of care and treatment, the advantages to the patient or client should always be assessed and demonstrated. Likewise, public health interventions command professional and public support more readily when there is evidence as both a guide for action and a measure of its impact. All practitioners, in both clinical and health protection and promotion programmes, must have access to databases of best practice. Developing and sustaining evidence-based practice is a challenge for practitioners, researchers, educators and managers alike.
69. It is now recognized that the scientific and evidence base of nursing and midwifery needs strengthening, and that a substantial part of the research and development work required can be led by nurses and midwives themselves. Governments should consider how best they can foster this, such as by earmarking public funds to develop or strengthen the requisite infrastructure of academic and professional institutions to support nursing and midwifery research.

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<sup>15</sup> The Family Health Nurse Multinational Study in 18 Member States in the European Region (report expected in 2004).

## Essential steps in improving education and professional development

70. While much has been done over the past ten years to strengthen the education and professional development of nurses and midwives, much remains to be done.
71. Nursing and midwifery education should normally begin after entrants have successfully completed at least 12 years of general education. All nurses and midwives should attain a minimum level of professional education based on WHO recommendations,<sup>16</sup> and those qualifications should be recognized across the European Region.
72. Higher education and continuing professional development should become the norm. Nurses and midwives with higher education are reported to be more satisfied and to make a more holistic contribution to the benefit of the health system as a whole. A well designed university-based education that integrates theory and practice will both strengthen the foundations of their contribution to the provision of better, more effective health care and lift their self esteem. It should enable them to work with physicians as equal partners whether in patient care, public health action or policy work.
73. More use could be made of the extensive know-how and organizing skills that nurses and midwives acquire in clinical management settings whenever policy development and general management positions are to be filled. Possession of an advanced university education combined with a record of relevant practical experience will make them strong candidates in any competition for posts. Over time, this should also lead to acceptance by the public of nurses and midwives in the most senior leadership positions in the health and educational systems.
74. In due course, this should encourage public authorities and other employers to adopt an open recruitment policy when filling the most senior posts. This would make it possible for nurses and midwives to apply for positions that have hitherto been filled exclusively by physicians or university-educated career civil servants.
75. It is essential that an education programme fits the intended purpose. In basic or initial education and training the purpose is to impart:
  - the values, ethics and expected behaviour that underpin nursing and midwifery as professions and vocations,
  - knowledge and skills essential for competence in clinical practice; and
  - an understanding of the full social and other environments in which the users of their services lead their lives.
76. A programme that meets these learning objectives will create the conditions for nurses and midwives to practice as independent and interdependent professionals in line with the Declaration and to the maximum of their potential (given an appropriate legislative and regulatory framework). It will provide the foundations for a career in clinical nursing in hospitals and other institutional settings that can be built on through advanced and continuing education and training. This career could be in the individual's chosen speciality, or in the management of clinical units.
77. The Declaration has also specified a new focus for nurses and midwives by identifying what it calls "key and increasingly important roles" that they should play in the areas of

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<sup>16</sup> *Nurses and midwives for health. WHO European Strategy for Nursing and Midwifery Education*. Copenhagen, WHO Regional Office for Europe, 2000 (document EU/00/5019309/15).

policy, public health and family care. The implications in terms of the learning needs are assessed and presented in more detail in Annex 2.

78. It should be noted that overall educational and professional development implications flow from the Declaration. The proposed roles demand both clinical skills and those related to public health, knowledge and understanding relevant to:

- health assessment
- early detection and prevention of disease
- prevention and mitigation of disability and handicap
- health education and behavioural change
- empowerment and community development strategies
- counselling and other personal contact with individuals, families and groups in both clinical work (family-centred care) and health protection and promotion (public health action).

79. All programmes, whatever the technical content and the qualification or proficiency to which they lead, should reflect essential professional values:

- sensitivity and respect towards users of services and advocacy for patients' and other user's rights;
- the central place of equity and social justice;
- ethical decision-making, reflective practice and “learning from doing”;
- a readiness to work in teams with physicians and others, both inside and outside the health sector, on the basis of mutual respect; and
- a sense of commitment and an acceptance of responsibility and accountability.

80. But beyond these common foundations of knowledge, understanding and skills and of essential professional values, the three areas identified in the Declaration differ quite markedly, at least in emphasis, in what is expected of the incumbent. The demands on them call for different learning programmes of advanced educational and professional development. These demands on incumbents, which tailored learning programmes must address, may be summarized in the following terms.

### **Family-focused care**

81. The majority of those who complete their education and enter professional practice will, as now, be engaged in clinical nursing and midwifery. Some of them, and it may be assumed in increasing numbers, will become involved in family-focused care. This will be a “hands-on” role. The tasks will be concerned with meeting immediate individual and family needs for care and treatment, but they will be carried out with an awareness that comes from a careful assessment of the social and economic circumstances and other aspects of their living conditions.

### **Public health action**

82. Those who become involved in local public health action will need to be aware of (and to have previous experience of) the demands of providing care and treatment. But their day-to-day tasks will require a wide range of background social, economic and political knowledge as well as know-how for health protection and promotion work. They will also need the leadership qualities and the advocacy, interpersonal, negotiating and teambuilding skills required to become effective in community development work.

## Policy-making

83. Those who become involved at the policy level will need to bring to their task experience of both clinical knowledge and public health oriented community development. Nurses and midwives in professional advisory and executive roles must acquire the ability to influence decision-making and to manage change.
84. They will need to acquire an understanding of politics as the social process whereby decisions on public policy and action are reached. They will need competence in policy analysis and the evaluation and uses of research in policy-making and management, and a capacity for strategic thinking.
85. They will need communication skills enabling them to be effective public advocates; the diplomatic, networking and negotiating skills to be able to relate with equal ease to politicians, community representatives, nongovernmental organizations and user groups, as well as to career civil servants and other health professionals; and the ability to form alliances.

## The need for joint learning

86. Everyone benefits from good collaboration between professions. Users benefit from the improved quality of service that is the product of properly coordinated action. All providers benefit because, with the complementary inputs from other professions, each profession can perform to the expected standard.
87. This notion of a dual benefit clearly holds true for the experience of patients. They enjoy a smooth pathway through a complex system of care and treatment, while the providers have the professional satisfaction of giving a service that rates high in patient satisfaction, cost-effectiveness and other dimensions of quality assurance. And, *mutatis mutandis*, it holds true no less for intersectoral and interprofessional health protection and promotion, such as when nurses, physicians and safety officers work efficiently together in an occupational health service.
88. This implies that the different professions know and understand how they complement each other, and that they have a shared view of the overall task and not only their own contribution. This has to be learned. That learning will bring awareness that as the technology available becomes more sophisticated and stimulates further specialization, no one group can serve the patient or client alone. Only partnerships between professions can provide comprehensive, integrated services.
89. To prepare for interprofessional practice<sup>17</sup> with physicians and others, nurses and midwives need interprofessional learning. The more the education is tailored to the interacting roles, the better are the prospects for real collaboration in daily practice. It will be collaboration based on mutual respect and, on the part of nurses and midwives, marked by a newly found professional confidence and, whenever called for, a constructive assertiveness (see Box 5).

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<sup>17</sup> “Interprofessional” is defined here as a working relationship between professional occupations (nursing, midwifery, medicine, etc). The term “interdisciplinary” is sometimes used for relationships between specializations within a profession.

### **Box. 5. Joint teaching and learning – physicians and midwives**

For many years the Chief Midwife at the State University Hospital in Copenhagen has also been one of the clinical lecturers of the Medical Faculty of the University of Copenhagen. She regularly teaches medical students about normal pregnancy and childbirth.

90. How this objective can be achieved will depend on a number of country-specific factors, such as the way these kinds of activity can be funded; which administrative body and health service or educational institution would be given responsibility for commissioning and organizing events on a continuing basis; and what kinds of linkage would need to be established between the various university faculties responsible for undergraduate and postgraduate programmes for each profession.
91. Whatever the decisions made on these and any related matters, it is important to create joint learning opportunities at all stages of professional development for nursing, midwifery and medical undergraduates; in postgraduate specialty programmes; in management and leadership development programmes; and especially in all educational and professional development programmes linked to the three areas of family-focused care, public health action and policy work.

### **The need for partnerships**

92. The vision of the future of the nursing and midwifery professions put forward in the Munich Declaration, and the magnitude of change it could imply, necessarily requires a comprehensive and integrated intersectoral approach. It will be based on the relevant public policies for health and for post-secondary education and vocational training and the frame of legislation and regulation of the professions, and should be guided by the WHO European Strategy.<sup>18</sup> A companion strategy on continuing education is in preparation.
93. In some countries regional or local government or other delegated public sector bodies may have major responsibilities in these fields, which in other countries are determined at a central level. Likewise, the responsibility for organizing and funding professional education is variously vested at higher or lower levels.
94. Regardless of how all these matters are ordered in a country, it is essential to ensure an efficient organization and adequate funding. There must be a sustainable infrastructure linking educational institutions, the examining and regulatory bodies for initial, advanced and continuing education and professional development, funding bodies and health sector employers.
95. The system in place for the professional development of nurses and midwives must do more than fit with both the country's education and its health system. It must be in itself a "learning organization" for all those involved in it, developing and implementing education and training policies and programmes and sharing knowledge and experience. This organizational learning can be powerful and cumulative in its effect, and the long-term outcome should be rewarding for everyone.

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<sup>18</sup> *Nurses and midwives for health. WHO European Strategy for Nursing and Midwifery Education*. Copenhagen, WHO Regional Office for Europe, 2000 (document EU/00/5019309/15).

96. The key is a common awareness of the need not just for action, but interaction. This idea has been referred to as a “co-production value constellation”.<sup>19</sup> In this case the co-producers will include administrators, teachers, learners and practitioners in nursing and midwifery, all active partners in creating value for the health system.
97. There also needs to be a long-term evolving flexible and pragmatic strategy drawn up. It would bring into one frame the needs of the population for services, the quality and type of education and training required to produce practitioners who will address those needs, and the numbers of nurses and midwives required to staff the services.
98. All this requires close cooperation and, at certain stages, joint planning by the responsible ministries and the educational and health authorities, and standing machinery for continuing consultations with the national associations representing the professions.
99. Countries where nursing and midwifery are relatively underdeveloped would benefit from the professional leadership potential that could be released by the establishment of national associations of nurses and midwives, whose functions would include consultation and negotiation with government, the regulatory bodies and the education sector, and involvement with the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM).

## **Workforce planning and equitable employment policies**

100. Strategic workforce planning supports the continuing development of the health system. It is based on estimates of the skills and competences required to meet expected future service needs. It should be integrated into a health development strategy, matching a well educated, skilled workforce to the national and local staffing needs.
101. It should seek to correct geographical imbalances (as for example in countries where professional staff are concentrated in the main urban centres). It also needs to address skill-mix imbalances (where, for instance, there are too few nurses, too many physicians and an excess of auxiliaries in terms of the duties they are each expected to carry out).
102. There is now considerable international migration of nurses and midwives, which creates a special problem when an outflow of nurses exacerbates a staff shortage in a country. There is therefore a need for greater intercountry cooperation so that migration can be monitored internationally, and for the common adoption of an ethical approach based on solidarity to cross-border recruitment.
103. In the general picture in countries, workforce planning practice often lacks a rigorous overview of staff recruitment, retention and wastage and an appraisal of present and future capacity to respond to pressures on the services and to meet identified service needs. Instead, it deals with professions separately and focuses narrowly on numbers of staff rather than assessing the overall picture.

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<sup>19</sup> From NORMANN, R. & RAMÍREZ, R. *Designing interactive strategy: from value chain to value constellation*. New York, Wiley, 1998. “Customers...are to be conceived not as passive consumers of offerings but as active contributors to value creation ...”. Provider–customer relationships should be conceived not as one-way transactions but reciprocal constellations in which the parties “help each other and help each other to help each other”. The book is not about the health care professions, but its ideas should be explored for their applicability to the health field. There is, however, one detailed case study (pp. 132–140) of the Danish Pharmaceutical Association that considers the implications of changing roles and relationships.

104. This is not to deny that accurate and relevant workforce statistics are an important tool in managing human resources. If such statistics are available they should be used. But the direct statistical evidence to support decision-making may not be available or easily collected. In such circumstances, managers need to piece together intelligence from various sources to build up a “good enough” picture of the overall staffing situation. They should then set this against their estimates of a skill mix and the staffing levels that would best meet service needs, and apply their judgement in deciding what action to take.

### **A cost-effective skill mix**

105. Constructing and managing an appropriate cost-effective skill mix is a major staffing challenge. The objective expressed idealistically is to secure in a local labour market, with its given supply of health professional staffs, the most appropriate blend of different professional staff to meet service needs. This workforce is deployed so that the best use is made of everyone’s professional competence.<sup>20</sup> This ensures the highest possible level of output and quality of service to meet the population’s needs for care and treatment and other public health action. Managers of human resources can take this ideal as a point of reference in deciding what practical strategies are possible for them.

106. It must be emphasized that “cost-effective” does not mean “cheap”, or even “cost saving”. In many cases there may be cost increases if a rational strategy requires the adoption of employment policies and staff development programmes designed to reverse obstacles to recruitment and retention, such as a bad public image, low wages and poor working conditions, or falling staff morale.

107. In some countries, such problems have been exacerbated through difficulties with health care financing and budgeting, leading to continued low pay scales and even a reduction in the number of nurses and midwives employed.

108. In these countries, governments will only be able to address the workforce strategy issues after they have succeeded in putting in place sustainable health care financing arrangements and have developed an equitable, politically acceptable method of resource allocation. Ultimately these are not technical questions, but matters of political will and moral choice.

### **Employment policies**

109. It is only when these basic social and economic policy problems have been properly resolved that action can be taken to ensure that nursing and midwifery are able to stand comparison with the attractions of other careers. There is an urgent need in many countries to introduce a staff remuneration and conditions of employment policy based on equitable rewards and recognition, and linked to a transparent career structure in order to improve staff motivation and retention.

110. This policy should be linked to policies on gender equality in employment and opportunities for nurses and midwives to develop personally and professionally, to enjoy autonomy in their professional tasks and to participate in decision-making affecting the running and future development of their service or organization.

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<sup>20</sup> One aspect of staff deployment is that staffing levels have to be matched to peaks and troughs in the workload over daily, weekly, and seasonal cycles. The design of rota systems and shift patterns need to take this into account. A strategy which might be appropriate in some circumstances would be to attract experienced staff who have left the work force back to work on a part-time basis.

111. It will be best served by a participative management style that seeks the cooperation of the workforce and consciously works to sustain staff motivation. Job satisfaction and high morale, the emotional rewards of work, are important for staff retention. Employers and managers who embrace this philosophy will also be mindful of the precautionary principle, and be ready to protect the health (in all its dimensions) of nursing and midwifery staff who work in high-pressure, stressful environments and are at high risk of burn-out and its consequences.
112. In countries experiencing staff shortages, there is a need to improve recruitment from both “conventional” sources (female school leavers moving into higher education and vocational training) and also “unconventional” sources. Recruitment strategies could be directed to male school leavers and to potential “mature” entrants, including those wishing to make a career switch.
113. Many industries and businesses are facing difficulties in recruiting and retaining skilled and qualified staff. Health sector employers should take note of employment practices by successful organizations in other sectors and consider their applicability. More research and development work in countries, together with opportunities for mutual learning between countries, as envisaged in the Declaration, should accelerate the adoption of effective approaches to all human resource planning and management.

### **Management’s responsibility**

114. The expectations that were born at the Munich Conference will only be realized if the whole body of practising nurses and midwives are in some way involved in realizing the implementation of the Declaration. This implies a commitment from the leadership in the ministries, in the professional associations and in the universities. In particular, they must give support to local managers, whose shoulders carry a heavy responsibility. It is they who will be engaging with and appealing to practising nurses and midwives.
115. The response they engender will be critical. As has been observed, organizations are webs of participation. Successful performance depends on participation with enthusiasm and commitment, two qualities that organizations can earn but not compel. Workers *choose* to opt in.

## **The contribution of the WHO Regional Office**

### **Strategic guidance**

116. The Regional Director was asked by the Munich Conference to provide guidance on the implementation of the Declaration. The Regional Office’s programme on nursing and midwifery has prepared, or has in preparation for dissemination when completed, specific guidance on the issues identified by Ministers on the Declaration. Some of this guidance has been referenced at appropriate points in the text of this memorandum. A complete listing of documents is given in Annex 1.
117. Future guidance material, whether relating directly to nursing and midwifery or to policy areas that touch nursing and midwifery (such as women’s health), will be reviewed to ensure consistency with the spirit and purpose of the Declaration.

## **International cooperation**

118. The Regional Director has also been asked to support international cooperation. The Regional Office will work through the European Forum of Nursing and Midwifery Associations and WHO and the Standing Committee of the Regional Committee (SCRC). It will work with ICN and ICM and other professional bodies, with the European Union and the Council of Europe, and with intergovernmental organizations both inside and outside the United Nations system on issues relevant to nursing and midwifery as they arise.
119. The Regional Office will consider (in response to a proposal that has been put to it) whether it should play a role in monitoring intercountry migration of nurses and midwives and migration in and out of the European Region, or whether this could or should be done in other ways, and will advise Member States in due course.
120. The Regional Office will consult the bodies concerned on the possibility of a joint meeting between the three European forums of national medical, pharmaceutical and nursing and midwifery associations on the theme of partnership working.
121. The Regional Office will seek to identify how international support of all kinds can be harnessed, to help countries with the particular problems they identify as requiring external assistance. This external assistance could take many forms. It might, for example, involve cooperation between national professional associations and bilateral university-to-university and government-to-government links. There could be networks established to facilitate and promote the exchange of information and experience. This could lead to the secondment of professional personnel, and other support in kind.

## **WHO support to countries**

122. The Regional Office will work with Government Chief Nurses and focal points for nursing and midwifery in health ministries and with WHO liaison officers where these are in place. It will seek opportunities to adopt a proactive approach to implementation as part of its regular ongoing work with countries, but implementation of the Declaration must be based on the principle of subsidiarity. The Regional Office is responsible for taking and coordinating necessary international action; it should not attempt to do what can be done by and within countries.
123. The Regional Office will initially respond to requests with a bilateral review of the problems that have been identified in the country. This will establish what kind of support would be crucial in overcoming any barriers to implementation of the Declaration and accelerating the developments envisaged in it. In general terms, the kinds of support that might be possible, if the country's circumstances indicated a need, include:
- a. short term technical help, such as in drafting:
    - i. legislation/regulations
    - ii. human resource development strategies
    - iii. curriculum development plans (with education institutions);
  - b. technical support to national Munich implementation groups; and participation at national events, either to raise awareness of the future for nurses and midwives envisaged in the Munich Declaration or to promote a strategy or a specific action plan once it has been drawn up;

- c. selective dissemination of WHO materials to key actors in the implementation process (i.e. documents could be sent to identified individuals with a follow up contact “would you like to discuss these with us?”); these could include packs of learning materials and guidance to nurse and midwife educators, so helping a country’s efforts to build capacity; and
- d. longer-term continuing support: a consultant might be assigned to the country to work with national counterparts on the preparation and implementation a Munich implementation strategy;<sup>21</sup> this would be dependent on external funding.

## Tracking implementation of the Declaration

124. The Regional Director has been requested to present regular reports to the Regional Committee on the implementation of the Munich Declaration, and specifically to hold a meeting in 2002 to review the “start-up” phase of implementation. This has an implied intent of sustaining and re-enforcing the sense of purpose and energy created at the Conference.
125. The need for a tracking process for implementing the Declaration is two-fold. First, it is to trigger a learning process, which is based on self-assessment of progress as measured against the objectives and political commitments in the Declaration. In this sense the tracking process is essential to an effective implementation strategy. Second, it is a necessary means for preparing the progress reports for the Regional Committee. It should facilitate the systematic collation and presentation of evidence on progress and problems.
126. Proformas for the tracking process are being sent out to countries separately from this guide. It suffices to say here that the underlying purpose is to invite in-country partners to *ask questions of themselves* and of each other. They should then reflect on the answers and decide what further action is required, or whether there needs to be changes made in the strategy followed so far.
127. It is anticipated that, in preparing progress reports for the Regional Office, it will be possible to draw on or adapt materials and information gathered for other purposes, such as the updated nursing and midwifery profiles, or the Prospective Analysis Methodology (PMA) tool, which supports the European Education Strategy.
128. The tracking process can also facilitate cooperation with counterparts in other countries. It could be used to help identify issues for the exchange of information and experience and for benchmarking progress against that made *either* in countries in similar circumstances (e.g. culture, experience, demography, resources available to the health sector) *or* in countries whose more developed nursing and midwifery services are seen as attractive models to emulate.
129. The Regional Office will keep under consideration the possibility of convening a reference group from time to time to review developments across the Region and advise on action to be taken; and of holding or sponsoring, with technical help, meetings with participants from different countries to pool their experience and expertise.

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<sup>21</sup> Note the crucial importance of identifying consultants who are properly equipped by temperament, background, skills and experience for each assignment.

## **Tentative framework for the follow-up meeting in 2002**

130. Work has now started on preparing for the meeting in 2002, which is seen as the means of maintaining momentum and direction. It is envisaged that the principal issues concerning countries, and on which the meeting would focus, will be as follows.

- What steps have been taken to introduce/strengthen and sustain the roles of nurses and midwives in the health system as envisaged in the Munich Declaration? What experience(s) have been particularly positive?
- Have any particular problems (expected or unexpected) been encountered and, if so, how have they been handled?
- What are the most important challenges currently being addressed in developing/sustaining the roles of nurses and midwives?
- What forms of help are needed (or would be useful), including information on how the same issues are being addressed elsewhere?
- How do countries envisage their strategies for maximizing the potential of nurses and midwives evolving from where they are now (and over what time scale)?
- In general, how do we assess the level of progress we have achieved collectively since Munich and what should be our next steps?

## Annex 1

### Technical tools and guidance documents<sup>22</sup> on nursing and midwifery Updated April 2000

1. *Research awareness in nursing and midwifery: a workbook*. Copenhagen, WHO Regional Office for Europe, 2000 (document EUR/00/5019309/17).
2. *Portfolio of innovative practice in primary health care nursing and midwifery*. Copenhagen, WHO Regional Office for Europe, 2000 (document EUR/00/5019309/16).
3. *Portfolio of innovative practice in mental health nursing and midwifery*. Copenhagen, WHO Regional Office for Europe (in preparation).
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<sup>22</sup> Copies of these documents are available on request from the WHO Regional Office for Europe in Copenhagen.

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## Annex 2

### Nurses' and Midwives' learning requirements to maximize potential

#### Basic assumptions in the Declaration

Ministers have identified their basic health policy objectives and the roles they see nurses and midwives playing in the pursuit of these objectives. Ministers' vision for the future of health can be fairly interpreted in the following terms. The value in expressing the future in ideal terms is not in assuming ingenuously that the world is already like this, but to make clear the goal towards which all efforts should be directed. This is also articulated in the WHO European Strategy for Nursing and Midwifery Education.<sup>23</sup>

1. Nurses and midwives are key players in a health system providing comprehensive care and functioning according to the objectives, values and principles of primary health care (PHC), i.e. a system that, when functioning properly within the requisite policy framework, will:
  - integrate all local health actions (preventive, promotive, “curative”, etc.), whether in hospital or community settings, with the necessary linkages, pathways and referral mechanisms to more specialized services available outside the locality and other help when needed;
  - involve all local health actors, i.e. in the health and related sectors both professional and non-professional (nongovernmental organizations as well as individual users of services, families, social groups, etc.), and
  - protect and improve (promote, restore, maintain) the health of individuals, families, groups and the community at large.
2. There is a real political, professional and managerial commitment to integrated health care based on the PHC (Alma-Ata) approach in the further development of the health sector and in collaboration between the health and other sectors.
3. There is a common understanding guiding people's behaviour that integrated health care is not a formal organizational structure but is:
  - a self-sustaining set of relationships between many partners, including different professional actors and levels of care (sustained by people themselves); and
  - all actors see the advantage of having a framework of thinking or understanding within which the biological, psychological, spiritual,<sup>24</sup> emotional and social aspects of the health (and ill health/sickness) of the individual, family or group can be addressed.
4. Nurses and Midwives who fulfil the roles envisaged in the Declaration and in the WHO Education Strategy will have the capacity to:

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<sup>23</sup> *Nurses and midwives for health: a WHO European Strategy for Nursing and Midwifery Education*. Copenhagen, WHO Regional Office for Europe, 2000 (document EUR/00/5019309/15).

<sup>24</sup> Although the WHO constitutional definition of health does not include a spiritual dimension, this was subsequently acknowledged in a World Health Assembly resolution adopted in 1983.

- assess and understand the economic, social and environmental circumstances in which the users of their services are living, the health implications and the need for services and support;
- assess from their particular perspective and based on their continuing contact with users the relevance and quality of the services and support the users are receiving;
- recognize the resources or strengths of the individual, family or other group (with whom they are working as co-producers) that can be built on; and
- decide what appropriate action to take to protect, promote or restore their health, which according to circumstances may be to provide counselling or other forms of support, care, treatment or rehabilitation; or to refer (under decision rules) to another professional or service; or to make representations on their behalf to another social agency.

This requires that the education of nurses and midwives provides them with knowledge, understanding and attitudes that enable them to interact as professional *partners* with others (decision-makers, providers, etc.) across the health field:<sup>25</sup>

- human biology and pathology (the causes and consequences of problems)
- lifestyles and behaviour (the psychosocial, cultural environment)
- environment (including physical, built, economic, occupational, etc.)
- health care organization (contacts with managers and providers)

and with the requisite competence in:

- clinical nursing (observation, history taking, examination, assessment (diagnosis), etc.) up to the limit of the role as defined by statute or other legal form;<sup>26</sup>
- assessing the psychological and social (and economic) circumstances/health needs of users and determining appropriate action;
- health education, counselling and other health promotion activities, which will be tailored to the recipient/user (individual, family, social group, community at large); and
- developing and following an advocacy and negotiating brief with interests in other sectors (economic and others) with the intent to influence their decisions/policies/ subsequent behaviour.

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<sup>25</sup> The concept of the “health field” was first promoted by the 1974 Canadian Government document *A new perspective on the health of Canadians* (known as the Lalonde report after Marc Lalonde, the then Minister of Health). Whether consciously followed or not, its thinking can be seen to have influenced WHO’s health for all thinking. Lalonde characterized the health field as having four elements: human biology, lifestyles, environment and health care organization. The purpose was to identify where the determinants of health (major influences) and the source of major problems were to be found as the basis for deciding what action should be taken.

<sup>26</sup> The key issue here is that nurses and midwives are enabled to function as “independent and interdependent professionals”. As with any health professional, the operational limit of the nurses’/midwives’ competence is reached when (under given decision rules) the clinical or other indications point to the need to refer the patient to another profession. This is typically to physicians who will apply their clinical method, which is appropriate to more complex diagnostic and disease management problems.

### Basic messages to be inculcated<sup>27</sup>

- Being committed to health for all values and principles, and with the intention to learn from and build on experience.
- Understanding the position of health in development as:
  - a creator of wealth, not a drain on society's resources
  - investment in health; investment for health
  - sustainable action/change.
- Recognizing that most determinants of health are in the hands of others:
  - the macro-environment as it affects health
  - the health sector's contribution
  - specific contributions of other sectors.
- Reaching out to other sectors/actors through:
  - advocacy
  - negotiation
  - collaboration (distinguish multisectoral and intersectoral action)
  - health protection and promotion action packages geared to families, particular population groups and the local community at large.
- The leadership of nurses and midwives “will make it happen” if they:
  - acknowledge and fulfil their responsibilities as professional and *political* actors
  - make sure that nursing and midwifery issues are formulated in terms that fit into the broader agenda of social and economic policy.

### More specific learning requirements

To understand their operating environment properly, nurses and midwives involved at the policy level need to have a good knowledge and understanding of the scope, the overall structure and the functioning of the *health system*, which can be understood as the linkages between activities in all services that are in one way or another health-related. Examples of *services* would be child health, the elderly, mental health, occupational health, food safety, rehabilitation and services for persons with disabilities, and accident services. Distinguish between *service* and *institution* as organizing concepts. “Service” focuses on the purpose of

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<sup>27</sup> These messages and the elaboration in the following paragraphs relate to the “view of the world” that Nurses and Midwives should bring to their work whatever and wherever it might be. There is much more to the full learning spectrum in nursing and midwifery from the tasks of basic clinical work to the management of clinical services to the planning and management of the health system itself. This learning spectrum, which necessarily has both theory and practice components, goes well beyond the intended scope of this note. See *Nurses and midwives for health: a WHO European strategy for nursing and midwifery education*. Copenhagen, WHO Regional Office for Europe, 2000 (document EUR/00/5019309/15).

activities and “institution” on the physical location of those activities. As the word is used here, a *service* will very often involve collaboration between different institutions and professions and agencies.

Nurses and midwives need to understand “how the health system really works”, what action is possible and where, and also where the obstacles to necessary change might be and how they could be removed. This means having a good sense of who is responsible for the formulation and implementation of the whole range of health policy, and especially the relevant national policies that influence local practice (e.g. the ministries, agencies and institutions responsible for environmental health, accident prevention, food safety and nutrition, health education in schools, etc. as well as those involved in health care). They also need an appreciation of:

- what “intersectoral collaboration” and “community participation/involvement” mean in the context of the health system;
- how the individual person: enters the health system (e.g. self-referral to first contact health care); receives advice, diagnosis and treatment; and is referred to other services, including specialist medical care, other social welfare, etc. (pathways through the system);
- trends in technology that could have local implications for the need for, location, configuration and resource mix of services, e.g. equipment used in diagnosis and treatment, care and rehabilitation, pharmaceuticals, information technology, etc.; and
- the often complex process of identifying, formulating and managing problems in health service provision (but also challenges and opportunities for improvement and development).

*Working definition:* a “problem” is where “doing nothing” is not an acceptable response; there is no obvious one way forward and various possibilities may be considered. Problems do not exist objectively, independently of the person(s) perceiving them. Problems are defined by those taking the action. *Note:* “managing” problems (i.e. deciding on and initiating an appropriate response) rather than solving problems – if it can be solved easily, it is not really a problem!

**Examples of situations that become defined as problems are:**

- some shortcoming in the running of a service that is acknowledged to be serious;
- a state of conflict with another agency (e.g. over the proper response to an issue concerning both agencies);
- growing pressures from groups in the local community population seeking improvement in the services provided; and
- a change in central government policy that has implications for what is done or how it is done at local level.

**The issues that arise in problem management include:**

- how a problem is clarified: by what pressures and processes it acquires its shape and comes to the top of the agenda;
- how the range of possible responses is built up, and the process by which the best (most feasible) response is identified; and

- the need to think through what new “problems” might emerge if various courses of action were adopted.

### **The dilemmas of policy-makers and managers**

If they are essentially reactive and focus on an immediate problem, then their operating mode is that of adjustment to and coping with that problem, with the risk that they miss the bigger picture.

If they are proactive and focus on the need to anticipate and prepare for future events, then their operating mode shifts from coping to preparing specific proposals for an expected future, with the risk that they overlook important immediate needs for action.

If they focus on achieving a desired result, then their operating mode shifts to developing a dedicated appropriate process (find the right new way), with the risk that they overlook existing processes that would work just as effectively.

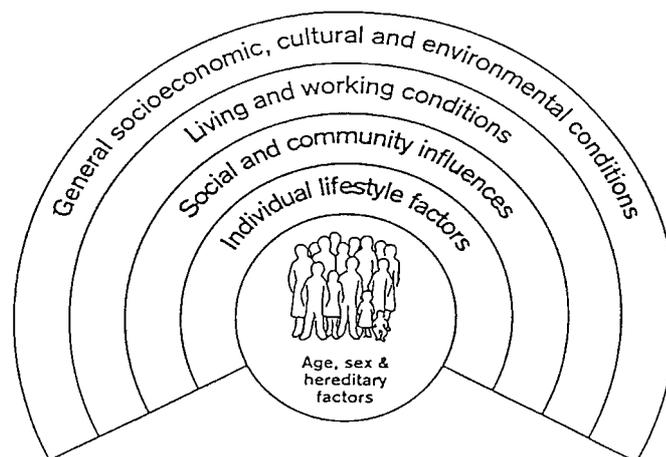
If they focus on articulating a vision (a fully developed coherent sense of purpose), then their operating mode is to design the “future” and to define the strategy to get there, with the risk that in their enthusiasm and sense of commitment they fail to apply rigorous reality checks to the strategy.

Nurses and midwives engaged in public health action and family-centred care require a good working knowledge and understanding of their operating environment. Their specific requirements and the level of detail necessary will depend on their actual tasks, but the following covers the general field:

- the demographic/socioeconomic profile of the area; local implications of social trends and changes with effects on need for services and the level of health of the population, e.g.
  - family patterns/cohesion
  - geographical mobility
  - patterns of employment/incidence of unemployment
  - prevailing lifestyles and patterns of behaviour;
- the strength and resources of communities and individuals and families as well as the main health and social problems that the services have to deal with, or for which other measures and/or policies are needed;
- the *local health system*; links between health services (as such) and other services; what each service is trying to achieve; and how each service is organized and managed: what are its component parts, how are they connected together to ensure that each person receives attention according to their actual personal need;
- local political factors and local implications of national factors, e.g.
  - approach adopted in the implementation of national and local priorities for health protection and promotion and for health care

- national/local government relations (degree of *subsidiarity* in practice);
- the actual and potential influence of different interests and stakeholders,<sup>28</sup> e.g. representative bodies of health professions at local level, trade unions, community representative bodies, pressure groups etc.; role and responsibilities of politicians; the nature of relationships between managers, professionals and politicians;
- local economic policy factors and local implications of national factors, e.g.
  - consequences for health of major policy thrusts
  - policies determining or influencing the level of allocation of resources to health care and health supportive purposes
  - trends in investments and outputs of economic sectors – health implications.

### Conceptual model for the main determinants of health



Source: DAHLGREN, G. The need for intersectoral action for health. *In*: Harrington, P. & Ritsatakis, A. *European Health Policy Conference: opportunities for the future, Vol. II*. Copenhagen, WHO Regional Office for Europe, 1995 (document EUR/ICP/HFAP 94 01/CN01 (II)).

Nurses and midwives engaged primarily in public health action will need to be alert and able to respond to intersectoral opportunities. This requires skill in:

- linking with partners within and outside the health sector and negotiating agreement with them on action to move toward intended outcomes, and
- continuously monitoring the environment and effects of actions taken, and reflecting and making the appropriate adjustments in ends and means.

<sup>28</sup> People who benefit in some way or have the means to make or stop action.

Nurses and midwives engaged primarily in providing or managing clinical services will need to be alert to and respond to local intrasectoral pressures and opportunities. This requires a good understanding of:

- relationships within the health care system, e.g.
  - relations between patients and professional providers (e.g. adopting the *co-production* concept)
  - how we make the most of human resources
  - whether there is any local pressure for/interest in new participative approaches;
- the challenges in service development, e.g.
  - being sensitive and responsive to the “needs”, expectations and wishes of service users
  - action to ensure continuity of care
  - benchmarking performance against those judged to be “best in class”; reviewing the effects of existing policies and services, and preparing proposals for their further development; and identifying and mobilizing resources
  - gaining professional and public acceptance of developments (e.g. through staff consultations and forms of community participation); and maintaining staff morale.