Regional Meeting
"The Role of Government Chief Nurses in the Countries of the Region of the Americas"

Havana, Cuba
10-12 September 1996

FINAL REPORT
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1. INTRODUCTION

The Regional Meeting on the Role of Government Chief Nurses in the Countries of the Region of the Americas was held in Havana from 10 to 12 September 1996. The working group analyzed how the ministries of health in the Region would assume a leadership role in the development of nursing so as to ensure levels of nursing care based on the needs of the population. The list of participants and observers in the meeting appears in Annex 1.

In July 1995 the WHO Expert Committee for Nursing Practice met in Geneva to examine the nature and scope of nursing as a response to the needs of individuals, families, and communities. The Committee’s report includes the recommendation that the World Health Organization and its Member States train nurses and midwives to discuss regulatory issues, to develop leadership capacity and to participate in policy forums. Other recommendations in the report are directed toward ensuring an integrated and effective approach to the delivery of high-quality nursing care.

The function of the ministries of health, in general, and the divisions of nursing and/or chief nurses, in particular, are key to the implementation in the countries of Resolution WHA 49.1 and the recommendations of the panel of experts. These responsibilities are described in the document “The Government Chief Nurse — Rationale, Role, and Function.”
2. OBJECTIVES OF THE MEETING

The objectives of the meeting were:

1. To consider the role of a division of nursing or its equivalent in a ministry of health for the development of nursing.

2. To analyze the recommendations of the expert panel on nursing practice.

3. To examine and discuss the document “The Government Chief Nurse — Rationale, Role, and Function”, and, if necessary, to propose modifications.
3. OPENING OF THE MEETING

Dr. Julio Suárez, Consultant of the Pan American Health Organization’s (PAHO) Office in Cuba, representing Dr. Patricio Yépez, PAHO/WHO Representative in Cuba, took the floor to extend a welcome to the participants, explaining the importance of the meeting as an essential component of the reforms under way in the countries in the area. He pointed out the role of leaders in nursing and the need for the meeting to bring forth fundamental ideas on how nurses can participate in the development of health policies in their respective countries. He described the important role of Cuba in that connection by presenting up-to-date health statistics demonstrating that all the countries could learn from Cuba’s example.

Dr. Hirschfeld, Scientist Chief for Nursing at the World Health Organization (WHO), conveyed greetings from the Director General of WHO and the Regional Nursing Advisers, noting that the significance of the meeting lay in its ability to examine the functions of government chief nurses, which should imply government support for this work.

Ms. Belkis Feliú, National Director of Nursing of the Ministry of Public Health of Cuba, also extended a welcome to the participants on behalf of her national colleagues.

Dr. Abelardo Ramírez, First Viceminister of the Ministry of Public Health of Cuba, then formally opened the meeting, noting that all of Cuba’s health policies included efforts to strengthen the position of nurses in health reforms. The meeting was the ideal setting for contributions and agreements, and the nurses of the Region could count on Cuba’s assistance. He said it was a pleasure to meet to discuss such important issues as those related to the strengthening of nursing/midwifery in the Region of the Americas, a key element in achieving the objectives proposed by the ministries of health, as well as the role and functions of government chief nurses or focal points in coordinating nursing in the ministries in the various countries.

He stated that in compliance with Resolution WHA 45.5 of May 1992, which urged the Member States to strengthen administration and leadership capacities and enhance the position of nursing and midwifery personnel in all health care settings and at all levels, including the central and local services of the ministries of health, and in compliance with Resolution WHA 49.1 of May 1996, which urged the Member States to involve nurses more closely in health reform and in the development of national policy. The Ministry of Health of Cuba had made efforts to strengthen leadership in nursing in the country and had encouraged nursing personnel to participate actively in the plans and programs contained in the principal objectives specified in both resolutions.

He also noted that discussion of the recommendations of the panel of experts was of great importance for nursing practice. It would make it possible to provide high-quality nursing care with an integrated approach that took into account demographic aspects and the changing needs for health care, the available resources, the political, social, and cultural factors involved, the overall development of human resources, interdisciplinary collaboration, environmental health, and ethical considerations. It provided an ideal framework for sharing experiences and for agreements that would enable the participating countries to define more clearly the role of nursing in formulating the policies of the ministries and orienting their contributions toward the achievement of the proposed objectives.
Lastly, he said that the Cuban Ministry of Health would provide the firmest support to such an important meeting to provide full backing for nurses in their noble task of serving more efficiently to improve the health of the peoples of the Region.
4. WORK METHODOLOGY AT THE REGIONAL MEETING ON THE ROLE OF THE GOVERNMENT CHIEF NURSES IN THE COUNTRIES OF THE REGION OF THE AMERICAS

1. Dr. Sandra Land, Regional Nursing Adviser, who presided over the meeting, explained its organization and requested details on its installation and program from the host country. The participants were then introduced in alphabetical order by country. The Cuban Provincial Chiefs of Nursing also participated as observers.

Each country had 10 minutes to present its report, describing its particular problems, the situation of nursing practice, and the participation of its nurses in the ministries. In addition, a framework was presented for work to be carried out between PAHO/WHO and the ministries of health in the Region.

Dr. Land, in referring to the working document "Nursing Practice and the Role of the Ministries of Health in Nursing Development to Assure a Safe Level of Nursing Care, Region of the Americas," noted that the United States, Canada, and Cuba enjoyed a favorable position with respect to nursing resources, since they possessed a larger number of professional nurses. Such was not the case in the rest of the countries represented, which had areas with limited nursing personnel, in some cases poorly trained. See Annex 3.

The formation of four groups was proposed:

- **Group I** (Spanish language), to analyze the recommendations of the Expert Committee. Members by county: 2 for Cuba, 1 for Guatemala, 1 for Mexico, and 1 for Honduras, in addition to Livia Victoria Cerezo (Colombia).

- **Group II** (Spanish language), to examine Resolution WHA 49.1. Members by country: 2 for Cuba, 1 for Mexico, 1 for Bolivia, and 1 for Guatemala, in addition to Marta Ligia Fajardo (PAHO/WHO, Brazil) and Yanuario García (PAHO, Venezuela).

- **Group III** (Spanish-English), to examine Resolution WHA 49.1. Members by country: 1 for Cuba, 1 for Mexico, 1 for Guyana, 1 for Haiti, and 1 for the United States, in addition to Dr. Sandra Land (PAHO/WHO Headquarters).

- **Group IV** (English language), to consider the recommendations of the Expert Committee. Members by country: 1 for Belize, 1 for Bolivia, 1 for Guyana, 1 for Canada, and 1 for the United States, in addition to Dr. Miriam Hirschfeld (WHO), and Ms. Belkis Feliú (Cuba).

2. Dr. Miriam Hirschfeld, Chief Scientist for Nursing at WHO, noted that all the groups would continue to analyze the functions of the government chief nurse. Countries that do not have government chief nurses should propose the structure they were considering for the function and specify who was to fill the post and how, and what the functions of the person were to be.
5. COUNTRY REPORTS

**CANADA**

Mary-Ellen Jeans, Executive Director of the Canadian Association of Nurses, said that in her country most of the nurses worked in hospitals and that incorporation into the community had been slow. Canada did not have a chief nurse in the government, although such a post existed in the provinces. Success had been achieved in linking nurses to the Regional Boards, and far-reaching changes were being planned.

**BOLIVIA**

María Luisa Suárez Lenz, in charge of nursing in the National Health Secretariat, said that in 1985 Bolivia had a solid nursing structure that included a chief nurse in the Secretariat. In 1995 reforms were undertaken to reduce the administrative apparatus, thereby eliminating the post, so that at the present time only offices remained, occupied by physicians to the exclusion of nurses. In the new nursing model, nursing personnel currently worked in the Department of Services in a multidisciplinary team, in which they dealt with regulatory aspects and project implementation, among other things. Present plans included inviting a consultant to prepare nursing policies for implementation in the country.

With regard to the nursing work force, no unemployment had been recorded in 1989. However, in 1990 the figures changed when graduates in nursing were obliged to provide one year’s social service and found that they no longer had a job when they returned.

There were three times as many nursing auxiliaries as graduate nurses, since the former could be trained in from nine to ten months, whereas the latter required five years of training, although they did not earn substantially more than the nursing auxiliaries.

Efforts were being made to strengthen nursing activities in management, research, and coordination.

**CUBA**

Ms. Belkis Feliú Escalona, National Director of Nursing in the Ministry of Public Health, spoke of the political and economic situation and its impact on current conditions. Reforms in Cuba’s health system had been under way for several decades, during which nursing had demonstrated sustainable development in reducing costs, improving the quality and efficiency of the services, and, consequently, the satisfaction of the population.

She described the strategies mapped out by the National Directorate of Nursing, which was attributable to the political will of both the Ministry of Health and nursing personnel. At the present time efforts were being made to modify nursing activities through application of the “Nursing Care
Process." The 1,000 nurses working in 1959 had now grown to 80,000, 25,000 with basic posts and 12,000 with university degrees at the baccalaureate level.

Among the areas to be developed over the coming five years were organization of the services and accreditation of hospitals, ethics and bioethics, continuing education, health education, care of the elderly, control of infections, and review of techniques, procedures, and research.

Other lines for development included increasing master’s and doctoral degree programs for nursing personnel and maintaining the development of primary care and human resources training.

**United States**

Drs. Marla Salmon, Director of the Division of Nursing, and Carolyn Beth Mazzella, Chief Nurse, U.S. Public Health Service in the Department of Health and Human Services, explained that access to and the quality of the health services were a matter of common concern. An excellent system of tertiary care was in operation, but the fundamental problem lay in the area of costs, inasmuch as they were more of a problem than professional practice. Changes were currently taking place in the direction of community health, for which multidisciplinary teams were being developed on the basis of the population’s needs. Health was a business in the United States, and a balance therefore had to be struck between costs and people’s needs to ensure that health services were safe, equitable, and appropriate. Access to the health services was not always feasible because of geographical difficulties.

A major problem faced by the country was the aging of its nursing personnel, since by the year 2010 half of the nurses currently working would be outside the job market because of their age.

The United States had a Chief Nurse, a Division of Nursing, an Advisory Council in the Department of Health and Human Services, and a National Institute of Nursing Research.

**Guatemala**

Lilian Barrillos de Rivas, Chief of the Department of Health Personnel Training in the Division of Human Resources of the Ministry of Health, and Almeda Aguilar de Urbina, Director of the National School of Nursing, explained that of the 9 million inhabitants of Guatemala, 65% lived in rural areas, speaking 22 different dialects. There were only 3,000 nurses in the country, but, even so, there were not enough positions available for them.

An early retirement process was under way; nurses were retiring after 20 years of service or upon reaching age 50 with 10 years of active service. After fulfilling either of these requirements, nurses began to shift to private organizations, thereby creating a large nursing deficit in the sector. As a consequence, it had been necessary to train nursing auxiliaries and to increase their numbers to 8,000, a figure higher than that for professional nurses. Attempts were being made to convert nursing auxiliaries into technical nurses and subsequently to professional nurses, although it was not an easy task because of the minimal differences in the wages paid to each. Seventy percent of health workers worked in hospitals, but 65% of the population lived in rural areas.
Efforts were under way to improve the health care model, and to that end Guatemala had allocated 70% of the budget for preventive care without diminishing the portion assigned the hospitals as a means of inverting the pyramid. The new health care model provided for three pilot areas based on the sizable number of ethnic groups in the country, grouped into a mixed Indian and Spanish sector, a mostly Indian sector, and a sector of almost pure European ancestry. Reforms had consequently been initiated in keeping with the characteristics of the various departments.

A leader in nursing was needed, since that position had disappeared in 1980. There was a nurse in every department, but since the nurses were located chiefly in urban areas, the most vulnerable population groups were left unprotected by the health services.

Despite such a panorama, nursing services were considered quite strong, since much had been accomplished extraofficially through the creation of working groups that planned activities designed to strengthen the profession and, consequently, the health services.

**VENEZUELA**

María Lourdes Serrano, Chief of the Technical Office of Nursing, Ministry of Health and Social Welfare, provided an overview of the health situation in her country, noting that there was a severe shortage of professional nurses in the nursing work force.

There were approximately 20,749 professionals in her country, 50% of whom were high school graduates, 10% professional nurses, 20% high-level technicians, and 20% university trained. In addition, there were 41,102 nursing auxiliaries and 2,545 medical assistants.

Ms. Serrano then outlined her country’s strategic plan for the development of nursing personnel up to the year 2001, which included increasing the number of professionals and high-level technicians, expanding graduate training at the specialization and master’s degree levels, and reorganizing continuing education programs.

**GUAYANA**

Joan Barry, Principal Nursing Officer in the Ministry of Health, after a description of her country’s geographic, demographic, and sociopolitical characteristics, spoke of Guyana’s medical situation, noting that maintaining the health of the Guyanese people was a challenge. Reforms were being undertaken in the health sector, supported by research. The government assumed 65% of the expenditures of the health sector, which consisted of four levels of care.

The nursing work force was largely university-trained and was working in all levels of health care in accordance with needs. There had been a nursing shortage for the past 10 years, since adequate training had not been provided. Time use studies would be undertaken to remedy what was felt to be a temporary situation.

Guyana had three government and two private schools, and programs were currently being studied to incorporate basic education programs in primary health care of three-year duration for
registered nurses and two-year duration for nursing auxiliaries. There was great concern about specialized nurses, since many had retired, abandoned the profession, or left the country. Salaries had been increased but did not meet their needs, since the cost of living was high.

Midwifery had been directed by the General Nursing Council, based on a 1953 ordinance that was presently under review. Concerning leadership functions, it was at times forgotten, for example, that the midwives had participated actively in policy-making and that primary health care had been emphasized. Nurses and midwives rotated their services in regional and district hospitals and in primary care units. A Nursing Association existed, supported by a labor union.

Among the goals proposed by a strategic plan under study were the organization of a database to place personnel, an evaluation of curriculum development, a review of job descriptions, and a review of salaries for the purpose of making recommendations.

CENTRAL AMERICA

Dr. Sandra Land requested Gisela Pimentel, a PAHO staff member in Honduras and Nursing Adviser to the countries of Central America (Panama, Nicaragua, Costa Rica, Honduras, Guatemala, and El Salvador) to speak about the situation in the subregion.

The Adviser reported that all the countries of Central America were engaged in political reforms, with a consequent impact on the health sector. Most of the nurses were participating in those processes, although it had not been easy to include them at the political level despite the fact that the subregion had approximately 40,000 nurses, 30% of whom were professionals and 70% auxiliaries, with a wide range of prior training and decision-making capacity from one country to another.

PANAMA

Fifty percent of Panama’s nurses were professionals, graduates of the single university school, and 50% auxiliaries, a distinct advantage, since the quality of care provided was very high. A very strong Nursing Association existed, in addition to a very well-structured Division. There was unity between educational institutions, the services, and professional organizations. At the present time studies were being conducted at the national level to propose to the government that nurses participate in the reforms under consideration.

COSTA RICA

Costa Rica also had a strong nursing structure. Most nursing personnel worked in the Social Security system, and although their principal function was to assist in the recovery of health, the current reforms envisaged a community approach. New nursing personnel were being trained with characteristics similar to those of nursing auxiliaries to provide health care in rural areas. Professional nurses worked at the secondary level. The Ministry of Health was maintaining a minimum of professional personnel, who were being assigned a more administrative role. There was
a good School of Nursing, and the Nursing Association functioned as a union with good integration of teaching, service, and union activities. There was a Chief Nurse in the Ministry of Health who participated in the reform process. The School of Nursing and the universities were well integrated. There was a state university and five private schools that trained graduate nurses, while auxiliaries were trained by the Social Security institute and the Ministry of Health. A good continuing education process was in place.

**Honduras**

Seventy percent of the nursing personnel in Honduras, Guatemala, and Nicaragua were nursing auxiliaries with varying and highly diverse levels of training. Honduras had the greatest disparity between the two nursing levels: 16% professionals and 84% auxiliaries. There was a state university and three schools of nursing, providing more than five courses of study in auxiliary nursing in various locations.

**Nicaragua**

Nicaragua had five state nursing schools and one private school, which in three years trained professional nurses who could subsequently become nurses at the baccalaureate level.

**General Discussion on Central America**

It was noted that in 1990 the Central American Group of Nursing Professionals was formed, whose mission was to ensure the role of nursing in the formulation of health policies in the subregion and to comply with WHO/PAHO mandates.

In response to a request for information on the role of nursing in the current situation by Dr. Miriam Hirschfeld of WHO, Gisela Pimentel, the PAHO Adviser, said that Central America had many problems, such as emerging and new diseases. Some countries also encountered difficulties in integrating nursing into the reform processes under way. Nurses had representatives at the local level and played a useful role in immunization programs and maternal and child care, providing prenatal checkups in Honduras and Costa Rica, and in Guatemala wherever it was possible. In remote areas either professional nurses or auxiliaries provided prenatal checkups.

Gisela Pimentel noted that while many problems existed, there were, nevertheless, certain positive aspects to the situation. Prospective analyses were being made of nursing education and practice, and plans of action had been formulated to improve the nursing situation. By way of example, she mentioned that in Costa Rica there were health programs managed by nurses. The same was true of Guatemala, although the latter was plagued by problems of personnel shortages and a lack of direction. A few nurses at the political level were attempting to negotiate the nursing situation. She thought that at the present time nursing practice in Central America was being recognized in the processes and reforms of the countries in the subregion, citing the present meeting as an example. In El Salvador a struggle was currently under way for recognition of the profession. Many countries
offered very low salaries and there were vast differences between nurses’ salaries and those of physicians. Salaries in Panama and Costa Rica were higher than in the rest of the countries of the subregion.
6. PRESENTATION AND ANALYSIS OF THE DOCUMENT “RATIONALE, ROLE, AND FUNCTION OF THE GOVERNMENT CHIEF NURSE IN THE MINISTRIES OF PUBLIC HEALTH”

Dr. Sandra Land began the presentation by providing background for the discussion of the document “Rationale, Role, and Function of the Government Chief Nurse in the Countries in the Region of the Americas.”

Ms. Belkis Feliú then pointed out the important components to be analyzed in the document.

Dr. Miriam Hirschfeld stated the objectives being pursued in the deliberations of the meeting, pointing out its usefulness, the pros and cons involved, and the means for determining the benefits and economies accruing to the countries from installing a chief nurse at the government level.

Discussion of the document was initiated by Mary-Ellen Jeans (Canada), who noted that her country had once had a chief nurse in the federal government, but that that was no longer the case. No formal nursing ties existed among the organizations. She thought there should be a chief nurse at the government level, but felt that the characteristics proposed for the post in the document were extremely exacting.

Dr. Marla Salmon of the United States said that what was proposed in the document was very risky, since a single person could not carry out all the functions proposed without the assistance of a substantial working group.

Ms. Belkis Feliú said in clarification that the civil servant appointed to the position should be an agent of cohesiveness who carried out her functions with a participatory approach and required a support structure.

Julia Castillo, Principal Nursing Officer in the Ministry of Health of Belize, said that the position of National Chief Nurse existed in her country but was not a government post. She considered the proposal a great challenge that demanded an in-depth analysis and felt that a working team rather than a government post was required.

María Luisa Suárez said that there was no Department or Division of Nursing in Bolivia, but that leadership in the nursing profession had been achieved by means of a multidisciplinary team. The organizational chart did not include a nurse, either functionally or organizationally. Nevertheless, she felt that nursing had earned its place because it had produced results that had been recognized for their technical, professional, and administrative excellence, which meant that they had met the requirements for the creation of the position of government chief nurse.

Lilian Barrilla de Rivas (Guatemala) questioned the viability of such a project. She claimed that nurses in her country had historically been subjected to repression and that they had gained the ground they now occupied through strategic planning. The structures could not be changed, but the unions safeguarded the welfare of nurses. Nurses in her country were underutilized and had not engaged in economic activities. It would be necessary for the profession to learn to negotiate, which would require a great deal of political preparation. She wondered if the proposal to create a post at
the governmental level was appropriate. There was a need to seek opportunities to make useful contributions, such as project development, analyses of the feasibility of the tasks proposed, participation in decision-making, and taking the vanguard in health care. Another representative of the country noted that her group was analyzing nursing strategies, which should be prepared more carefully, focusing more deliberately on the tasks at hand rather than planning for the creation of new posts.

Livia Victoria Cerezo (PAHO) expressed the fear that the document overemphasized the compartmentalization of the chief nurse’s functions, noting that nurses should participate to a greater degree as members of a profession and as part of a whole rather than as a specialized group.

Guadalupe Gaona Tito, Special Projects Coordinator, Department of Medical Benefits, Mexican Social Security Institute, said that in 1959 Mexico had a Division of Nursing at the national level but that in 1981 the Division had been eliminated as a result of administrative reforms. She added that the situation was difficult, since it had been possible to retain only an office of advisory services at the level of the Secretariat of Health.

Rosa Garrido Gómez, Administrative Systems Analyst of the Mexico City General Hospital, Secretariat of Health of Mexico, said that although there was no talk of creating the post of chief nurse, the absence of such a position created a vacuum at the decision-making level, and for that reason the position was an important one.

Ms. Belkis Feliú (Cuba) clarified that the document under discussion was a WHO/PAHO proposal with which Cuba was in agreement. She noted that it was important not to focus the discussions on the position, but rather on the functions and that it was not sufficient merely to seek opportunities. It was necessary to create such a position at the decision-making level that would make it possible to make a better contribution to the health and well-being of the people.
7. ANALYSIS OF THE DIFFICULTIES ENCOUNTERED IN IMPLEMENTING RESOLUTIONS WHA 45.5 AND WHA 49.1

Dr. Miriam Hirschfeld explained the methodology for the group work and recalled the difficulties involved in the implementation of Resolution 45.5 by the Member Governments, since in some cases the officials who attended the World Health Assembly did not inform nursing leaders about issues that concerned them. She added that it was thought in WHO that education alone would not improve the health services; nevertheless, there was also a need for legislation and suitable working conditions. It had been observed in some countries with high educational levels that controversies had arisen that on some occasions caused damage, and that other considerations should be addressed.

It was also important to determine what nurses had achieved to date in the area of health policies and to trace their own successes with regard to such policies. An information system should be established that would make it possible to know what each country had achieved and to establish indicators that would make it possible to assess the progress made by nursing in the Region.

With respect to nursing practice, Dr. Hirschfeld suggested the importance of providing good education for the future, since current teaching modalities could not continue to function as they had in the past.

Gisela Pimentel, PAHO/WHO Nursing Adviser for Central America (Honduras), said that it was important to transmit the Resolution to nursing entities at all levels.

Berta Camacho, Chief Nurse, noted that the Mexican Secretariat of Health was the prime regulatory body and that its Social Security system covered a large segment of the population. A census was being planned to determine the number of nurses working in the country and their locations.

María Luisa Suárez Lenz (Bolivia) pointed out the importance of the present meeting and requested that in drafting the Resolution the characteristics of the countries be taken into account, since the opportunities proposed to them represented a challenge, and these considerations therefore needed to be transmitted to the health authorities at the highest level.

Dr. Miriam Hirschfeld said that the Resolution had been distributed to all the countries. Unfortunately, however, the authorities had not been forceful enough in acting on it.

María Serrano (Venezuela) noted that reforms in her country were currently under way, which meant that a position was being sought within the Ministry of Health. There were approximately 20,000 nurses in Venezuela, 70% of whom were auxiliaries, and consequently a policy to train the latter had been implemented. She believed that the participation of the countries at meetings like the present one made a great contribution to the development of the profession.

The representatives of Guatemala noted that nursing personnel should be the first to be apprised of the resolutions.
Ms. Caridad Cairo Soler, Chief of the National Nursing Group (Cuba), said that the organization of nursing in Cuba, in close association with the Cuban Nursing Society (SOCUENF) ensured that information arrived uniformly and in such a manner that it created a common language within the sector.

Mary-Ellen Jeans (Canada) suggested taking up Dr. Hirschfeld’s proposal concerning finding the means for making reports that would collect data on what the countries had in common. It should be verified that the authorities knew what was being done, and she consequently suggested sending a letter to the ministers urging the establishment of a system to monitor issues under examination.

Dr. Miriam Hirschfeld said that by early October a report should be prepared for Dr. Nakajima, Director-General of WHO, since it was the responsibility of nurses to insist on monitoring the issues referred to in Resolution WHA 49.1.

Dr. Marla Salmon (United States) said that the Division of Nursing in the United States had been in existence for more than 50 years and had provided nurses with a significant source of information.

Joan Barry (Guyana) agreed that a letter should be sent to the ministers, but that it should also be delivered through the nursing organizations.

Marta Ligia Fajardo (Brazil) noted that the nursing personnel were associating themselves with all the organizations in the profession, thereby enabling them to study international resolutions. Brazil had had a nurse representative in Geneva when Resolution WHA 49.1 was being examined.

Ms. Jovita Páez, President of the Cuban Nursing Society (SOCUENF) said that the countries had to work to strengthen and unite nurses. The National Directorate of Nursing in Cuba and the Cuban Nursing Society (SOCUENF) had organized joint venture programs that assisted in improving the health of the population. She stressed the need for documents to be delivered directly to nurses. In Cuba a request had been made through the International Council of Nurses (ICN) and delivered to the National Director of Nursing. She requested that PAHO, when it was to discuss documents related to nursing, see to it that nurses themselves participated in the discussions, a measure that would undoubtedly strengthen the profession. She further noted that professional organizations were not independent, and made an appeal to uphold the motto employed by the ICN: “United for Quality.”

Ms. Belkis Feliú (Cuba) said that there was familiarity at the ministry level with Resolution WHA 45.5, but suggested that the existing structures perhaps did not assist in ensuring that the information flowed to other institutions. For that reason and others, a request had been made to the Ministry to approve moving nursing affairs from the department level to the National Directorate of Nursing and that it be assigned advisory and executive functions. She supported the remarks made by the President of SOCUENF and added that other means should be sought for exchanges between nurses and that nurses should formulate their own proposals.

Dr. Sandra Land thought that it was perhaps necessary to draft resolutions at the regional level as well and that the issues raised should be discussed in the executive bodies.

Dr. Miriam Hirschfeld replied that it was not easy to draft guidelines for each country by means of resolutions, and it was therefore necessary to hold general meetings, which would require PAHO/WHO financing. She added that specific indicators to measure the quality of nursing care should be formulated.
8. PRESENTATION OF THE AGREEMENTS AND RECOMMENDATIONS OF THE GROUP DISCUSSIONS

Ms. Almeda de Urbina (Guatemala), Representative of Group I, presented considerations and recommendations on the document of the panel of experts:

GROUP I (SPANISH LANGUAGE)

Members: Almeda de Urbina (Guatemala), Gisela Pimentel (Honduras), Livia Victoria Cerezo (Colombia), Elba Padrón (Cuba), Arelys Yero (Cuba), Lourdes Serrano (Venezuela), and Guadalupe Gaona (México).

Considerations and Recommendations

1. Integration of subregional groups to discuss nursing. Each group should be made up of the various nursing sectors (service, education, professional associations), identifying the focal point for each country:
   a) Take advantage of existing groups (Central America Nursing Group of the development of nursing).
   b) Take advantage of political opportunities.
   c) Organize the group for the countries of the Caribbean and other countries.

2. As part of PAHO/WHO annual programming, include as a necessary activity for each country the financial support required for making the work of the subregional groups viable. Both strategies should be applied for socialization, monitoring, and evaluation of the recommendations.

3. In order to maintain a PAHO Expert Committee, a critical analysis should be made of the status of nursing in the Organization, since it had been weakened, creating a negative image for the countries and adversely affecting the possibility of developing nursing at the regional level.

4. Sharing of intercountry experiences through the Collaborating Centers that will make it possible to develop nursing in each country. Stepping up the promotion and reactivation of the Collaborating Centers and performing periodic evaluations to provide guidance for them in their work.

5. Organize a PAHO nursing program that will make it possible to use the centers of excellence for reproducing information on nursing and the training of human resources that will respond to the health needs of the population.
6. Government chief nurses should participate in PAHO programming to determine the activities to be carried out with regard to nursing practice in each country.

7. Promote research in multidisciplinary teams at the regional level to redefine medical practice.

8. With regard to the program for implementation of sectoral reform, chief nurses should present proposals on policies for using nursing personnel in the framework of government and health sector policies.

9. Develop management training for nurses in national teams that will enable them to participate with the multidisciplinary team in determining costs and redefining technologies in nursing practice.

10. Undertake multidisciplinary work that will strengthen the profession and make it possible for nursing to participate in the redefinition and adaptation of nursing practice to current processes.

11. Set up a representative ethics and bioethics team composed of the various nursing sectors that will respond to advances in technology and nursing care needs.

12. Maintain an ongoing review of nursing practice and the training of nurses that will allow for change and the necessary adaptations.

13. Maintain and strengthen nursing representation at the regulatory levels of the health system in each country.

GROUP II (SPANISH LANGUAGE)

Members: María Luisa Suárez (Bolivia), Martha Ligia Fajardo (Brazil), Lilian Brasillas de Rivas (Guatemala), Rosa A. Garrido (Mexico), Yanuario García (PAHO/Venezuela), Raizza Estrada Muñoz (Cuba), Caridad Cairo Soler (Cuba).

Agreements and Recommendations

1. Send a letter from the Director-General of WHO to all current ministers reminding them of Resolution WHA 49.1 and suggesting that they set up a National Focus Group (NFG) to follow up on the Resolution. This focus group could be made up of representatives of institutions connected with nursing.

2. In addition, the reminder should request the ministers of health to issue a periodic report on how Resolution WHA 49.1 is being implemented.

3. Articulate schools, university faculties, professional associations, unions, PAHO and WHO representatives, and the national nursing offices in order to disseminate the Resolution and ensure its appropriate use as a policy tool.
4. Promote an encounter among the entities representing nursing in each country to discuss the implications of Resolution WHA 49.1 and be apprised of the results of the Regional Meeting of Government Chief Nurses of the Region of the Americas.

5. Seek support from PAHO and WHO in countries with a National Office of Nursing for the development of dissemination strategies.

6. Disseminate the contents of the Resolution through the available media in each country (bulletins, journals, pamphlets, television, radio, etc.) taking advantage of events such as seminars, workshops, and congresses.

7. Send a copy of the Resolution to the countries' legislatures for dissemination to the members of the health commissions and other representatives.

**Implementation of Resolution WHA 49.1**

For this purpose it is suggested that:

1. The countries become more involved in health sector reform.

2. The significance and implications of the new world order and its impact on the health of each country be vigorously disseminated.

3. The capabilities of nursing professionals in strategic management and project formulation and negotiation be developed and strengthened.

4. Nursing personnel be competitive as well as competent.

5. The National Focus Groups (NFG) organized be charged with preparing and promoting specific national, provincial, or institutional plans conducive to implementing Resolution WHA 49.1.

**Monitoring and Evaluation**

**Method:** The Group suggested annual or semiannual meetings for monitoring the National Focus Group as a methodology for evaluating progress in the implementation of Resolution WHA 49.1 through consultations, reports, encounters, and the like with the institutions involved, such as schools of nursing, Social Security institutions, ministries of health, nursing associations, PAHO, WHO, etc.

**GROUP III (ENGLISH LANGUAGE)**

Members: Ms. Beth Mazzella (USA), M.s. Marilú Sangueza (Bolivia), Dr. Miriam Hirschfeld (WHO), Mary-Ellen Jeans (Canada), Julia Castillo (Belize), Joan Barry (Guyana), Belkis Feliú (Cuba).
Conclusions and Recommendations

The discussions considered the possible benefits of a regional resolution to strengthen nursing and midwifery, as recommended in Resolution WHA.49.1. All of the countries should respond to the recommendations. An interesting discussion ensued concerning specific examples that had been discovered, and it was noted that the cost-benefits and value of nurses should be demonstrated. Several proposals were made:

1. Identify strategies for disseminating the report and the recommendations. Each country needs to target its actions to an appropriate level of government, or no government agency will be able to establish responsibility for continuing dissemination. It is important to commit both the central level and the authorities and to obtain the resources necessary for this purpose.
   - Each country should commit all nursing sectors, such as schools, associations, unions, etc., to discussing the recommendations of the "experts" and the "Foundation" in order to arrive at agreements; build unity and consensus; carry out specific actions (which should be controlled and monitored), and seek indicators for their evaluation.
   - The nursing profession should form a group in each country to plan health in terms of finances and human resources and subsequently analyze the impact of nursing on health, showing the recommendations of the Panel of Experts.

2. Identify strategies to implement the recommendations, promote ideas for the development and execution of plans, and carry out strategies for the dissemination and implementation of Resolution WHA 49.1 by government nurses or nursing focal points.

3. Professional nursing associations should, in conjunction with government nurses, promote the implementation of the recommendations, establishing a timetable for professional, educational, and political actions.

4. Support the incorporation of material, including reports, into nursing curricula at all levels, with a view to initiating the training of dynamic professional nurses to assume these functions.

5. Reaffirm Recommendation 7.3. WHO and the Member States should encourage agencies such as the International Council of Nurses (ICN), the national groups that represent the nurses, other pertinent NGOs, and the WHO Collaborating Centers for the Development of Nursing and Midwifery to actively support the global approach to the development of nursing practice (described in the recommendations to the Member States) at the international, regional, national, district, and local levels.

6. Analyze the implementation of the Resolution for the Americas and the subregions as support for professional development through continuing education, providing training for the nurses and midwives who perform these roles in all areas of health, in PAHO, and in the subregions, and supporting subregional agendas, health officials, and debate among leaders in health.

7. Identify who has governmental responsibility and what the role of the nurse is. Governments need to meet their targets and therefore need nurses.
8. The countries should establish structures through the government and/or formal relations with nongovernmental organizations in order to meet these objectives.

GROUP IV (LANGUAGES ENGLISH/Spanish)

Members: Dr. María Dolores Pérez (PAHO/WHO officer in Haiti), Dr. Sandra Land (PAHO/Washington), María Salomón (USA), Jovita Páez Armenteros (Cuba), Bertha Olivia Camacho (Mexico), Aubrey Williams (Guyana).

1. Transmit Resolution WHA 49.1 to all nursing personnel, utilizing all available media, such as videotapes, to inform the schools of the importance of the strategy (since the schools play a role in the political process), and send letters to journals mentioning the Resolution and/or nursing associations.

2. Make an attempt to contact the focal points at the ministry level, or in their absence, the key people involved.

Strategies for the Implementation of Resolution WHA 49.1

Responsibility for the implementation of Resolution WHA 49.1 rests with the ministries of health.

1. The Government Chief Nurse, if such a post exists, could be instrumental in promoting implementation of the Resolution by sensitizing the minister of health to the issues involved.

2. If no such post exists, this may be effected through the Office of the Director or Human Resources Services.

3. If both entities exist, responsibility should be shared between the two.

4. Appointment of an initially provisional group to work specifically toward implementation of the Resolution. Such a group would eventually become permanent in order to sustain the process, involving all groups and associations concerned, and marshaling the support of the private sector. The human resources available in the ministries of health could also be utilized for this purpose.

5. Technical support from international organizations, such as PAHO/WHO.

Drs. Sandra Land and Miriam Hirschfeld congratulated the groups for their excellent work and requested the participants’ opinions on the recommendations made, noting that it was necessary to further explore the proposal for indicators and urging that the groups meet again at some future date.
9. INDICATORS PROPOSED FOR MONITORING AND EVALUATION

INDICATORS PROPOSED BY GROUP II

1. The existence of the National Focus Group (NFG).
2. The incorporation of nursing professionals into the groups carrying out health sector reform at the national, provincial, and municipal levels.
3. Number of institutions represented in the National Focus Group (NFG).
4. Number of plans under way related to implementation of Resolution WHA 49.1 in the areas of research, education, and the training of human resources in nursing through community-based nursing practice and legislation.
5. Number of programs for training of nursing leaders in strategic management and participatory planning.
6. Number of nurses who participated in courses and international meetings related to the implementation of Resolution WHA 49.1.
7. Number of monitoring meetings held by the National Focus Group (NFG).
8. Have nurses been included in the groups carrying out health sector reform in the country?
9. Has the country formulated a policy for nursing activity in primary health care?

Indicators for Monitoring Intervention Strategies

1. Formation of subregional groups:
   - Central America: Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama.
   - English-speaking Caribbean: Guyana, Haiti, Jamaica, Bahamas, Belize, and the other members of CARICOM.
   - Spanish-speaking Caribbean: Mexico, Colombia, Venezuela, Cuba, and the Dominican Republic.
2. Annual meeting of each subregional group.
3. Intergroup biennial meeting.
5. Creation of a focal point in nursing in each country, with a view to reviewing the reform process for participation and decision-making in health, budget, and evaluation policies.

6. Presentation of the request to the ministers of health to place nursing advisers in strategic positions to contribute to the development and strengthening of nursing and midwifery in the countries.

7. Progressive increase in the number of PAHO regional nursing advisers.

8. Gradual increase in the technical and financial support furnished by PAHO/WHO for the development of nursing/midwifery in the countries.

   Participation of the national nursing team in the annual programming of the national PAHO budget for the attainment of nursing/midwifery goals and resolutions.
   - Periodic collection by PAHO/WHO, through the countries, of data and information to permit verification of compliance with the Resolution.
   - Dissemination of multidisciplinary research findings to confirm the participation of nursing.

Indicators to Analyze the Level of Nursing Responsibility in Each Activity

Example 1

If 100% of the population should be immunized and it was possible to vaccinate only 87%, this is a task to be measured by nursing. Thus, the reasons why this task could not be carried out should also be analyzed.

Example 2

If the level of nursing work improves, it means that training has also improved.

Example 3

If nurses are lost to the profession and health status declines, it can be said that nurses are needed to reverse the situation.

Dr. María Dolores Pérez, speaking on behalf of Group IV, said that certain indicators should be scrutinized to see if the following exist:

1. Equitable distribution of nursing personnel in the various health services.

2. Steady improvements in basic training:
   - Evaluation of graduates in the workplace.
   - Evaluation of the quality of the services.
   - Increase in the education budget over previous years.
3. Participation of nurses in the formulation of national health policy:
   - Number of nurses working in offices and departments of the ministry of health.
   - Number of nurses working with delegations or meetings of the PAHO/WHO Governing Bodies.

4. Increase in the financial resources allocated for primary health care.

5. Equity in education:
   - Equitable balance between the number of grants awarded to nurses and other professionals.
   - Evaluation of the number of grants with respect to previous years.

6. Increase in the nursing component in the investment projects of other lending institutions, such as the Inter-American Development Bank (IDB), the World Bank, etc.

7. Statistical data on the work force (nurse/population, nurse/physician ratios, etc).

**Examples of Macroindicators**


2. Strategies:
   a. Adequate prenatal care
      - Number and quality of consultations
   b. Family planning
      - Intervals between births
      - Access to contraception
   c. Prenatal care and delivery
   d. Postnatal maternal and child care.
Table 1. Evaluation Indicators

<table>
<thead>
<tr>
<th>Process</th>
<th>Structure</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost per patient</td>
<td>Division of labor</td>
<td>Satisfaction with care received.</td>
</tr>
<tr>
<td>Timely attention</td>
<td>Access to the health services</td>
<td>Low level of infection.</td>
</tr>
<tr>
<td>Number and first consultation</td>
<td></td>
<td>Reduction in maternal and child mortality.</td>
</tr>
</tbody>
</table>

Table 2. Level of Nursing. Responsibility for Nursing Activity.

<table>
<thead>
<tr>
<th>Immunization indicators</th>
<th>25%</th>
<th>50%</th>
<th>75%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal and Child Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Neonatal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Low birth weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Maternal mortality</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

1. Each country selects/identifies its level of responsibility for the level of nursing in a particular activity.

2. Correlation of the level with indicators of health status and changes in health status.

3. Investigation into nursing statistics (number of nurses per 10,000 population). Professional and nonprofessional nurses per 10,000 population.

4. Correlation of the changes in nursing statistics, health indicators, and level of responsibility.
10. RECOMMENDATIONS

1. In view of the magnitude of the changes and complexity expected for the development of nursing practice in the countries of the Region and the implementation of Resolution WHA 49.1, it is necessary that nursing institutions in the countries, in addition to PAHO and WHO, promote a strategy that will result in the creation of positions of national and international nursing advisory posts in all the countries in the Region.

2. We recommend and hope that the nursing structures in the ministries of health will authorize the dissemination of nursing policies through active participation in the overall development of health, health policies, and health sector reform.

3. It is requested that Dr. Carlos Dotres Martínez, Minister of Health of the Republic of Cuba, participating in the closure of this event, communicate the main pronouncements and recommendations of the Regional Meeting on the Role of Government Chief Nurses in the Region of the Americas to the Meeting of Ministers in Washington, D.C.

4. Based on the presentations of the countries and the discussions that have taken place during the three working days, the participants have prepared and committed themselves to disseminating the following declaration:
Nursing leaders from 12 countries who were delegates to the WHO/PAHO meeting in Havana, Cuba this week, made a strong declaration in support of primary health care as the best available strategy to improve the health of all people. Reform of the health sector is occurring in many countries and is often driven by fiscal constraints.

The nurse delegates expressed concern about mounting evidence of inadvertent negative effects of health sector reform upon the most vulnerable population groups: the poor, women and children, the elderly, chronically ill, disabled and indigenous peoples. They witnessed in many countries a trend to move from public health measures to curative care and less investment in:

1. Health education.
2. Epidemiological monitoring.
3. Improved nutrition, breastfeeding, prenatal, and delivery care.
4. Community participation in health planning.
5. Community resources for health care.
6. Disease prevention and health promotion.

Since nursing personnel have major responsibility in implementing the strategies of health care in the communities - urban and rural alike, they must be involved in all health care policy development and evaluation. Grassroots feedback from nurses and midwives is crucial to the successful implementation of the processes of health sector reform which are designed to bring about an improved quality, cost-efficient and accessible health service.

Nursing personnel comprise the world's largest number of health care providers and are committed to high quality and affordable health care for all people. Governments are, therefore, advised to incorporate the knowledge and expertise of nursing personnel at all levels of health care planning, implementation and evaluation in order to achieve significant health gains for their populations. Specifically, Ministries of Health are being requested to develop strategies to implement the WHO resolution 49.1 (May 1996) to strengthen nursing and midwifery in their respective countries.

Havana, Cuba
September 12, 1996
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La Habana, Cuba
AGENDA AND WORK PLAN

Tuesday, 10 September

08:30 - 9:00  Welcome

- Dr. Julio Suárez, Consultant
  Pan American Health Organization in Cuba

- Lic. Belkis Feliú, National Director of Nursing
  Ministry of Public Health of Cuba

- Dr. Abelardo Ramírez, First Vice Minister
  Ministry of Public Health of Cuba

Selection of the facilitator and the rapporteurs

- Dr. Sandra Land, Regional Nursing Advisor, PAHO/WHO

Approval of the working agenda

- Dr. Sandra Land, PAHO/WHO

- Dr. Miriam Hirschfeld, Chief Scientist for Nursing, WHO

09:00 - 10:15  Country Reports

- Canada  Mary-Ellen Jeans, Executive Director of the Canadian Association of Nurses

- Bolivia  María L. Suárez Lenz, in charge of Nursing in the National Health Secretariat

- Cuba  Lic. Belkis Feliú, National Director of Nursing in the Ministry of Health

- USA  Dr. Marla Salmon, Director of the Division of Nursing and Carolyn Beth Mazzella, Chief Nurse in the Public Health Service in the Department of Health and Human Services

10:15 - 10:30  Coffee

10:40 - 12:30 Discussion of the regional document "Role of the Government Chief Nurses".

12:30 - 14:00 Lunch

14:00 - 16:00 Discussion of the recommendations for the Government Members of the Expert Panel of Nursing and the Resolution WHA 49.1.

16:00 - 17:30 Work Group (will session 4 groups)
   - Group I (Spanish) Will analyze the recommendations of the Expert Committee
   - Group II (Spanish). Will analyze Resolution WHA 49.1
   - Group III (Spanish/English). Will analyze Resolution WHA 49.1
   - Group IV (English). Will analyze Expert Committee’ recommendations.

Wednesday, 11 September

09:00 - 10:15 Continuation of the Work Group

10:15 - 10:30 Coffee

10:30 - 12:30 Plenary: Presentation of the work groups and discussion.

12:30 - 14:00 Lunch

14:00 - 14:10 Presentation of the country report:
   - Venezuela: María L. Serrano, Chief of the Technical Office of Nursing, Ministry of Health and Social Welfare

14:10 - 17:30 Work groups for plans/country questions.

Thursday, 12 September

09:00 - 10:15 Report presentation by countries:
   - Guyana: Joan Barry, Principal Nursing Officer in the Ministry of Health.
Central America: Gisela Pimentel, PAHO staff and Nursing Advisor for the Central America countries. Panama, Costa Rica, Nicaragua, Honduras.

10:15 - 10:30 Coffee
10:30 - 12:30 Plenary discussion of the results of the work group and plans for the country.
12:30 - 13:00 Closing
13:30 - 14:00 Lunch
ANNEX III

NURSING PRACTICE AND THE ROLE OF MINISTRIES OF HEALTH IN NURSING DEVELOPMENT TO ASSURE SAFE LEVELS OF NURSING CARE IN THE REGION OF THE AMERICAS

Introduction

The decade of the 1990's has been characterized by an emphasis on the reform of the health care systems, in most countries, as part of significant changes in the role and functioning of government in different sectors including health. This reform is affecting how health care services are planned, financed, delivered and evaluated. While there is variation in some aspects of the reform in different countries, a number of common elements are seen. There is growing concern about costs and cost benefit while assuring coverage to a basic package of health care; at the same time the trend is toward reducing the size of government and a continuing process of decentralization. With a renewed emphasis on social participation, and because nursing personnel comprise 50-80% of the work force in health, an active involvement of nursing in this reform process is fundamental.

As we near the year 2000, and consider the progress made in achieving the goal of Health For All, WHO/PAHO and our Member Governments are renewing the commitment to the goal and to the principles which will guide our future work. Nursing personnel and the health workers they supervise are the continuing contact of the health sector with individuals, families and the community in all health care settings. The nursing and health care they provide will, therefore, need to be a key component of programs, projects and interventions developed to bridge the gaps in health status and health care access which are the reality for vulnerable populations in our countries.

Within this context of health sector reform and renewal of the goal of Health For All, it is important to consider how Ministries of Health will take a leadership role in nursing development to assure safe levels of nursing care based upon the needs of the population. A multicountry meeting is planned.

Background and Justification

A proposal for a multicountry meeting and use of Country APB funds.

1. WHO Resolution 49.1 "Strengthening Nursing and Midwifery" provides a mandate for PAHO and Ministries of Health to continue efforts to improve the quality and efficiency of health services through an emphasis on the nursing component. See attachment 1.

2. Research has demonstrated the cost-effectiveness of primary health care delivered by nursing personnel in different settings. However, these research findings have not resulted in adequate investment in nursing work force planning and development.
3. Most countries continue to have serious shortages in nursing personnel and ratios to populations of professional nurses well below acceptable levels. The following table shows the distribution of countries by total nursing personnel per 10,000 population and professional nurses in relation to all nursing personnel. Countries have different ratios of nursing personnel per population and variation in skill mix.

<table>
<thead>
<tr>
<th>Total Nursing Personnel and Nursing Skill Mix</th>
<th>Low &lt; .3</th>
<th>Medium .3-.59</th>
<th>High .6 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region of the Americas, around 1992</td>
<td>Bolivia</td>
<td>El Salvador</td>
<td>Paraguay, Uruguay</td>
</tr>
<tr>
<td>Professional Nurses/Total Nursing Personnel</td>
<td>Dominican Republic</td>
<td>Haiti</td>
<td></td>
</tr>
<tr>
<td>Low up to 10</td>
<td>Guatemala</td>
<td>Belize, Colombia, Ecuador, Jamaica, Nicaragua</td>
<td></td>
</tr>
<tr>
<td>Medium 11-20</td>
<td>Honduras</td>
<td>Argentina, Brazil, Chile, Venezuela</td>
<td></td>
</tr>
<tr>
<td>High &gt; 20</td>
<td></td>
<td>Anguilla, Antigua, Bahamas, Costa Rica, Martinique, Panama, Peru, Trinidad and Tobago</td>
<td></td>
</tr>
</tbody>
</table>

Source: "Health Conditions in the Americas 1994"

In the short term countries with serious shortages or problems with skill mix need to determine how best to deploy small numbers of professional nurses and supervise other nursing staff while at the same time implementing strategies to increase the number of nursing personnel. In the medium and long term research must demonstrate the value of a larger and better prepared nursing workforce in terms of Health For All targets.

In a study of responses of countries to implementing WHA Resolution 45.5 on strengthening nursing and midwifery, preliminary findings show a correlation between positive responses to nursing development areas and the achievement of certain Health for All targets.

4. The World Bank Report, Investing in Health, suggests that nurses can deliver most of the services in the basic public health and clinical packages. Nursing personnel can be a key factor in developing and implementing strategies to extend coverage of basic health care to currently unserved or underserved populations.
5. In July 1995, an expert committee met in Geneva to consider the nature and scope of nursing practice as it responds to the needs of individuals, families and communities. The report of the committee includes twelve recommendations for Member States to ensure an integrated and comprehensive approach to the provision of high-quality nursing care. See Attachment 2.

6. The role of Ministries of Health in general and Divisions of Nursing and/or chief nurses in particular is fundamental in implementing Resolution 49.1 and the recommendations of the expert panel in countries. These responsibilities have been described in the document, The Government Chief Nurse—rationale, role and function, prepared in Europe and currently under review in other Regions including the Americas.

7. WHO/PAHO is sponsoring a meeting on nursing development in conjunction with the Division of Nursing in Cuba to be held September 10-12, 1996 in Havana. Cuba has a high ratio of nursing personnel to population and the highest ratio of skill mix with a nursing work force almost 100% professional. The purpose of the meeting is to consider the role of a Division of Nursing or its equivalent in a Ministry of Health in assuring an adequate nursing work force and safe level of nursing care to meet the needs of the country. The group will also consider the recommendations of the expert panel on nursing practice. The program of Intensive Cooperation in Geneva has agreed to finance the participation of two persons from each of the countries they support in the Region—Bolivia, Guatemala, Guyana and Haiti- to include the Chief Nurse or focal point for nursing and someone representing human resources, both from the Ministry of Health. Other countries will be invited to send representatives but without financing provided.

8. It would be very beneficial to have participation by Canada and the United States in the meeting. As seen in the table, they have both a high ratio of nursing personnel to population and a high skill mix. Furthermore, they represent two extremes for dealing with nursing at the national level; while the United States has both a Chief Nurse and a Division of Nursing with different but complementary functions, Canada has no Chief Nurse or nursing unit.

9. The possibility of using Canada and US APB funds to fund the participation of one or two persons from each country will be explored. The cost would be approximately $1200 per person.
THE GOVERNMENT CHIEF NURSE - RATIONALE, ROLE AND FUNCTION
AWHO DISCUSSION PAPER

Introduction

1. The WHO Regional Office for Europe is often asked to provide guidance on the role and function of nurses working at government level, usually in Ministries of Health (or equivalent Ministries). Countries which already have such posts are concerned to make them more effective. Countries which do not have them require help in considering how to establish government nursing roles relevant to their own particular setting. WHO policy clearly advocates the strengthening of nursing leadership at national level, but to date the Organization has not produced specific guidelines to help countries put the policy into practice. This paper is therefore intended to encourage debate on the issue, and to assist the process of developing a description of the rationale, role and function of the post of government chief nurse. It will be reviewed by countries, finalized by WHO and, if appropriate, adopted as policy by relevant bodies.

2. The role and function of the government chief nurse, where such roles exist in Ministries of Health, differs between countries. It is influenced by many factors including the country's political agenda, the attitude of permanent officials of the Ministry such as the chief medical officer, the strength of the organized nursing profession and the regard in which the profession is held. Another major factor is the country's administrative structure, which influences the strength or weakness of central government functions. Such factors have, in whole or in part, been responsible for the huge diversity between countries, where at best there is a Ministry nursing position with great authority and responsibility, and at worst there is no such role and nursing has no formal means of contributing to the work of government.

3. For the purpose of this paper the title "chief nurse" is used to denote the position of the most senior nurse employed in a nursing capacity in the Ministry of Health and providing a focal point for nursing within the Ministry. Some ministries of health employ nurses in certain departments to work on specific health programs. These nurses - important though their positions are - are not the focus of this paper, which is concerned primarily with the issue of professional nursing leadership. The words "nurse" and "nursing" are used here to apply equally to midwifery which in many countries is a separate profession. Chief nurses may carry responsibility for midwifery in some countries whilst in other countries the position of "chief midwife" exists or is advocated. No view is taken in this paper on the desirability or otherwise of chief midwife positions, which are the subject of a separate debate.

4. This paper does not propose a blueprint for the role and function of the chief nurse which could be applied in each country. A prescriptive approach could reduce the potential success of such roles, as national, political and cultural considerations must be taken into account. This paper
sets out the rationale for the creation and continuing existence of such roles, and describes the key elements necessary to endow the role with the necessary characteristics for success in influencing health policy and leading and developing the profession. It is therefore the generalities which matter at this stage of the debate, in order to capture those important elements which justify the need for the role. More specific questions (for example, should the chief nurse have executive responsibility or an advisory role?) are secondary to the primary issue of securing an effective nursing contribution to health policy and the development of nursing, and therefore to the people’s health.

**RATIONALE FOR THE ROLE**

5. There can be only a single rational argument for the existence of a government chief nurse: that the nursing profession makes a major contribution to the health and care of people and is therefore an integral and vital asset to the health care system. It follows that ministries of health should recognize this asset and secure the contribution of suitably experienced and able nurses at a senior level in the Ministry to translate the nursing contribution to health into policy terms. This will ensure that the development and implementation of health policy, and management of health systems, are enriched by a nursing contribution.

6. The nature of the nursing contribution to health care varies between health systems, but what is constant in every country is that disease and ill health are widespread, that health promotion is necessary to improve health gain, and that people of all ages who are ill and vulnerable require skilled nursing care at their time of need in addition to their need for medical attention. The contribution which the nursing profession is permitted to make in each country is determined by a number of factors such as the traditional role of the profession, its relationship with the medical profession and the degree of public recognition. In turn, these matters are influenced by the position of women in society and their access to educational opportunity and to positions within health, social and political systems, as well as the degree to which the profession has been able to organize itself as a collective body with agreed aims and plans. Whilst the profession in each country may have a different history, the restraining factors are common to nursing in all countries. It is the constant need for nursing which requires health policy to be sensitive to the nursing care needs of people, and which provides the rationale for establishing the role of government chief nurse in every Ministry of Health.

7. The rationale requires further elaboration in order to clarify the purpose of the role. The primary purpose is to ensure a nursing contribution to the development of health policy, to lead the profession and to assist the Ministry in its work for the benefit of citizens who depend upon nursing when their health is compromised. The purpose of the role is not to advance or represent the profession at the Ministry for the sake of the profession. It is likely that a chief nurse will have an effect in advancing the profession as a leader of nursing in her country, but such effects are secondary and only justified if the advancement and leadership serves the primary purpose of the role. There are a number of secondary effects of a chief nurse’s role which may benefit the health system and the profession, such as systematic information-gathering through networks, testing proposed plans of the Ministry with leaders of the profession outside the Ministry, and improving education or working conditions for nurses. Nevertheless the primary purpose of the role must always be clear. Any proposed initiative by a chief nurse should be tested against the
question: is this for the public good, to benefit society? Put more clearly, the primary purpose is to serve the public interest, or public good, and not simply to serve the interest of the profession.

8. Other arguments may be used to justify the role of chief nurse, such as the large number of nurses in a country, the cost of nursing as a proportion of the health budget, and the need for a nursing "voice" at the Ministry. These arguments alone do not provide any real justification for the role. It is the nature of the nursing contribution to the health care system that provides the single rational argument - the only argument likely to be sustained in the face of political, administrative or other challenge.

EXISTING POLICY STATEMENT

9. The linked issues of government chief nurse positions and the nursing contribution to developing health plans and policy at government level have received some attention from WHO and other agencies in recent years. The First WHO European Conference on Nursing (1) held in Vienna, 1988, expressed the need for nurses to develop roles as partners in decision-making on the planning and management of national health services. In 1989 the World Health Assembly (2) urged member states to encourage and support the appointment of nursing personnel in senior leadership and management positions, and to facilitate their participation in planning and implementing the country's health activities. The First WHO Meeting of Government Chief Nurses of the Newly Independent States (3), held in Kazakhstan in 1993, identified the need for the position of chief nurse in ministries of health and for each country to develop a national action plan for nursing. The Second Meeting (4), held in Kyrgyzstan in 1994, recommended that each country should establish, or where appropriate enlarge, the nursing department of each Ministry of Health. The European Government Chief Nurses and WHO Collaborating Centres for Nursing and Midwifery (5), meeting in 1994 in Glasgow, urged European countries to ensure that the professional and corporate contribution of nursing leaders was recognized and encouraged in ministries of health.

10. Other leading international organizations have made similar recommendations. For example, in 1991 the International Council of Nurses (6) urged national governments to recognize and capitalize on the experience of nursing managers, and to educate nurses to fill management roles at country level. In 1993 the Commonwealth Secretariat, in its Commonwealth Action Plan for Nursing (7), identified the need to recognize and strengthen the government-level nursing policy function in each country, to provide informed intelligence on nursing practice and management to ministers and others. This followed recommendations made by the Commonwealth Chief Nursing Officers and Professional Associations at the Malta conference (1992).

11. Surprisingly little research has been carried out on this key topic. A notable exception is a major international study of chief nursing officer positions in national ministries of health conducted by Splane and Splane (8) and published in 1994. They collected data using a variety of methods over an eight-year period, including visits to 50 countries and interviews with over 90 past and present chief nurses. They concluded that all national governments should establish a senior nursing position in their ministries of health, as the requisite means of promoting the best utilization of nurses in improving the nation's health.
12. These position statements and research have a common theme which illustrates the need for a strong nursing contribution at national government level. The following section identifies some characteristics of ministries of health which influence the environment in which chief nurses operate.

**THE MINISTRY OF HEALTH**

13. The Ministry of Health is a complex environment in which the chief nurse must learn to function effectively. In many cases the chief nurse will have had no previous experience of government service. In those countries where the role is not yet established, it is most unlikely that potential chief nurses will have experience of work in government. This creates a special need to prepare nurses for the role of chief nurse, and to support and develop chief nurses once in post. The following factors are some of those which influence the work of chief nurses.

14. In some countries senior officials are appointed by politicians and, therefore, as politicians change officials may also change. The political agenda will largely determine the priorities and plans of the Ministry. Permanent officials will also strongly influence how the work of the Ministry is carried out, by whom, how officials are appointed and how the work of department is supported. Other professional staff - such as the chief medical officer - will also influence the work and priorities of the Ministry and its staff. Employees of ministries are appointed to serve the government and loyalty to the government and, often, the promotion of government policies is required of them. Government servants are also expected to adopt the values of government service. This can create a particular challenge for chief nurses who need to interpret professional events and dilemmas in the world outside the Ministry to those within. If a chief nurse is perceived within the Ministry as an advocate of the profession - and not with a clear focus on the primary purpose of the role as described above - her role may be endangered.

15. These circumstances contribute to a challenging environment and a complex set of working relationships. They can also create conflict for the chief nurse. For example, how does she respond when the ambitions of the government do not concur with the ambitions of the profession? Such an example illustrates both the complexity of the role and the personal tensions that such circumstances can create for the chief nurse. She is a government servant, yet she also needs to be perceived as a leader by the nursing community in order to influence professional developments. Reconciling these different and sometimes apparently conflicting perspectives and expectations requires great skill.

16. The position of the chief nurse within the structure and organization of the Ministry is of considerable importance. If the chief nurse is appointed to a senior level with access to the most senior officials and, critically, to the Minister, then the effectiveness of the role is greater than if she is appointed to a less senior level with no direct access to the Minister or senior officials. The relative influence of the division or department in which she is based is another factor. Often linked with this, her budget and the extent of her administrative and professional staff support are also important influences on her effectiveness.
17. All these circumstances combine to create a complex context within which the chief nurse functions. They begin to indicate some of the considerable personal and professional qualities a chief nurse requires in order to succeed, develop and sustain the role.

**THE ROLE AND FUNCTION OF THE GOVERNMENT CHIEF NURSE**

18. The role will differ between countries and will be influenced by the factors described above, and others. In some countries the chief nurse has other nursing colleagues to assist her, and other staff to manage. In other countries the chief nurse may have executive responsibilities in addition to those for nursing, or may have an executive nursing role rather than an advisory one. These two models - the executive model and the advisory model - were fully described by Splane and Splane (8). It would not be appropriate to propose one or other model here as the WHO recommendation, since no single blueprint is suitable for all national contexts. The following description of role and function is based on the primary purpose of the role described earlier, and should be seen as a checklist to be reviewed, applied and adjusted according to the needs of each country.

19. One further point should be noted before studying the checklist. The creation of a new chief nurse post, and the existence of current roles, do not guarantee their continuation. Even in countries where the role is well established, the need for its existence is challenged from time to time and there is no room for complacency. Strategies are required not only to enable these posts to be created where they do not exist, but also to secure their continuing existence. This is not directly the subject of this paper, but the development of such strategies is a matter which requires attention, and one key element of them must be emphasized here. The chief nurse should recognize that her contribution must be seen to be of value to ministers, officials and the work of the ministry. She will encounter a number of key people inside the Ministry, as well as others outside, who have differing expectations of her. This, together with the environment and relationships within the Ministry itself, poses a particular challenge: one way to meet it is to create alliances within and outside the Ministry which will enable her to operate effectively, to meet these conflicting expectations and to sustain the role in the face of any threat.

20. The checklist below sets out the key functions and the most desirable arrangements for the role to make a positive impact on the Ministry and its work. It may take time for each element to be achieved, and stages may need to be identified to improve and strengthen the role over time. Patience and determination are just two of the qualities required for sustained success. The checklist is not exhaustive and is presented for debate and refinement.

**CHECKLIST - THE ROLE OF THE GOVERNMENT CHIEF NURSE**

21. The chief nurse is the leading nursing expert in the Ministry of Health responsible for providing the professional nursing contribution to health policy, planning and programs. The chief nurse will lead the development of the profession in the interests of health care, and assist the Ministry in developing and managing the health care system. As a minimum the role will have advisory and consultative, leadership, intelligence-gathering and liaison functions. Specific organizational requirements are also necessary for the chief nurse to make an effective contribution.
THE ADVISORY AND CONSULTATIVE FUNCTION

22. The chief nurse will:

1. Advise and be consulted by the Minister and senior officials on all matters relating to nursing.

2. Advise and be consulted by the Minister and senior officials on all aspects of proposed health policy, plans and programs which have nursing implications.

3. Advise and be consulted by ministers and officials of other ministries (such as welfare, education and environment) on all issues which may relate to nursing and on issues which may have implications for nursing.

THE LEADERSHIP FUNCTION – STRATEGY

23. The chief nurse will:

1. Lead the development of strategies and of a national action plan for nursing to increase the positive impact of nursing on health.

2. Provide an expert nursing contribution to national health policy, plans and programs including investment projects.

3. Provide strategic leadership and overall direction for the profession through alliances and influence.

THE LEADERSHIP FUNCTION - NURSING PRACTICE

24. The chief nurse will:

1. Lead the preparation of a statement of purpose of nursing to promote the optimal contribution of nurses to the health system.

2. Lead initiatives to establish criteria for assessing, improving and researching standards of nursing practice and care.

3. Lead initiatives to establish the effect of nursing on health gain and the effectiveness of nursing practice and care.
25. The chief nurse will:

1. Lead initiatives to ensure the standard of nursing education is at least comparable to that of education for other health professions.

2. Lead initiatives to ensure that the standard of nursing education meets WHO recommendations and other appropriate international standards.

3. Lead initiatives to ensure the necessary focus on primary and secondary health care.

4. Lead initiatives to improve standards of schools/colleges of nursing and the preparation of teachers of nursing.

26. The chief nurse will:

1. Lead initiatives to ensure any new laws relating to nursing are prepared, and existing laws reformed, to enable the nursing contribution to health care to be realized to its full potential.

2. Lead initiatives to collaborate with the medical profession and others to ensure the scope of practice of nurses enhances and develops, not constrains, the nursing role.

3. Lead initiatives to ensure that the profession’s regulatory body is assisted in developing a code of conduct and practice and, where a regulatory body does not exist, to promote its creation.

4. Lead initiatives to ensure that a register is maintained of all nurses trained in the country, and of all nurses migrating from other countries, kept up to date and developed as a tool for human resource planning purposes.

27. The chief nurse will:

1. Receive and interpret information from within the Ministry of Health, and from other ministries where relevant, on proposed health policy, plans and programs.

2. Receive and interpret statistical and other information on health services and human resources in health care, including medical, nursing and auxiliary staff.
3. Receive and interpret information from the profession, the health and educational systems and other sources relevant to the breadth of the chief nurse's functions.

4. Alert the minister and officials to events within the profession or beyond which may require attention, including relevant policies and recommendations produced by national and international organizations.

THE LIAISON FUNCTION

28. The chief nurse will:

1. Liaise with the minister and officials to ensure an adequate flow of information.

2. Liaise with other ministries as necessary.

3. Liaise with leaders of the profession’s representative, educational and regulatory organizations.

4. Liaise with key nursing and other staff throughout the health system to ensure adequate flow of information to assist and inform the chief nurse.

5. Liaise with international organizations relating to nursing including WHO and the International Council of Nurses, and with chief nurses of ministries of health in other countries.

ORGANISATIONAL REQUIREMENT FOR THE CHIEF NURSE

29. The chief nurse has requirements of an organizational kind which are necessary for the role to be carried out effectively. These include authority, access, organizational position and support as set out below.

AUTHORITY

30. The chief nurse should have - and be seen by others within the Ministry to have - the authority and approval of the Minister and/or the most senior officials of the Ministry to carry out the full range of functions of the role.

ACCESS

31. The chief nurse requires the following access:
1. To the Minister on all professional matters and on matters which may have implications for nursing.

2. To senior officials, including the chief medical officer, on all professional nursing matters and on matters which may have implications for nursing.

3. To all papers and other sources of information, both within the Ministry and elsewhere, relating to the chief nurse’s breadth of functions.

4. To staff of the Ministry of Health and other ministries related to breadth of functions.

5. To leaders and organizations outside the Ministry as necessary.

6. To nurses and others within the health system as necessary.

7. To all papers and other sources of information from international and other national organizations relating to nursing.

ORGANISATIONAL POSITION

32. The chief nurse should:

1. Report to the most senior permanent official within the Ministry.

2. Be a member of the most senior group within the Ministry responsible for determining health policy and making decisions regarding the health system. Be a member of the group responsible for managing the health services.

3. Be a member of all groups which consider policy issues relating to the chief nurse’s range of functions and which deal with international and national matters which may have implications for nursing.

SUPPORT

33. The chief nurse requires:

1. Support of other nurses to assist with role and functions.

2. Support as necessary from administrative, library, computer/information technology, statistical and other experts.

3. Support of secretarial and clerical staff to provide adequate support for the chief nurse and the chief nurse’s office and systems.

4. Support of computer/information technology system to assist chief nurse, the chief nurse’s office and systems.
5. Provision of adequate finance to meet the requirements of the role and range of functions, and the power to authorize expenditure from this budget.

PERSONAL CHARACTERISTICS OF POTENTIAL CHIEF NURSES

34. Just as it is inappropriate to be prescriptive about the role and function of chief nurses, so too is it inappropriate to be prescriptive about the characteristics of chief nurses. Effectiveness is often a personal matter, and success in a role depends not only on formal qualifications and preparation but also on the person's intuitive, intellectual, interpersonal and presentational skills. The following is therefore simply a guide to the desirable background and characteristics of potential chief nurses:

1. Education is nursing-related studies to at least degree level.
2. Experience in clinical nursing in primary and secondary health care.
3. Responsibility - experience in managerial posts, and/or educational posts, responsible for nursing services.
4. Interest in nursing practice, education, management, research and in health policy.
5. Intellectual ability to conceptualize and analyze options and issues.
6. Political understanding of systems and processes and of the politics of organizations.
7. Intuitive skill - a developed sense of intuition and sensitivity to hidden as well as disclosed agendas.
8. Interpersonal understanding and ability to develop collaborative relationships, secure consensus and develop alliances.
9. Facilitation skills - ability to lead a team towards shared goals and to help the team solve problems.
10. Communication - ability to communicate messages in succinct and persuasive manner in writing and verbally.
11. Presentation - ability to speak with authority and to represent the profession with impact and influence.

CONCLUSION

35. This paper has proposed a rationale and primary purpose of the role of government chief nurse. A checklist of key functions, organizational requirements, and personal background and characteristics has also been presented. The position of chief nurse is of great importance to ministries, health systems and the profession. To achieve the demands of the role, the support of
key people within the Ministry of Health is essential, together with the necessary authority and assistance. It is impossible for the chief nurse to succeed alone: the support, assistance and cooperation of others is needed. The role, relationships with others in the Ministry, the profession and beyond, the culture of ministries of health and the effect of often conflicting priorities and demands calls for chief nurses of exceptional ability. The contribution of chief nurses is critical to the development and advancement of the profession for the good of people in every country. It is hoped that this paper will assist in further refining the rationale and the key elements of this important role and its functions.
REFERENCES


FORTY-NINTH WORLD HEALTH ASSEMBLY

WHA49.1

Agenda item 17  23 May 1996

Strengthening nursing and midwifery

The Forty-ninth World Health Assembly,

Having reviewed the Director-General’s report on strengthening nursing and midwifery;¹

Recalling resolutions WHA42.27, WHA 45.5 WHA 47.9 and WHA 48.8 dealing with the role of nursing and midwifery personnel in the provision of quality health care in the strategy for health for all and education of health care providers;

Seeking to apply the spirit of the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995) and the Fourth World Conference of Women (Beijing, 1995);

Concerned about the problems resulting from the emergence of the new diseases and the re-emergence of old diseases as highlighted in The world health report 1996;

Concerned about the necessity of effectively utilizing health care personnel, in view of rising costs, and mindful of the cost-effectiveness of good nursing/midwifery practice;

Recognizing the potential of nursing/midwifery to make a major difference in the quality and effectiveness of health care services in accordance with the Ninth General Program of Work;

Recognizing the need for a comprehensive approach to nursing/midwifery service development as an integral part of health development to maximize the contribution of nurses and midwives to achievements in the field of health;

Recognizing also that such an approach must be country-specific and be assured of the active involvement of nurses and midwives at all levels of the health care system, together with the recipients of health care, policy-makers, the public and private sectors, representatives of professional associations and educational institutions, and those who have responsibility for social and economic development,

1. THANKS the Director-General for his report and for the increased support to nursing in Member States;
2. **URGES Member States:**

   (1) to involve nurses and midwives more closely in health care reform and in the development of national health policy;

   (2) to develop, where these do not exist, and carry out national action plans for health including nursing/midwifery as an integral part of national health policy, outlining the steps necessary to bring about change in health are delivery, ensuring further development of policy, assessment of needs and utilization of resources, legislation, management, working conditions, basic and continuing education, quality assurance and research;

   (3) to increase opportunities for nurses and midwives in the health teams when selecting candidates for fellowships in nursing and health related fields;

   (4) to monitor and evaluate the progress toward attainment of national health and development targets and in particular the effective use of nurses and midwives in the priority areas of equitable access to health services, health protection and promotion, an prevention and control of specific health problems;

   (5) to strengthen nursing/midwifery education and practice in primary health care;

3. **REQUESTS the Director-General:**

   (1) to increase support to countries where appropriate in the development, implementation and evaluation of national plans for health development including nursing and midwifery;

   (2) to promote coordination between all agencies and collaborating centers and other organizations concerned in countries to support their health plan and make optimal use of available human and material resources;

   (3) to provide for the continued work of the Global Advisory Group on Nursing and Midwifery;

   (4) to promote and support the training of nursing/midwifery personnel in research methodology in order to facilitate their participation in health research programs;

   (5) to keep the Health Assembly informed of progress made in the implementation of this resolution and to report to the Fifty-fourth World Health Assembly in 2001.

Fifth plenary meeting, 23 May 1996

A49/VR/5
ANNEX VI

PROPOSED OUTLINE FOR REPORT ON NURSING IN COUNTRIES

A. Introduction
   - Country profile

B. Health care and health care systems
   - Health care reform, public/private mix
   - PAHO and nursing/midwifery development
   - The nursing contribution to health

C. Nursing/midwifery workforce profile
   - Supply of nursing personnel
   - Deployment
   - Basic education
   - Education for nursing specialization
   - Continuing education
   - Nursing/midwifery practice

D. Regulatory framework for nursing/midwifery
   - Legislation
   - Registration and license to practice (if existent/planned)

E. Status and Working conditions
   - Status and image of nursing/midwifery
   - Working conditions, e.g.
     - remuneration
     - safety
· work environment
· housing
· transport
· etc.

F. Nursing midwifery in MOH
   - Nursing/midwifery leadership and management
   - Nursing/midwifery input to policy

G. Major issues affecting nursing/midwifery development in country
   - Changing scope of practice
   - Health policy / health reform
   - Professional associations and trade unions
   - Other

H. Strategic plan of action for nursing/midwifery development activities (for 1996-2001)
   - Specified by themes/priorities
   - Mechanisms for coordination and collaboration WHO/HQ—WHO/RO—countries

I. Requirements for national planning for nursing and midwifery development

J. Conclusion and recommendations