



**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

**WHO European
Region meeting of
Chief Nursing
Officers**

7-8 October, 2011

Warsaw, Poland

Meeting Report



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ABSTRACT

Participants in this meeting had the opportunity to discuss WHO's vision, key policies and strategies. These included Health 2020, the evolving European health policy framework (WHO 2011b); the Tallinn Charter on health systems (WHO 2008); and the global strategic directions for nursing and midwifery (WHO 2011c). Chief Nursing Officers debated these and other key issues such as migration and capacity building.

The meeting acknowledged that important steps had already been taken. The Policy Advisor on Nursing and Midwifery had been working at regional level since July 2011. There was a window of opportunity for advocacy and communication, and the focus of activities in 2012-2013 should be on reassessing and reinforcing the development of a shared vision aligned with Health 2020 and contributing to the wider health agenda; learning from each other and sharing knowledge and experiences though at least biennial meetings; working with other stakeholders (e.g. European Forum of National Nursing and Midwifery Associations) to raise nursing and midwifery issues at the highest levels. Additionally the Nursing and Midwifery Programme should begin to be mainstreamed across divisions and programmes at the Regional Office; in national health plans and strategies; and in the biennial collaborative agreements between WHO and Member States.

Keywords

NURSING MANAGEMENT
NURSING SERVICES – trends
MIDWIFERY
HEALTH POLICY
HEALTH PERSONNEL
PROGRAMME EVALUATION
EUROPE

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CONTENTS

	<i>Page</i>
Setting the scene.....	1
Rationale for meeting.....	1
WHO CNO meeting objectives.....	1
Opening session	2
Technical sessions	4
Health system strengthening	4
Health policy responses to the economic crisis	5
Mobility and migration.....	6
Expanded roles	8
Strategic directions for nursing and midwifery in the WHO European Region	9
Responding to the policy challenges.....	10
Building capacity	11
Future directions for nursing and midwifery	12
References	13
Annex 1: Programme.....	15
Annex 2: List of participants.....	17

Setting the scene

Rationale for meeting, objectives and opening session

The World Health Assembly recently highlighted the importance of strengthening nursing and midwifery for building sustainable national health systems and addressing health inequities in resolution WHA64.7 (WHO 2011a). Nurses and midwives who work at government level are central to achieving this goal. They are important national and international leaders of health development: professional leaders playing strategic, empowering and enabling roles in their countries; catalysts of practice development; convenors of leadership groups; collectors of relevant evidence; advocates and influencers; visionaries, planners, implementers and reviewers; and key partners with WHO.

The WHO Regional Office for Europe is encouraging and supporting Member States to implement resolution WHA64.7. In recognition of the key role of government chief nursing officers (CNOs) and the need for networking and capacity building, the Regional Office held the first meeting for all CNOs in the Region since 2005. This offered a unique opportunity to renew collaboration and exchange knowledge, revitalizing the pan-European CNO network and encourage its full engagement in regional level decision-making.

Participants were able to discuss WHO's vision, key policies and strategies. These included Health 2020, the evolving European health policy framework (WHO 2011b); the Tallinn Charter on health systems (WHO 2008); and the global strategic directions for nursing and midwifery (WHO 2011c). CNOs and other focal points attended from 30 countries, along with representatives of two WHO Collaborating Centres for Nursing and Midwifery, external experts and WHO Regional Office staff.

To promote synergy and make the best use of resources, the CNO meeting immediately followed the European Union (EU) presidency meetings for CNOs and chief medical officers (CMOs), held in Warsaw on 6–7 October 2011 during Poland's presidency. A bridging session was held to link the meetings and update CNOs from non-EU countries on their outcomes.

WHO CNO meeting objectives

The objectives of the meeting were as follows:

- to engage CNOs in the development of high quality health services in the Region
- to discuss strategic directions for nursing and midwifery in Europe
- to establish a platform for the Regional Office and CNOs to share information and knowledge
- to determine future directions for joint work by CNOs and the Regional Office
- to build CNOs' leadership capacity.

Opening session

Professor Jose Martin-Moreno, Director of Programme Management, WHO Europe, and Dr Wojciech Kutyla, Director General, Ministry of Health, Poland, welcomed the CNOs and CMOs, whose joint meeting had just concluded. Dr Hans Kluge, Director, Division of Public Health and Health Systems, and Dr Valerie Fleming, Policy Adviser, Nursing and Midwifery, both WHO Europe, then opened the CNOs' meeting. Mrs Beata Cholewka, Director, Department of Nurses and Midwives, Ministry of Health, Poland, welcomed participants and declared that Poland was proud to host them.

Dr Kluge remarked that the estimated six million nursing and midwifery staff who comprised the majority of the health workforce in the Region had a huge part to play in meeting health challenges. WHO Europe's Regional Director was committed to reviving the Regional Office nursing and midwifery programme, and welcomed ideas on how best to achieve this. The aims were to renew collaboration with CNOs and rejuvenate the network; involve CNOs fully in WHO strategy and debate; and exchange knowledge and information. The European Forum of National Nursing and Midwifery Associations (EFNMA), which had met in Copenhagen on 29–30 September 2011, supported this move and it was the start of a long journey together.

Mrs Sandra Roelofs, First Lady of Georgia and WHO European Region Goodwill Ambassador for the health-related Millennium Development Goals, was guest of honour. She spoke of the importance of nursing and midwifery and the need to reach out to Europe's huge army of health workers – of whom she was one, working as a nurse in Georgia. "Health is the cornerstone of human development and security," she said. She also addressed participants later, speaking of her delight that WHO had



relaunched its CNO meetings. The new European Health Policy “Health 2020” provided an ideal opportunity for WHO and Member States to re-engage with the vision and strategies of the Munich Declaration, Nurses and midwives: a force for health (WHO 2000).

Sound professional education is key to creating a workforce that could meet population health needs. It includes enhancing decision-making skills as well as political advocacy, and also comprises developing skills and competences related to health services management. If WHO and CNOs could work together to harness the huge potential of Europe’s nursing and midwifery staff, “it would be the guarantee of high quality, personal, accessible, affordable, equitable and efficient care”.

Technical sessions

The meeting held several technical sessions presented by experts in the field on current European health priorities and strategies crucial to the CNO's role.

Health system strengthening

Professor Martin-Moreno and Dr Kluge outlined the core challenges facing European health systems today: addressing health inequities and social determinants, the current burden and patterns of disease, the impact of globalization, the changing role of citizens, financial stability, governance, monitoring and intersectoral actions and health in all policies.

The 2008 Tallinn Charter, *Health systems for health and wealth*, inspired countries to act on their values to improve health and wealth; affirmed a value-based approach to health system strengthening; and empowered health ministries to lead change for health improvement. Progress in implementation included promoting or maintaining solidarity and equity, and increasing or maintaining pro-health and pro-poor investments. Transparency and accountability for health system performance had been enhanced, with greater stakeholder engagement in policy development and implementation.



The charter has led to more vigorous policy dialogue on the importance of investing, reforming and preserving health systems, and Member States have made remarkable efforts to reinforce their health systems based on the values of solidarity, equity and participation. Leadership, innovation and openness have been key. Limited resources sometimes prevented gains, but the charter's values and policy objectives were being put into practice. The lessons learned from implementation formed the evolving European health policy framework, Health 2020, by supporting the values of solidarity

and equity, taking a holistic approach to health and emphasizing the central role of health systems. Health 2020 would move forward in several areas mentioned in the charter, including public health and health governance.

Dr Kluge said the financial crisis put these values to the test. Across-the-board budget cuts affected health outcomes hurting the poor and vulnerable who need protection by means of additional health, social and economic measures. Effective policy instruments were developed to reduce the impact of the crisis. These included cost reduction through hospital reconfiguration, more focus on primary health care, speeding up the shift from inpatient to outpatient care, rational use of medicines, and cheaper medical goods.

Health policy responses to the economic crisis

Dr Philipa Mladovsky, Research Fellow, London School of Economics Health/European Observatory on Health Systems and Policies, reported some findings from a study of health policy responses to the economic crisis in the EU, supported by the Observatory and the European Commission. The study asks whether countries' responses are likely to improve health system efficiency without reducing quality, access and financial protection. The full analysis will be published in 2012 (Cylus et al forthcoming).

In 2009, the WHO Regional Committee adopted resolution EUR/RC59/R3, *Health in times of global economic crisis: implications for the WHO European Region* (WHO 2009). This urged Member States to ensure their health systems continued to protect vulnerable people; demonstrate effectiveness in delivering personal and population health services; and behave wisely and economically in terms of investment, expenditure and employment. This set the context for the study asking health policy experts in the 53 European Region countries to describe their government's health policy responses to the 2008 economic crisis.

Analysis of the EU27 countries showed that many new policies were introduced in some countries, few or no policy changes in others, and the rest somewhere in between. Some planned or implemented policy measures were quickly reversed due to their unpopularity with stakeholders, especially physicians. Government health budgets were cut in most countries, and increased or maintained in very few.



Some countries were already undertaking significant health sector reforms when the crisis struck. Some planned reforms were slowed down or abandoned, including building new health facilities. Some countries were using EU and private funds as a stimulus for health sector investment, often as part of ongoing reform rather than in direct response to the crisis. Policies planned before 2008 were implemented with greater intensity or speed as they became more urgent or politically feasible, such as the restructuring of secondary care. Some governments used the crisis to strengthen their bargaining position, for example, with the pharmaceutical sector.

Very few countries had reduced eligibility for statutory population coverage. Most of the EU27 introduced or strengthened existing policies to cut the prices of medical goods and improve the rational use of drugs. A number of countries reduced or froze the salaries of health professionals, cut or froze payments to providers, and linked payments to improved performance. Publicly owned or operated health service provider networks and ministries of health were restructured to save money. User charges for health services and social health insurance payments were raised in 11 countries. Some countries increased taxes on alcohol and tobacco, but few reformed fiscal policy to expand the tax base of health system financing.

In conclusion, there is a mix of both positive and negative policy responses. Increased user charges were likely to affect low-income and other vulnerable groups disproportionately, while cuts in necessary care as well as unnecessary care could actually increase costs in the long term. Little had been done to strengthen public health policies and thereby improve health and increase efficiency – a missed opportunity. It is too early to measure the effects on health status, and it was unlikely that the impact had yet been felt. It is always difficult to establish a causal link between health system reforms and health status outcomes, but existing evidence has not influenced policy decisions during the crisis.

Mobility and migration

Dr Irene Glinos, Technical Officer, European Observatory on Health Systems and Policies, presented findings from the PROMeTHEUS study of health professional mobility in the EU (Wismar et al 2011). The study collected quantitative and qualitative data in 17 European countries. The aim was to explore the magnitude of health worker migration, geographical patterns, effects of EU enlargement, motivations to move, impacts on health systems performance and policy options.

Mobility patterns concerned both direction and magnitude of flows. There were three different patterns in the direction of flows of health professionals in general. First, movements took place between neighbouring countries within the



EU and across EU borders. These were all relatively 'natural' and predictable according to historical ties, work opportunities and salary levels. Second, flows generally went from east to west and from south to north. For example, Germany attracted thousands of nurses and midwives from Croatia, Turkey, Poland, Serbia, and Bosnia and Herzegovina, while the UK was a major destination attracting health professionals from all over Europe. Third, movements took place mostly within the region, but Europeans also went elsewhere, such as to North America and Australia/New Zealand, while the UK, Spain and French-speaking countries received significant numbers from Africa, Asia and Latin America.

The magnitude of mobility was significant but diverse. Three EU countries had 10-15% foreign nurses; in others, the proportion of foreign nurses was 0-5%. Countries had more and better data on medical doctors, and greater reliance on foreign doctors than foreign nurses. Many countries collected no data to assess how much their health systems relied on foreign health workers.

These stock data give only a static picture of migration (a person might have moved 10-20 years ago). Inflow data show how migrants contribute to replenishing the workforce, and give a more accurate and up-to-date picture. Only six countries had good data on the ratios of foreign inflows to all new entrants in 2007-8, however. The number of nurses of foreign origin who entered their workforces varied widely. Migrants were often heavily relied on to replenish the workforce: the percentages of foreign nurse inflows out of all new entrants were in Italy 28%, Spain 20%, UK 15%, Belgium 14% and Hungary 2%. These foreign nurses came from many places. Italy, for example, with a chronic nursing shortage estimated at 70,000, attracted thousands of nurses from Romania and Poland, while the UK attracted staff from India, the Philippines, Spain and Poland.

In many destination countries, the effect of the growing EU on immigration flows had been less than expected, especially for nurses. There were many problems with outflow data, however, and nursing staff in the informal and home care sectors might not be professionally registered, so there was much undocumented immigration. National statistics could also hide local effects and disparities at regional or hospital level. Enlargement had increased the imbalances between flows east and west. EU accession had probably made it harder for non-EU health professionals to enter the new (and neighbouring) EU Member States. Although outflow trends in a country tended to fall after accession, there had been a new surge in outflows in 2009-2010, for example from Estonia, Hungary and Romania, perhaps owing to the financial crisis.

The study highlighted growing shortages and increasing competition for nurses and midwives within the EU, within wider Europe, and globally. The EU recruited nurses from an exceptionally varied and complex number of sources. A discussion was held on what the WHO code on ethical recruitment could do for less economically advantaged EU countries, and what impact the financial crisis might have on the ability to attract and keep staff using incentives such as higher salaries.

The study exposed the severe limitations on both policy-makers and researchers because of the lack of good data. There was less mobility among nurses than among doctors, but also less data – countries might be losing their nursing workforce and not even know it. Good data was not seen as a priority, even though nursing and midwifery

staff were the largest part of the health workforce. This could have a negative impact on policy-making.

Expanded roles

CNO Mrs Sheila O'Malley presented a case study from the Republic of Ireland, where the policy context and previous achievements created significant opportunities to expand nursing and midwifery roles in a proactive, solution-focused manner to improve the quality of patient care. A strategic framework for role expansion of nurses and midwives was devised in response to service needs, and to promote high quality care and patient safety (Department of Health and Children 2011). The *Strategic framework for role expansion of nurses and midwives – promoting quality patient care* sets the policy direction for the enhancement of nursing and midwifery roles, providing a six-step process to expand roles in line with service need and national policy direction. A new Nurses and Midwives Bill going through the Irish parliament provides for a modern statutory framework for the regulation of the nursing and midwifery professions, with an emphasis on protection of the public and assuring competency in the professions.



Strategic directions for nursing and midwifery in the WHO European Region

Dr Fleming outlined the strategic directions for nursing and midwifery in Europe. According to the Munich declaration, nurses and midwives have key and increasingly important roles in society's efforts to tackle public health challenges, as well as in ensuring the provision of high quality health services that address people's rights and changing needs. Three surveys were undertaken to ascertain progress on implementing the declaration; 35 Member States responded to the last survey in 2008. The principles supporting the declaration appeared just as relevant today, but progress was slower than hoped – even taking into account each country's different stage of development. A review of the declaration was necessary.



Dr Fleming described the current international health policy context and the challenges of growing demand for services; increasing staff shortages; uneven distribution of the skilled workforce; and lack of public health skills. Major drivers included Health 2020 and the Tallinn Charter, as described earlier, and EU enlargement and its implications. The World Health Assembly had passed three relevant resolutions:

- WHA Resolution 59.27, *Strengthening Nursing and Midwifery* (WHO 2006);
- WHA Resolution 63.16, *WHO global code of practice on the international recruitment of health personnel* (WHO 2010);
- WHA Resolution 64.7, *Strengthening Nursing and Midwifery* (WHO 2011).

The WHO *Nursing and Midwifery Services Strategic Directions 2011-2015* were a global response to these resolutions, and built on the 2002–2008 strategic directions (WHO 2002) by providing a framework to enhance the capacity of nurses and midwives to contribute to universal health coverage; people-centred health care; policies affecting practice and working conditions; and scaling up national health systems to meet global goals and targets. Their core vision was ‘improved health outcomes for individuals, families and communities through the provision of competent, culturally sensitive, evidence-based nursing and midwifery services.’

The global key result areas were health system and service strengthening; education, training and career development; policy and practice; workforce management; and partnership. In Europe, the key areas were building workforce capacity, professional roles, leadership, education, legislation, regulation and ensuring evidence-based quality care. CNOs needed to provide strong leadership and identify the key areas they could take forward in partnership with WHO, Dr Fleming concluded.

Responding to the policy challenges

A panel of four senior CNOs described how they had responded to the challenge of developing new policies for health and their visions for the next five years.

Mrs O'Malley, CNO, Republic of Ireland, described their policy direction as emphasizing integrated care, with less reliance on acute hospital services and more emphasis on managing patients in the community. A new government and tough economic times offered potential to expand roles and develop nurse- and midwife-led services in response to service need. This is supported by a new strategic framework for expanding roles to promote the effective utilisation of all nurses' and midwives' skills. All nurses and midwives now qualified through a four-year honours degree, and there was also a 4.5-year integrated programme for children's and general nursing. A forthcoming review of nursing and midwifery undergraduate pre-registration programmes would establish their efficiency and effectiveness in preparing nurses and midwives to practise now and into the future. Her vision was for enhanced use of nursing and midwifery skills, an increase in the number of nurse prescribers, and a greater awareness of public health as integral to all nursing and midwifery roles.

Mrs Stavroula Michael, CNO Cyprus, remarked that all nurses had been trained at first level since 2007, and their education was moving toward a four-year bachelor programme. Specialist training in areas including community nursing and midwifery would become master's level. The challenge now was to make better use of resources. In her vision for the future, the focus should be on quality, patient satisfaction and community wellbeing, looking at the human being, holism and population wellbeing.

Ms Gulnara Usmanova, CNO Uzbekistan, described her country's progress towards a bachelor degree in nursing. The nursing voice was getting stronger, as was multidisciplinary teamwork. She had seen many positive developments during her career in nursing, particularly in education.

Mrs Fetije Huruglica, CNO Kosovo, described the preparation of a strategic plan with help from nursing education colleagues from Finland. Forty people had been trained as

trainers of family nursing. With support from Glasgow Caledonian University, a WHO Collaborating Centre for Nursing and Midwifery in Scotland, a bachelor's degree had been developed and nurses were taking master's courses in Finland to create a leadership cadre. The nursing association was growing. In future, she hoped, nurses would become more accountable and confident, and undertake greater responsibilities.

In discussion, other CNOs shared notes on progress. Kyrgyzstan had implemented many aspects of the Munich declaration and adopted a new concept of nursing, but progress had been mixed owing to political instability and financial problems. Many nurses were emigrating, and the skill drain was affecting leadership. The future focus should be on primary health care and midwifery.

Workshop on building capacity

Professor Jane Salvage, WHO Consultant, ran a workshop with the following aims:

- to share experiences of what works in policy-making
- to identify how to be an effective policy-maker.

Participants were asked to think of a recent example of their involvement in making nursing and midwifery policy, i.e., what they discovered that worked well, what could have been improved, and what skills they brought to the policy-making process? Policy-making involved many challenges, they concluded. It happened at many different levels, and there was often tension between top-down and bottom-up approaches. In many countries, there was policy overload and too much change, while in others policy could be stagnant and unresponsive. The evidence base for policy was often poor. There was too much focus on policy content rather than process, implementation was difficult and frequently had unintended consequences with sustainability very weak.

Policy-making was less a rational act than a process of social influence. Policy windows opened rarely and did not stay open long. CNOs should understand what policy options had the greatest potential for adoption or, when small, incremental changes were preferred. CNOs should link the key issues from 'outside' the world of nursing with the 'inside' issues, and treat them as an integrated agenda. As policy entrepreneurs, they should position themselves to influence policy, and bring together problems, policies and politics in a new mix, presenting stakeholders with new stories and solutions.

Capacities needed included a good understanding of policy-making, strong leadership, the ability to influence stakeholders, good use of the media, effective, wide-ranging networks, mobilizing communities and front-line workers; making alliances with communities and patients; and building an evidence base of that which is successful.

WHO work in the 1990s on developing national action plans for nursing and midwifery (NAPs) and country nursing and midwifery profiles (WHO 1997) was discussed. Some of today's CNOs had been closely involved in this programme, helping to develop the tools that they then used in their own countries with good results. The process had been

endorsed by WHO at global level, and the underlying principles and tools remained valid.

Creating a country nursing and midwifery profile using an agreed minimum data set facilitated comparisons over time within one country, and potentially across regions and worldwide. It might appear simple to countries with sophisticated information systems, but even these often had major gaps in data. Producing a profile was a major step for countries where nursing and midwifery was under-valued – often those where there was the greatest need for development. The profile could then be used to underpin the development of a NAP.

The chief nursing officer should lead the process of developing the NAP. This was complex work that required adequate human and financial resources as well as stakeholder involvement. The main stages of the process, was to form a national leadership group; collect evidence on key indicators; create and disseminate the country profile; conduct a situation analysis; develop a shared vision for nursing and midwifery; agree priorities for action; draft a national action plan; consult widely on the plan; finalise the plan; and gain official endorsement. The NAP should then be launched with maximum publicity. A plan for implementation should be developed, with time scale, budget, and designated responsibilities. Monitoring was essential, as part of the non-stop cycle of analysis, planning, implementation and evaluation.

Closing Session: Future directions for nursing and midwifery

Dr Kluge summarised proposals developed during the meeting to continue the network and revitalise the Regional Office nursing and midwifery programme. CNOs made a number of suggestions on how they could work with WHO in the future, including:

- developing a shared vision aligned with regional strategic directions for nursing and midwifery and contributing to the wider health agenda;
- learning from each other, collecting evidence on good nursing and midwifery practice and sharing information;
- convening regional CNOs meetings biennially
- working with other stakeholders and partners, promoting inter-and multidisciplinary approaches;
- raising nursing and midwifery issues to the regional policy-makers discussion (Regional Committee).

Important steps have already been taken:

- collaboration between WHO and EFNNMA has been strengthened through the forum meetings;
- a review of the role of WHO Collaborating Centres for Nursing and Midwifery is in the pipeline
- the strategic directions are also under consideration for further improvement

There is a window of opportunity for advocacy and communication, and an action plan is needed for implementation. The focus of activities in 2012-2013 should be on

reassessing and reinforcing commitments in relation to workforce capacity-building, professional roles, leadership, education, legislation and regulation, and evidence-based practice.

The Nursing and Midwifery Programme should be mainstreamed across divisions and programmes at the Regional Office; in national health plans and strategies; and in the biennial collaborative agreements between WHO and Member States. Innovative solutions were needed, learning and sharing country good practices, with continuing collaboration and support to Member States, and partnerships.

In conclusion, Dr Kluge encouraged participants to be committed and seek joint efforts which are needed at all levels (local, national and regional); to share responsibility in the countries and the Region; to embrace passion and innovative leadership, develop a sense of what is possible and choose leaders to turn this into reality.

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Annex 1: Programme

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA



ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

WHO Meeting of Chief Nursing Officers
Warsaw, Poland
7–8 October 2011

3 October 2011

Friday, 7 October 2011

- 10.30 - 11.00 Registration of all CNOs in WHO European Region
- 11.00 - 11.50 **Welcome and Introductions**
- Dr Hans Kluge, Director, Division of Public Health and Health Systems, WHO Europe
- Dr Valerie Fleming, Policy Adviser, Nursing and Midwifery, WHO Europe
- 12.00 - 13.00 **Closure of EU presidency CNO/CMOs' meeting**
Opening of WHO CNOs' meeting
- Prof Dr Jose Martin-Moreno, Director of Programme Management, WHO Europe
- Dr Wojciech Kutyla, Director General, Ministry of Health, Poland
- 13.00 - 14.00 Lunch
- Technical Session 1**
- 14.00 -14.20 **Implementing the Tallinn Charter and beyond**
- Prof Jose Martin-Moreno
- Dr Hans Kluge
- 14.20 -14.40 **Responding to the financial crisis**
- Philipa Mladovsky, London School of Economics
- 14.40 -15.00 **Nursing and midwifery mobility and migration**
- Irene Glinos, European Observatory on Health Systems and Policies
- Coffee/tea break

15.00 - 15.30

15.30 - 16.30

Panel discussion

Participants from CNOs, WHO staff, etc.

16:30 - 17:15

Discussion and conclusions of the day

20.00

Gala Dinner

Saturday 8 October 2011

Technical Session 2

09.00 - 10.30

Strategic Directions for Nursing and Midwifery in the WHO European Region: Where to after Munich?

- Dr Valerie Fleming

10.30 - 11.00

Coffee/tea break

11.00 - 12.30

Capacity building workshop

Policy-making: Jane Salvage, Temporary Adviser, WHO Europe

12.30 - 13.00

Feedback and summary of workshop

13.00 - 13.30

Future Directions for nursing and midwifery

- Dr Hans Kluge

13.30 - 14.00

Closure of the meeting

- Dr Hans Kluge

Annex 2: List of participants

Armenia

Ms Alina Kushkyan
Chief Specialist in Nursing
Ministry of Health
Yerevan State Medical College Erebouni

Belarus

Mr Siarhei Zhavaranak
Director
Republican centre for Higher and Specialized
Secondary Medical and Pharmaceutical Education
Minsk

Belgium

Mr Miguel Lardennoius
Chief Nursing officer
FPS Public Health
Healthcare institutions – quality of nursing
Brussels

Bosnia and Herzegovina

Ms Zivana Vukovic Kostic
Coordinator of the Ministry of Health
and Social Welfare of the Republika Srpska
Banja Luka

Ms Suvada Svrakic
Head Nurse
Clinical Center Sarajevo

Ms Edina Dulic
Head Nurse
Klinikal Center Sarajevo Bojnja
Plastic and Reconstructive Surgicle
Sarajevo

Cyprus

Ms Stavroula Michael
Head Nursing Officer
Nursing Services
Ministry of Health
Nicosia

Finland

Ms Marjukka Vallinies-Patomaki
Ministerial Adviser
Ministry of Social Affairs and Health

Ms Virpi Jylha
Researcher
The Nursing Research Foundation
Helsinki

Georgia

Mrs Ketevan Garsevanishvili Gudushauri
National Medical Center
Head of Nursing Department
Tbilisi

Ireland

Sheila O'Malley
Chief Nursing Officer
Department of Health
Dublin

Kazakhstan

Mr Sultan Seidumanov
Director
Republican Medical College
Ministry of Health Service of the Republic of Kazakhstan
Almaty

Kyrgyzstan

Ms Yusupova Bermet
Chief Nursing Officer
Ministry of Health of Kyrgyzstan Republic
Bishkek

Latvia

Ms Biruta Kleina
Deputy Director
Ministry of Health of the Republic of Latvia
Riga

Lithuania

Ms Odeta Vitkuniene
Chief Officer
Ministry of Health
Vilnius

Malta

Mr Jesmond Sharples
Director
Directorate Nursing Services
Ministry of Health, Community and Elderly Care
B'Bajda

Montenegro

Mrs Marijana Bogovac
Chief Nursing Officer
Clinical Center of Montenegro
Podgorica

Netherlands

Ms J.F. de Vries
Chief Inspector Nursing and Long-term Care
Health Care Inspectorate
Utrecht

Poland

Department of Nurses and Midwives
Ministry of Health
Warszawa
Poland

Ms. Jolanta Skolimowska
Ministry of Health

Mr Bartosz Baran
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Mr Mcihal Skoczynski
Ministry of Health

Portugal

Mr Sergio David Lourenco Gomez
Chief Nursing Officer
Directorate-General of Health
Lisboa

Mr Raul Miguel Pires Fernandes
European Officer
Ordem dos Enfermeiros
International Affairs Department
Lisboa

Republic of Moldova

Mrs Ala Greco
Main Nurse
Institute of Oncology
Chisinau

Romania

Mr Mircea Timofte
Chief Nursing Officer
Ministry of Health
Bucharest

Ms Nicolet Pirvu
Interpreter
Romanian Order of Nurses, Midwives and Medical Assistants

Russian Federation

Ms Kupeevea Irina
Head, Department of Education and Human Resources
Ministry of Health and Social Development
Moscow

Ms Pavlova Gulnara Azatovna
Adviser, Department of Education and Human Resources
Ministry of Health and Social Development
Moscow

Serbia

Mr Dragan Sasic
Director
Serbian Chamber of Nurses and Medical Technicians
Belgrade

Slovenia

Ms Zdenca Ticar
Secretary
Ministry of Health
Health Care Directorate
Ljubljana

Ms Tamara Lubi
Director
WHO Collaboration Centre
Health Centre Maribor
Maribor

Spain

Ms Ana Gimenez
Chief Nursing Officer
Ministry of Health and Social Affairs
Madrid

Tajikistan

Ms Zukhro Abdurakhmanova
Director of National Nurses Centre
Ministry of Health
Dushanbe

The Former Yugoslav Republic of Macedonia

Ms Nermina Fakovik
WHO National counterpart for medical nurses and midwives
Ministry of Health
Skopje

Turkey

Ms Avci Keziban
Development of Nursing Services
Ministry of Health
Ankara

Turkmenistan

Mrs Jeren Jumayeva
Chief Nurse

Ashgabat

Ukraine

Ms Tetyana Chernyshenko, Director
Central Methodics Department Associate Specialists' Training
Ministry of Health

Uzbekistan

Ms Gulnara Usmanova
Deputy Head of Nursing Committee
Ministry of Health of the Republic of Uzbekistan
Head Nurse of the First Medical Academy
Tashkent

UNMIK/Kosovo

Ms Fetije Huruglica
Chief Nursing Officer, Department of Health Services
Ministry of Health
Pristina

TEMPORARY ADVISERS

Ms Philippa Mladovsky
Technical Officer
London School of Economics
London, UK

Ms Irene Glinos
Technical Officer
European Observatory on Health Systems and Policies
Brussels, Belgium

Ms Jane Salvage, Rapporteur
Temporary Adviser
London, UK

Ms Lene Svendsen
Temporary Adviser
Snekkersten, Denmark

INTERPRETERS

Mr Georgy Pignastyy
WHO Conference Interpreter
Moscow
Russian Federation

Mr Vladimir Ilyukhin
WHO Conference Interpreter
Moscow
Russian Federation

WORLD HEALTH ORGANIZATION

Regional Office for Europe

Dr Valerie Fleming
Policy Adviser, Nursing and Midwifery

Dr Hans Kluge
Director, Health Systems and Public Health

Dr Jose Martin-Moreno
Director, Programme Management

Ms Sharon Miller
Programme Assistant, Human Resources for Health

Dr Galina Perfilieva
Programme Manager, Human Resources for Health

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World Health Organization Regional Office for Europe

Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 39 17 17 17. Fax: +45 39 17 18 18. E-mail: contact@euro.who.int
Web site: www.euro.who.int