

Munich Declaration: nurses and
midwives: A force for health

**By/Edited by: Andreas Büscher
and Lis Wagner**

**Analysis of
implementation
of the Munich
Declaration
2004**



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Preface

The Munich Declaration: Nurses and midwives: a Force for Health, adopted at the Second WHO Ministerial Conference on Nursing and Midwifery in Europe, held in Munich in June 2000, stresses the potential of nurses and midwives as a significant political and social force and resource for public health. The Munich Declaration is the basic foundation of the Nursing and Midwifery Programme which is one of many programmes within Country Policies, Systems and Services (CPS) in the Division of Country Support (DCS), WHO Regional Office for Europe. The Nursing and Midwifery Programme has a big influence on the stewardship, human resources allocation and service delivery. In the Declaration, Ministers of Health identified their overall health policy objective as: “to tackle the public health challenges of our time, as well as ensuring the provision of high-quality, accessible, equitable, efficient and sensitive health services which ensure continuity of care and address people’s rights and changing needs”.

Ministers affirmed that to contribute to the fulfilment of that objective, nurses and midwives should work to their full potential as independent and interdependent professionals; that the necessary legislative and regulatory frameworks should be in place; and that obstacles, such as those relating to gender and status issues, must be addressed.

Ministers identified key and increasingly important roles for nurses and midwives to play:

- to contribute to decision-making at all policy levels (development and implementation);
- to be active in public health and community development; and
- to provide family-focused community nursing and midwifery services.

Ministers proposed in consequence of these roles the development of:

- knowledge and evidence for practice through research and information dissemination;
- improved initial and continuing education, and access to higher nursing and midwifery education;
- opportunities for nurses, midwives and physicians to learn together, to ensure more cooperative and interdisciplinary working in the interests of better patient care; and as prerequisites for action:
 - partnerships with all ministries and other bodies within countries and internationally; and
 - workforce planning strategies and employment policies to ensure adequate numbers of educated, trained and rationally deployed nurses and midwives, who would enjoy fair rewards and recognition (incentives) and opportunities for career advancement.

Ministers requested the WHO Regional Director for Europe to provide:

- strategic guidance in the implementation of the Declaration;
- help to Member States in developing coordination mechanisms for partnerships with national and international agencies to strengthen nursing and midwifery;
- regular reports to the Regional Committee; and

- a first meeting in 2002 to review the implementation of the Declaration.

In 2001 a reference guide “Moving on from Munich” to the implementation of the Declaration was developed and made available to Member States. In 2001 questionnaires to track the implementation of the Declaration were sent out to all Member States. Questionnaires were sent to the Ministries of Health and the national nursing associations and national midwifery associations (NN/MAs). A discussion of results was planned during the Sixth Annual Meeting of the European Forum of National Nursing and Midwifery Associations and WHO in March 2002 in Copenhagen. Due to a small number of responses no conclusions could be drawn and the discussion was postponed until 2003.

In 2002 WHO headquarters developed a framework for collaborative action to support countries in enhancing the capacity of nursing and midwifery services to contribute to national health goals outlined in the document: Strategic directions for nursing and midwifery services 2002–2008. Five key result areas have been identified that are crucial to strengthening nursing and midwifery services. These areas are:

1. health planning, advocacy and political commitment;
2. management of health personnel for nursing and midwifery services;
3. practice and health systems improvement;
4. education of health personnel for nursing and midwifery services; and
5. stewardship and governance.

In March 2003 a progress report on the implementation of the Declaration was presented at the Government Chief Nurse meeting in Madrid. This progress report took into account the Strategic Directions 2002–2008 document from WHO Headquarters. The progress report revealed that responses from 28 countries have been received (21 Ministries of Health and 15 NN/MAs). Only from five countries answers have been received from Ministries and both NN/MAs. The responses varied in quality and depth, and it was impossible to give a definitive picture. All conclusions were therefore tentative and provisional. It was not possible to draw any conclusions on midwifery at all.

The results revealed:

- obstacles, including lack of status, tradition, gender discrimination, lack of appropriate legislation, poor education and dominance of medical profession;
- that the nurses role in decision-making at all levels ranges from “key” to “not involved at all” across the Region;
- that the role in public health varies from broad participation in community-based, family-focused services to specific tasks such as immunization and health promotion;
- that legislation is inadequate in many countries, and changes are underway in some countries; and
- that recruitment and retention is a major concern in many countries.

Concerning the impact of the Declaration it was concluded that there was no evidence of any impact on the quality or delivery of nursing and midwifery practice or services, but that the Declaration prompted innovative thinking and reassessment of the nursing and midwifery contribution in Member States.

A resolution *Re-emphasizing Munich: Nurses and Midwives: a Force for Health* was endorsed by the Government Chief Nurse meeting in Madrid (2003), in which Member States were urged to:

- strengthen, encourage and promote their efforts to implement the aims of the Declaration, particularly the participation of nurses and midwives in decision-making at Ministry of Health and all other levels of policy and practice development and implementation;
- reassess the contribution of nurses and midwives to meeting the health needs of the populations they serve and to realizing the professions' potential to tackle these needs;
- prepare a strategy for evaluating nursing and midwifery services; and
- establish appropriate measures and systems for reporting on nursing and midwifery issues within their health care systems.

The Regional Director was requested to:

- continue to provide technical support and assistance on issues linked with the Declaration and in this respect to stimulate networking between countries;
- to strengthen the WHO advocacy role on nursing and midwifery issues with Ministers of Health; and
- ensure appropriate staffing for the nursing and midwifery programme at the WHO Regional Office for Europe.

Government Chief Nurses in collaboration with nursing and midwifery associations and, where appropriate, with WHO Collaborating Centres for Nursing and Midwifery were urged to:

- strengthen their efforts to deliver high-quality patient care based on sound scientific and clinical evidence, patient/client/user satisfaction and cost effectiveness;
- develop plans and tools that provide evidence for the nursing and midwifery contribution to better health and well-being for the people of the WHO European Region; and
- develop the necessary mechanisms, including tools for assessment and monitoring, to evaluate the quality of their services.

Executive summary

The Munich Declaration: Nurses and midwives: a Force for Health was adopted at the Second WHO Ministerial Conference on Nursing and Midwifery in Europe in June 2000 in Munich, Germany. Ministers of Health identified key aspects by which the potential of nurses and midwives as a significant political and social force and resource for public health are stressed. The WHO Regional Office for Europe developed a reference guide: Moving on from Munich to support the implementation of the Declaration. In 2001 questionnaires were sent out to Member States' Ministries of Health and national nursing and/or national midwifery associations to track the implementation of the Declaration. In 2003 the Government Chief Nurses of the European Region re-emphasized the need for implementing the Declaration. Three years after the first questionnaire, which revealed rather disappointing results for the implementation of the Declaration, a second questionnaire was sent to Member States in April 2004. The main results from this questionnaire are presented in this executive summary.

Eighteen Ministries of Health and twenty-nine national nursing and national midwifery associations (NN/MAs) replied to the questionnaire (response rate 40%), representing twenty-nine countries. This is a slightly better response rate as in 2001 where twenty-one Ministries of Health and fifteen NN/MAs from twenty-eight countries responded. Questionnaires 2001 and 2004 were returned by the Ministries of Health: Armenia, Croatia, Czech Republic, Greece, Ireland, Israel, Latvia, Malta, Slovenia, Switzerland, United Kingdom (England) and the NN/MAs of: Denmark, Germany, Lithuania, Malta, Norway, Slovakia, Slovenia, Switzerland, and the United Kingdom. The responses varied in depth and quality, as in 2001. The analysis focused on trends and tendencies rather than on numbers. The responses from individual countries will be useful for WHO in developing tailored country activities on nursing and midwifery.

1. Many improvements have been made to ensure that nurses and midwives can work to their full potential as independent and interdependent professionals including legislative frameworks for regulating the scope of practice and degrees in nursing and midwifery. Nevertheless many obstacles such as medically dominated health care systems, lack of financial resources and difficulties in defining the roles of nurses and midwives are still reality. An appropriate education was stated as the key to work to the full professional potential.
2. A range of involvement in decision-making is reported. There is a clear hierarchy of more powerful and less powerful ways of ensuring nurses' and midwives' involvement in decision-making with having a Government Chief Nurse or a Chief Nursing Officer in the Ministry of Health being the most powerful one. Beside that there are various examples of permanent membership in important boards and councils. A master's degree or a PhD is mentioned as prerequisite for participation in decision-making. While nurses and midwives quite often are involved in decisions with regard to nursing and midwifery, their contribution to general health care decisions remains rather limited.
3. The contributions of nurses and midwives to public health are most visible on community level. The broad range of activities reported does not imply that nurses and midwives contribute in all countries, but gives evidence of how they can shape the public health agenda. Inclusion of public health in the basic nursing and midwifery curriculum has become more a rule rather than an exception. The contributions are limited due to financial resources, particularly reimbursement policies for health care services.

4. With regard to legislative and regulatory frameworks there is a border between EU and new EU countries, on the one hand, and non-EU countries on the other. Reforms were and are underway in all parts of the Region, but while the Declaration had an impact in the non-EU part of the Region, the impact is reported as rather low in the EU part, where different legislative frameworks had to be adapted according to EU regulation.
5. Similar to the area of basic education a lot is happening with regard to building a knowledge/evidence base for nursing and midwifery. Although national research strategies are still the exception, many examples of nurses and midwives conducting their own research projects or participating in interdisciplinary research are reported. Governmental funds for research are only available in some countries. In general research funds are limited, if existing at all. All countries report opportunities for disseminating research results via professional journals. The evaluation of nursing services seems to be in the very beginning. Where it occurs it is usually done according to predefined indicators.
6. Reforms in nursing and midwifery education have been undertaken in many countries during the past years, although only some of these reforms were initiated because of the Declaration. The full range of professional education for nurses and midwives is an exception, but many options for continuous professional development are offered. There is no shared understanding of the health sector's need for university-prepared nurses and midwives, but most statements refer to a number of 5–10% of nurses with master's degrees and PhDs.
7. Joint learning possibilities are an exception and occur at post-graduate level or at clinical sites where nurses and midwives work together with physicians. As in other areas the educational level is the key for progress in this area.
8. A range of national and international partnerships has been reported, but they were derived from a different understanding of partnerships. They included formalized agreements of working together on particular issues, on the one hand, and being a member of international organizations on the other. Twinning arrangements between countries were an exception.
9. Despite some contradictions in the numbers provided it can be stated that within the countries that responded to the questionnaire, 2.9 million nurses and midwives constitute the current workforce. A targeted workforce strategy has been implemented in only in few countries for more or less the same reasons across the Region: lack of data, lack of assessment of future needs for nursing care and financial limitations.
10. Salaries of nurses and midwives cannot be compared across the Region, because the economic situation in countries is too diverse. Concerning average salaries in countries the salaries of nurses and midwives have been reported to be below, above and according to the national average of comparable professions. Pay structures usually follow the same pattern and that is: level of education, actual position and experience in terms of working years.
11. WHO guidance has been made available to most of the respondents. Some critique is stated on less guidance during the past two years and on the fact that documents have been sent out in English. It is asked for documents in Russian where they are needed.
12. WHO guidance in general has been very useful, particularly in the area of education and continuing education. Useful support is stated in the areas of developing research and databases on nursing and midwifery, the development of midwifery curricula, and in terms

of supporting negotiations with Ministries of Health on the implementation of the Declaration.

13. The results reveal a range of action that has been taken to ensure an appropriate contribution of nurses and midwives in tackling the public health challenges of our time. Obviously education for nurses and midwives at all levels of professional education and appropriate legislative frameworks are the predominant prerequisites for nursing and midwifery to be considered as an equal partner in health care and political decision-making.

Introduction

The questionnaire used for tracking the implementation of the Declaration in 2001 was revised and slightly amended before it was sent out to Member States in April 2004. The questionnaire was sent to 50 Member States. The questionnaires were sent in English, French, German and Russian. A reminder was sent in July 2004.

Within WHO Europe's new strategy, "Matching services to new needs", Biennial Collaborative Agreements (BCA) between Ministries of Health and the WHO Regional Office for Europe were signed. This is to ensure mutual commitment to identified health priorities in these countries and to spend scarce resources most effectively. Because BCAs are a core element of current WHO Regional Office for Europe policy, in the following analysis the number of countries in total and the number of BCA countries is stated separately. Responses from BCA countries are a valuable source for including a nursing and/or midwifery component in future BCAs.

As of January 2005 out of 118 questionnaires to Ministries of Health and NA/MAs 47 responses have been received (response rate: 40%). A more specific perspective shows that 18 out of 50 Ministries of Health have sent a reply (response rate: 36%) and 29 out of 68 NN/MAs (response rate: 43%). The total number of countries that replied is 29 with England, Northern Ireland and Scotland counted as three. Nine Ministries of Health from BCA countries replied to the questionnaire, which is exactly 50% of all Ministries of Health that replied. Fifteen professional associations from BCA countries replied to the questionnaire (which is more than 50% of all associations that replied). Compared to 2002 this is an increase in replies by one country. Opposite to the previous questionnaire in 2004 more NN/MAs than Ministries of Health replied. From 12 countries a response was received from the Ministry of Health and the NN/MA as well. The questionnaires from 2001 and 2004 have been returned by the Ministries of Health of: Armenia, Croatia, the Czech Republic, England, Greece, Ireland, Israel, Latvia, Malta, Slovenia and Switzerland, and the NN/MAs of: Denmark, Germany, Lithuania, Malta, Norway, Slovakia, Slovenia, Switzerland and the United Kingdom.

An overview of the responses from 2004 is presented below.

Table 1: Overview of responses 2004.

Countries	Ministries of Health	NN/MAs
Armenia	X	
Belarus		XX
Croatia	X	X
Czech Republic	X	X
Denmark		XX
Georgia		X
Germany	X	XX
Greece	X	X
Hungary		X
Ireland	X	XX
Israel	X	
Latvia	X	X
Lithuania		X
Malta	X	X
Republic of Moldova		X
Netherlands		XX
Norway		X
Poland	X	X
Russian Federation		X
Slovakia		X
Slovenia	X	X
Sweden	X	X
Switzerland	X	X
The former Yugoslav Republic of Macedonia		X
Turkey	X	
United Kingdom	XXX	XX
Uzbekistan	X	
Jan 7, 2005	18	29

The questions were mostly open-ended with some questions that asked for facts. A quantitative analysis therefore was only appropriate as far as response rates and numbers of respondents were concerned. Exceptions were sub-questions under 11, where respondents were explicitly asked for numbers. Because of the nature of the questions and answers, this analysis focused on trends and patterns that could be identified from the answers. The situation in individual countries is described in their respective reports. As it is not the intention of this report to highlight particular countries and put others on spot, in most instances the countries are not mentioned when examples are provided.

Response rates to all questions will be provided in a table at the beginning for each question. For each question a concluding summary will be drawn from the answers of the sub-questions. Exceptions are questions 12, 14 and 15, where such a summary was not appropriate.

O. Government statements

Government statements made “on the record” that can be taken as a clear commitment to implement the Declaration and especially specific proposals in the Declaration

Table 2: Responses to question 0.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
0.1.	17	14	6	17	N/A
0.2.	16	13	6	16	N/A
0.3.	20	16	9	20	N/A

0.1. *Have any such statements been made and to what audiences?*

In only two countries governmental statements on the Declaration were made. In most of the countries the answer to this question was a clear “no”. However, some countries state that despite a lack of statements on the Declaration there was positive support from governments for nursing and midwifery issues. Examples included the reinstatement of the Government Chief Nurse, plans for including public health aspects in nursing education, commitment for the work of midwives, considering the role of midwives in recognizing domestic violence and general recognition and appreciation for nurses and midwives.

0.2. *Were there any explicit statements of intended action and, if so, what action has followed?*

Most NN/MAs state that there were no such statements or that they don’t know about them. Discussions on the implementation of the Family Health Nurse take place with governmental support (Germany) and without governmental support (Denmark). Better coordination and improvement of nursing education is reported from one country. Three countries report recommendations and action on midwifery. While in one instance a recommendation on midwifery practice is still pending implementation, the situation in other countries has moved beyond that. The recognition of midwives as independent professionals has been implemented in Latvia by adapting EU directives. There are still unresolved issues of payment for midwifery services. These issues have been resolved in the Netherlands, where payment, cooperation and the establishment of regional branches for midwifery and obstetric care have been implemented.

0.3. *Have the NN/MAs made any moves to secure government commitment? How have they done this?*

Most of the associations have continuously worked on securing governmental support. The activities included sending statements, distributing the Declaration among Members of parliament after translating it, influencing legislative processes, and regular meetings and discussions between NN/MAs and governmental representatives and/or members of parliament. Others have made specific suggestions on how to implement the Declaration according to the national situation. Particular issues that have been addressed include: the role of nurses in primary health care, establishment of a regulatory body, primary health care and participation in decision-making and differentiating nursing and midwifery, preparation and successful implementation of an Action Plan, including the establishment of a legal basis and professional standards.

Only one NN/MAs stated explicitly not to have made any efforts for ensuring government support, but have been very active in promoting the Declaration among the nurses.

Summary

From the point of view of NN/MAs, governments haven't been very active in supporting the Declaration and acting on it. There are, however, several statements that report governmental support in general and increasing awareness on issues such as nursing education and nursing in primary health care in particular. Positive examples on midwifery practice have also been reported.

The Declaration might serve as a means for NN/MAs to establish regular meetings with governmental representatives and ensure contribution to legislative processes with regard to nursing and midwifery.

1. Legislation and professional regulation

Reviewing and amending legislation and professional regulation to ensure that nurses and midwives can work to their full potential as independent and interdependent professionals

Table 3: Responses on question 1.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
1.1.	42	26	16	25	17
1.2.	37	23	13	25	12
1.3.	39	26	17	23	16
1.4.	43	27	16	26	17
1.5.	42	27	16	25	17

1.1. *How is the role of a nurse and/or midwife defined (by legislation, custom or practice)?*

The most common answer to this question is that the role of a nurse and/or midwife is defined by law. The definition may include a legal protection of the title. In several countries new laws have been put into place during the last three years with considerable improvements with regard to the Declaration, e.g. moving from a definition by customs to a legal definition of nursing, establishing midwives as independent professionals, the establishment of self-regulation and the requirement of an academic degree for teachers in nursing education. In terms of contents the laws state nursing and midwifery as independent professions and define the target groups for nursing and midwifery care and/or address specific areas of practice such as illness prevention, health promotion and home and community care.

Despite positive trends reported by most of the countries, others report severe difficulties. This is true for the Republic of Ireland where there is a lack of adequate statutory recognition for midwives. It is also true for Slovenia, where nursing is not yet included in the national health legislation, but where there is recognition of the problem by the Ministry of Health. A definition is lacking in The former Yugoslav Republic of Macedonia, too. The Russian Federation reports that the role of the nurse by definition is assistance to physicians.

The answers to this question are quite diverse in terms of length and content. Some countries provide a very detailed description of the existing laws on nursing and midwifery, while others simply state “by legislation”.

1.2. *In your judgement, do nurses and midwives work to their full potential? Have you any examples where nurses and midwives are doing this?*

Most answers indicate that nurses and midwives do not work to their full potential, and that there is still some way to go to achieve this. Reasons for that are mainly medically-dominated health care systems, including a strong focus on treatment and cure aspects, but also including difficulties in defining roles of health care professionals. Another reason mentioned is the financial aspect that prevents nurses from working to their full potential.

Despite the majority of negative answers to this question, examples of nurse-led initiatives and opportunities for nurses and midwives are provided. Those examples stem from the primary health care sector and include nurses’ and midwives’ work in health promotion, illness prevention and caring for the chronically ill.

An explanation of why nurses don't work to their full potential is provided by the Czech Republic, stating that while legally nurses have the opportunity to work to their full potential, they actually perform a lot of unskilled tasks, and there is an overlap of nurses' and physicians' work that needs to be clarified.

The statement from Sweden points out that today the development of interdisciplinary health care teams is high on the agenda and that the work of nurses and midwives will be even more visible when interdisciplinary approaches are performed successfully.

1.3. What prevents nurses and midwives from doing so at present? What changes have to be addressed and what action has been taken so far?

Several reasons are provided of why nurses and midwives don't work to their full potential. A lack of adequate legislation is identified as the most prevailing reason, including the need for a definition of roles and scope of practice. Another important reason identified is a lack of appropriate education and the educational level on which nursing and midwifery education takes place. The latter is strongly supported by statements from countries that have established academic programmes for nurses and midwives. Another important reason identified is the shortage of nursing personnel that causes a high workload and risks for nurses and patients. In some countries it is not shortage but the decrease of nursing posts that causes problems. Economic problems in countries, including lack of equipment and deteriorating state of health care facilities, as well as problems in nursing management and leadership, were also described as reasons. Finally the existing hierarchy in many health care facilities serves as a reason for preventing nurses and midwives to work to their full potential. Some answers are even more specific about the problems and included the organization of perinatal care and the reimbursement of voluntary caesarean sections as inhibiting factors for midwives to work to their full potential.

Many changes for nurses and midwives practice have taken place and are a constant matter of discussion. Those include the establishment of a centre for science, research and nursing care, an adaptation of legislation to existing practice, negotiations on workload and working conditions, discussions on a programme for continuous professional development, and preparatory work for a national strategy, a national action plan and an ethical code.

Some respondents give valuable hints on a broader level, including the need for nurses and midwives to be prepared for transformations of health care systems, the need for learning and accepting accountability and the need for more nurses and midwives in higher positions in health and social care, which only can be achieved through higher education opportunities.

Extreme differences between nurses and midwives are also stated. In Ireland and Latvia there is recognition of the need to work on the clarification of the role of midwives. From Switzerland it is reported that midwives, as opposed to nurses, may serve as first entry contact into the health care system.

1.4. How widely understood is the contribution that nurses and midwives can make to the health system (e.g. provision of health promotion, care and treatment)?

The answers to this question vary in terms of the perspective from which the contribution is assessed. Many NN/MAs state problems on the political level, while many Ministries of Health state that their perception of public recognition and awareness of nursing and midwifery.

The majority of answers are quite positive, stating that the contribution of nurses and midwives seems to be understood and recognized. Nevertheless there is a call for improvements. Problems occurred with the image of nursing that often still is quite narrow. Public appreciation and understanding for nursing and midwifery is reported from local levels, rural areas and departments of nursing care, where people experience the impact of the nursing and midwifery.

Answers to this question are more different between Ministries of Health and NN/MAs compared to the previous questions. Obviously there is a difference on what counts as a wide understanding of the nursing and midwifery contribution.

1.5. Are nurses and midwives themselves generally aware of their potential?

The majority of answers state that nurses and midwives are aware of their potential, although many limitations and problems are reported. These limitations include economic problems, a low percentage of nurses being organized in professional associations, obstacles to their potential by limited possibilities and lack of legislation.

Academization is considered a factor contributing to a higher self-esteem among nurses and midwives, providing the opportunity to obtain a degree, as well as the opportunity to use research results in practice.

Summary

Many improvements have been made to ensure that nurses and midwives can work to their full potential as independent and interdependent professionals. Legislative frameworks that regulate degrees and/or scope of practice have been developed, and they accounted for improved professional recognition and performance of nurses and midwives. It is obvious that where such initiatives have not been initiated the potential of nurses and midwives remains hidden and cannot fully contribute to health care. Medically-dominated health care systems, lack of financial resources and difficulties in defining the roles of nurses and midwives are the predominant obstacles for nurses and midwives to work to their full potential. Medical dominance is related to health care systems focusing mainly on cure and treatment. Positive examples of nurse-led initiatives stem from the primary care sector, where the contribution of nurses and midwives seems to be more widely understood than on the more abstract national level. Despite considerable improvements there is still some way to go. Appropriate education is mentioned as the key to reaching full potential.

2. Contribute to decision-making at all policy levels

Table 5: Responses on question 3.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
2.1.	43	27	16	26	17
2.2.	37	23	15	25	12
2.3.	42	27	17	27	15
2.4.	42	26	15	28	14
2.5.	41	25	14	26	15

2.1. *How are nurses and midwives acknowledged to be relevant stakeholders at the different levels by government, by national and sub-national health administrations, etc.?*

The answers to this question reveal a rather positive image of nurses' and midwives' involvement in decision-making. However, acknowledgement of nurses and midwives as relevant stakeholders has quite diverse structural implications, and the answers were given from different viewpoints. The strongest position for nurses and midwives is the structural establishment of Government Chief Nurse posts, which is true in some of the countries. This takes place on national, but also on regional level. By this means the nursing and midwifery perspective is most effectively represented, although it has to be kept in mind that in some countries the private sector or third-party players also influence in health care.

The next level of acknowledgement is that of regular representation on national councils, national boards and expert committees. This may take place on regional and local level as well. It is characterized by participating in discussions on health care issues and preparing acts of legislation. The third level is that of being heard or having the right for proposals on legislative acts. Different persons and organizations are involved. In some countries, such as Denmark and Hungary, the professional associations have been successful in establishing good links with decision-makers and are regularly consulted and well-accepted. In others it is more a matter of individual people who, due to their educational and professional background, are considered experts in nursing, but do not necessarily represent the profession in itself.

An important issue is the scope of involvement and acknowledgement as stakeholder. From most countries it is reported that nurses and midwives are basically involved in decisions and processes around nursing and midwifery issues, but not to a large extent in general health care discussions and decisions.

Low acknowledgement as stakeholder and low influence is also reported and occurs in different ways. Two Ministries of Health state that nurses and midwives influence is quite insignificant on general health care issues despite strong efforts, so action has been taken to move nursing forward by establishing a national coordinator and a national strategy group.

2.2. *What is the current nursing and midwifery input into the policy-making decision process on health related issues?*

The answers confirm and specify what has been said under 2.1. Again there is a mixture of structural aspects and content issues. The structural aspects are related to nursing bodies and associations as partners in health care decision-making. Examples include the nursing chamber as partner in health policy, the advisory-only role of nurses outside the decision-making centres, the participation in forums on various health care issues, lobbying activities with different

success and the naming of institutions that have an influence such as directorates of nursing services and departments of nursing services.

In terms of contents a broad range of issues where nurses have an influence were stated including: quality improvement of medical care, planning of nursing actions, family medicine reform, compulsory medical insurance, participation in social care and educational issues, mental health, data collection on nursing, recruitment and retention, and with regard to midwifery prenatal and neonatal screening and preconception.

Further answers indicated that many more activities have been performed and that much work is still in progress. This involves the establishment of regional advisors for midwifery, promoting nursing issues via the media, working on a policy document and its implementation. One statement addresses the fact that in order to be involved in decision-making processes and to be acknowledged as a stakeholder a university education is required.

2.3. *What strategies do nurses and midwives themselves adopt to ensure that they contribute? How do nurses and midwives contribute at each level of policy and decision-making in the country?*

A range of strategies is reported in the answers to this question. They may be summarized under different headings. Strategies aim at strengthening the nursing contribution, making it visible, and searching for institutionalized participation in decision-making.

Efforts on strengthening the nursing contribution include activities for university education for nurses on the one hand, and developing proposals on relevant national health and nursing care issues on the other. Both efforts aim at providing a knowledge base that allows for active participation and sufficient contribution to health care policy. It is acknowledged that research and evidence contribute to a stronger influence.

Making the work of nurses and midwives visible includes the organization of conferences and seminars by which nursing and midwifery issues are disseminated to the public and decision-makers. Publications are also used for dissemination purposes. A second means of making nursing and midwifery visible is active lobbying that occurs via regular meetings with local, regional and national decision-makers.

The search for institutionalized participation starts with regular meetings with decision-makers. Other efforts include constant negotiations on posts such as a government chief nurse, the involvement in national boards and councils and self-regulation.

While these three strategies can be identified the situation in countries is more diverse. While some countries state not to have a particular strategy at all, there is a longstanding history of institutionalized participation in decision-making by different means (United Kingdom).

2.4. *How are the contributions of nurses and midwives received by the relevant authorities at these levels? Are they seen to be taken into account in policy formulation?*

A general pattern in the answers to this question is “the contributions are received, but...”. NN/MAs and Ministries of Health do agree principally that the contributions are welcome, but that there is only limited impact of these contributions in actual policy-making. Some countries state that influence is often a matter of personal relationships between political and professional representatives. On the positive side this indicates success of lobbying activities; on the negative

this is nothing to rely upon in the long run. It may be a good starting point, but it needs to be more institutionalized.

Apart from countries with a well-established structure of participation (Netherlands, United Kingdom) other countries report significant improvements during the last years, as a developing stage or as experience or expertise being attributed to nurses and midwives by politicians.

2.5. *How does the involvement of nurses and midwives in decision-making compare with the involvement of other interests in the health sector?*

There is overall agreement from the National Associations that the medical profession is still by far more influential than the nursing and midwifery profession. Different reasons are stated for that including better education, public perception, traditions and history. Due to the longer professional history of physicians their associations have a stronger organizational structure.

Ministries of Health approach the question a bit more careful by stating that there is growing awareness for the importance of nurses' and midwives' participation, but principally they agree that the medical profession is most influential.

Summary

A range of involvement in decision-making is reported. There is a clear hierarchy of more powerful and less powerful ways of ensuring nurses' and midwives' involvement in decision-making, with having a Government Chief Nurse or a Chief Nursing Officer in the Ministry of Health being the most powerful one. There are various examples of permanent membership in important boards and councils. It has to be taken into account that some countries don't have a centralized political structure which has implications for involvement in decision-making. There is general agreement that appropriate education is a prerequisite for adequate participation, in case of participation in political decision-making, this means a university education with a master's degree or a PhD.

While nurses and midwives quite often are involved in decisions with regard to nursing and midwifery their contribution to general health care decisions remains rather limited. Nurses and midwives use various means to make themselves visible and disseminate their ideas such as conferences, journals, active lobbying and statements. A research and knowledge base serves as a supportive factor in gaining influence.

3. Play a role in public health action and community development

Table 5: Responses on question 3.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
3.1.	44	29	17	28	16
3.2.	41	26	16	25	16
3.3.	44	27	16	27	17

3.1. *What contributions do nurses and midwives make to public health and community development? (e.g. are they contributing to debates on public health priorities at governmental level? Are they contributing to public health programmes at regional and community level?)*

The contributions of nurses and midwives to public health and community development are quite diverse, but the main message is that they do contribute. Only two countries state that there is hardly any contribution. A limited contribution is expressed in a few countries where efforts are underway to implement strategies to ensure more sufficient nursing and/or midwifery input to the public health agenda.

All other countries report significant contributions on the community, regional and national levels with the community level being the most developed. It becomes obvious that nurses and midwives have an increasingly important role where people's health and illness is concerned and where they live and work. Midwives play an important role in supporting women during pregnancy and deliveries, and valuable counselling of mothers and fathers was also mentioned. Broader issues such as women's health and involvement in broader public health issues are, however, still the exception.

The primary health care sector is strongly influenced and shaped by the nursing contribution. The list of activities includes: school health, telephone counselling, outpatient clinics, health centres, screening for risk populations, parent education, immunization, alcohol and tobacco prevention, prevention of domestic violence, providing knowledge on health related issues, health promotion, promoting healthy lifestyles, palliative care, elderly care, prevention of sexually transmitted diseases and allergies. Another important issue is the contribution to caring for the chronically ill and care dependant people in long-term care facilities and home care. In this area there is also a considerable influence on the different levels in decision-making.

Involvement in planning of health care priorities is not the rule for the nursing and midwifery professions. It occurs more on community and regional level than on national level. Again the big exception is the situation in the United Kingdom, where a range of measures have been implemented to ensure a nursing and midwifery contribution on all aspects of health care.

3.2. *Do nurses and midwives receive any specific training in public health and public health policy? If so, how is it structured? If not, what changes in their education and training are required or would be desirable to enhance their public health activity work?*

In most countries public health is part of the initial nursing education. The judgement varies if the amount is sufficient or not. Only two countries report that there is no training. Beside integration into the basic curriculum public health is taught in refresher courses or courses of

continuing education. Bachelor's and master's degree programmes on public health are available or are in the process of being developed in many countries.

The situation of continuing education is diverse. While it is an obligatory part of professional practice in some countries it is just a voluntary option in others. Diversity is present in the development of public health programmes, too. In some countries there are special public health courses for nurses and midwives, while in others there are general public health study programmes at universities or other institutions for higher education and nurses and midwives are free to enrol for such a programme, if they fulfil the prerequisites.

3.3. What legislation or other measures are required to establish/consolidate a public health and community-oriented role for nurses and midwives?

Many countries report that there is no need for further legislation or other measures as they are already in place. Having legislation in place does not guarantee a public health role for nurses and midwives. Problems in actualising the legislative framework are reported.

Some countries still face enormous difficulties as far as a legislative framework is concerned. A definition and clarification of the role of nurses in general is needed and the public health aspect should be part of it. But the main problem is having a legislative background for nursing and midwifery in general.

An interesting aspect is the fact that even where appropriate legislation is in place, problems in implementation may be caused by funding. Practice is often influenced by funding policies and priorities. If there is a legal basis for nurses and midwives to act upon public health issues, they may be prevented from doing so because of not being reimbursed for it.

In addition to legislative changes some countries report other aspects such as reinstatement of a department of nursing at the Ministry of Health or other ways of institutionalized representation.

Summary

The contributions of nurses and midwives to public health are most visible on the community level. The broad range of activities reported does not imply that nurses and midwives contribute in all countries, but gives evidence of how they can shape the public health agenda. Inclusion of public health in the basic nursing and midwifery curriculum has become more a rule than an exception. Contributions are limited due to financial resources, particularly reimbursement policies for health care services.

4. Provide family-focused community programmes and services

Table 6: Responses on question 4.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
4.1.	44	28	17	27	17
4.2.	17	13	8	11	6

4.1. *Are there any family-focused community programmes or services established? Where are they based and how are they structured?*

Almost all countries report family-focused community programmes. The only exception is Malta, where those programmes are not known. Examples include nursing care centres, polio clinics, schools with programmes for reproductive health for teenagers, alcohol and tobacco prevention, family midwives, health visits to children and the elderly, primary health care centres in cities and rural areas, models with one nurse for a given population of 2000 inhabitants, programmes for HIV prevention, Sure Start programme and national programmes “for a healthy generation”. Most of these examples are community-based, some are part of a national strategy and others stem from private or NGO-initiatives. These programmes were established as interdisciplinary and/or mono-disciplinary programmes. While in some countries the establishment is just underway, others have a long-standing history of more than several decades (e.g., Sweden).

4.2. *If none, what are the reasons that no programmes and services have been established?*

There are only very few answers to this question. The prevailing reason for the non-establishment of family-focused programmes is lack of adequate financial resources. This may be due to overall scarce resources or it may be a question of priority-setting. The answers were not very clear on that. From two countries it is reported that the midwifery profession is not adequately recognized and therefore cannot develop family-focused programmes. A final reason is that “visiting service” as such are not a part of the health care system, and their implementation would require a fundamental system change.

Summary

Similar to the answers in category three, a range of activities has been reported at the community level. The examples provided may serve as tools for initiatives in other countries. The ongoing multi-national study on the WHO Family Health Nurse is expected to provide a stronger knowledge base for the implementation of family-focused community programmes.

5. Health systems conditions

The Government and WHO provide the right health system conditions: Legislative and regulatory frameworks

Table 7: Responses from question 5.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
5.1.	39	25	14	24	15
5.2.	39	24	13	24	15

5.1. *What frameworks are currently in place at all levels of the health system and are they sufficient according to the Munich Declaration?*

Answers to this question vary more than others between answers from Ministries of Health and NN/MAs which indicate that there are different opinions and perspectives. The frameworks include general nursing or midwifery acts, general health care acts, acts on insurance, national action plans, compilations of different acts, consumer-protection legislation, acts on standards and practice, regulation on titles, competencies, ethics and teachers qualification. Some countries report that their legislative frameworks are sufficient to implement the Declaration.

Problems are reported on the implementation of the Family Health Nurse and the independent status of nurses and midwives, and there is work to be done to ensure participation in decision-making on all levels.

Frameworks on education have a strong focus on higher education opportunities for nurses, particularly in nursing management and nursing education. Plans on educational reforms should consider the Bologna Process of mutual recognition of diplomas and degrees. Academization in midwifery is reported as an imported issue. Apart from where this is already established, not very much is happening.

5.2. *Have the existing national legislative and regulatory frameworks been reviewed in the light of the recommendations of the Declaration? Are there any plans for action on that and if so, what are the anticipated time-scales?*

This is only true for some of the countries. Those that report a sufficient legislative framework to question 5.1 did not review the existing legislation in the light of the Declaration. Some countries report reforms due to regular review of existing legislation that considered the Declaration. Other reforms within regular reviews have not considered the Declaration at all. Apparently in western Europe reforms have taken place in the eighties and nineties and therefore the need for new amendments and changes due to the Declaration was not existent.

The new EU member states in particular have reviewed their legislation, as they actually were required to do so. Within these review processes the main focus was on adapting existing legislation to EU recommendations and EU legislation, which concerned all areas of health care and not only nursing. In some instances the Declaration was used for this process as well.

The biggest influence is to be found in eastern European countries such as Belarus, Republic of Moldova, Croatia, Armenia and Uzbekistan, where existing legislation has been reviewed and reforms were undertaken with regard to the Declaration

Summary

With regard to legislative and regulatory frameworks there is a border between EU and new EU countries on the one hand and non-EU countries on the other. Reforms were and are underway in all parts of the Region, but while the Declaration had an impact in the non-EU part of the Region, the impact is reported as rather low in the EU part, where different legislative frameworks had to be adapted according to EU regulation.

6. Obstacles

Obstacles, such as those relating to gender and status issues

Table 8: Responses from question 6.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
6.1.	43	28	16	26	17
6.2.	43	27	16	26	17
6.3.	43	27	16	26	17
6.4.	43	27	16	26	17
6.5.	43	27	16	27	16

6.1. Is there a national recruitment and retention policy in place? Is it gender-sensitive?

Although there are some countries that have a recruitment and retention strategy in place for the majority that is not a big issue. Where a strategy has been developed the information provided is quite limited. Beside structured recruitment strategies some countries refer to image campaigns for nursing and midwifery, meaning that a sufficient amount of applicants is sought inside the country by stressing career prospects within nursing and midwifery. Another strategy concerns the retention of older workers in the workforce or the comeback of women after child-rearing. The provision of adequate educational capacity is considered a prerequisite for successful recruitment and campaigning. Where strategies exist, a minority of countries state that they are gender-sensitive. Associations are quite active in initiating campaigns and strategies and linking them with improving working conditions.

The issue of recruitment and retention is not an issue of national policy everywhere. In countries with a federal system, recruitment and retention is the responsibility of the federal entities. In other instances they are the responsibility of the health care institutions themselves.

Increasing awareness on the matter is reported as discussions are underway of implementing a recruitment and retention strategy. General economic conditions have an impact on the retention of nurses and midwives. Poor economic conditions cause migration of workers. In one instance unemployment of nurses is the problem.

6.2. Do recruitment policies of other countries have an impact on the situation of nurses and midwives, such as the effect of western Europe attracting nurses from eastern European countries?

In the broad perspective this does not seem to be a problem. Countries report insignificant numbers of nurses that move across borders. In border regions numbers are slightly bigger. Countries that accessed the EU in 2004 express some concern, but it is not yet clear if there is an impact.

A real problem exists for the Republic of Moldova due to the general economic conditions, reporting the problem of preparing qualified nurses who then work abroad. Only a few countries discuss ethical aspects of attracting nurses from other countries. The United Kingdom and the Netherlands report more incoming than outgoing staff due to the comparably good working conditions. A problem for English-speaking countries is migration to the United States and Australia. Recruitment takes place not only within the Europe but also from the Philippines and India.

6.3. *What is the public perception of nurses and midwives in the country? Does it appear to be changing? Have any activities been initiated to promote nursing and midwifery?*

The overall perception of nurses and midwives is reported to be positive. Many countries report an increasingly better image of the nursing profession. The work of NN/MAs is often stated as the main driving factor for the better image. Another reason mentioned is the academization of nursing, which results in higher positions and better public perception.

Despite increases in public perception questions of status and better working conditions remain unresolved. There is no apparent connection between improved working conditions from increased positive perception. Interestingly some countries report recent studies on social trust of the population towards professions. Nurses were always reported to be the most trusted professionals.

There are reports of a few instances of negative perceptions, such as the old stereotyped view of nurses as doctors' assistants. Another negative aspect is the public's lack of awareness of the role of nurses and midwives. Concerning midwives, the problem of public perception is reported to be serious in Ireland and Latvia, given that midwifery is not formally recognized as an independent profession in those countries.

6.4. *What is the approximate ratio between women and men: (a) within the nursing profession and (b) within the health care system as a whole? Are these now changing? If so, what might this indicate?*

The answer to this question is not surprising. In most of the countries the ratio between women and men is 90:10 or higher. Other countries' ratios are between 85:15 and 70:30 women to men. The only exception is Malta with 66:33 women to men. In midwifery the percentage of men is below 1%, where there are any. The only exception is the Netherlands with 2% men.

Numbers are different for the health care system as a whole, although the majority clearly is female in all countries. Even figures for physicians that are provided by some countries show an increase in women entering the medical profession.

Some countries mention the fact that where the percentage of men increases in higher positions. Better educational, development and salary opportunities are seen as a means of attracting more men. On the other hand, attracting more men is seen as a means of improving payment, education and working conditions.

6.5. *What opportunities do nurses and midwives have to be heard in public debate on policy issues outside their own defined professional boundaries?*

The main focus of answers on this question is on the professional associations and unions as the voice and advocates for nursing and midwifery. Many countries state that nothing prevents nurses and midwives from participating in public debates and raising their voice, and they have the same rights as other citizens. Often they are not used to doing this. Within the public media the focus traditionally is more on medical aspects of the health care system. A change could be identified in many countries where nurses actively started to develop ideas and promoted their own work and contribution to the society's agenda.

On a more institutionalized level, capacity for development is seen in regular consulting of nurses and midwives on health care, social care and general policy issues in the community.

Summary

There is no overall predominant tendency of obstacles for nurses and midwives. However, because of nursing and midwifery being female professions they have to face problems of low payment and low public recognition that go along with it. Gender-sensitive recruitment and retention strategies seem to be the exception. Migration does not seem to be a big issue at the time being, but financial aspects have an influence on migration from poorer countries to others where financial prospects are better.

The public perception of nurses and midwives is very good, but this does not result in better working conditions and more influence. There are no structural boundaries for opportunities outside the professional scope and nurses and midwives in some countries managed successfully to be heard within the public media.

7. Knowledge and evidence base

Strengthened knowledge/evidence base for nursing and midwifery practice

Table 9: Responses from question 7.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
7.1.	45	28	17	28	17
7.2.	42	26	15	27	15
7.3.	32	21	14	19	13
7.4.	42	26	15	25	17
7.5.	41	25	14	24	17
7.6.	38	25	15	23	15

7.1. *Is there a national nursing and midwifery research strategy? What institutions exist to support nursing and midwifery research?*

A national nursing research strategy is the exception in countries. Such a strategy exists in Ireland, the Netherlands, England, Northern Ireland and Scotland. A midwifery research strategy was not reported, although it is being prepared in the Netherlands and midwifery research being integrated part of the United Kingdom's health research strategy. In Denmark and Norway the national nursing associations work on the implementation of a national strategy for nursing research. In other countries associations actively promote research initiatives. In some countries nursing research is part of a general research strategy in health care.

The lack of strategies, however, does not mean that research in nursing and midwifery does not take place. The opposite is revealed by the answers. Universities, universities of applied sciences, nursing research departments in hospitals and other health care institutions can be found in many parts of the Region. The lowest level of research is that of small empirical studies for getting master's degrees, followed by PhD dissertations. The institutions mentioned above initiate their own research by using regular university or governmental funds or by being funded by foundations and other donors.

Other countries report no particular nursing research initiatives, but opportunities for nurses to participate in health care research in medical academies or national institutes of health, given they meet the requirements for doing research. A need for further action is reported from countries that have no research institutions for nursing at all and from those, where there is no focus on nursing and midwifery research at all.

7.2. *Do nurses and midwives have the opportunity to study for research-based degrees in their field of practice or are such opportunities only available in other subject areas, such as education or psychology or do nurses and midwives have to go outside the country in order to pursue research training and careers? What research questions are research students interested in; are they building the foundations of knowledge?*

Within the old and new EU countries that answered this question there is only Slovenia, where such opportunities do not exist. Opportunities are available in Norway, Switzerland, the Russian Federation and Uzbekistan, while in the other countries that are not members in the EU opportunities for research-based degrees in the field of nursing and midwifery are nonexistent. In one instance WHO support is requested, explicitly stressing the need for nursing research.

Where the opportunity for research-based degrees exists, research questions are extremely diverse as can be seen by the following list. It is reported that research undertaken contributes to

generating evidence on nursing and midwifery. Nevertheless, the building of research networks on particular areas of interest is still in the initial stage.

Midwifery research issues are: dystocia, ultrasound scans, informed choice, obesity and pregnancy, effectiveness of midwifery in primary care, growing need for pain relief and whether or not the introduction of improvements in midwifery care leads to improved knowledge and skills.

Nursing research issues are: developmental work, clinical nursing, practice-related subjects, neurobiology, multiple organ dysfunction, lived experience of chronically ill, ethical codes, cancer nursing, infection control, nursing diagnoses, quality of life, health education, caregivers experiences, outcomes following nursing and midwifery interventions, nursing administration, quality of nursing care, evidence-based nursing, dementia care and nursing knowledge.

7.3. If nursing research facilities do not yet exist, are there any links with other countries that do provide research training, or with other professional groups within the country for the purpose of developing research capacity?

The answers to this question were rather poor. Mostly these links do not exist. Different kinds of partnerships have been established that may be helpful in developing research capacity. Organizations for partnerships include the Workgroup of European Nurse Researchers (WENR), the International Council of Nurses (ICN), Sigma Theta Tau International and membership in the European Nurses' Early Exit Study (NEXT). Beside this examples of joint research projects between Baltic and Scandinavian countries were provided. Finally it is mentioned that universities usually link with other universities and there were some examples where this occurred in nursing related subjects.

7.4. How are research results disseminated in the country? Are there journals for the dissemination of research results?

The predominant way of dissemination is publishing articles in journals. Journals are of varying quality and varying numbers of adequate publications are available. Professional journals are available in many countries. Peer-reviewed nursing and midwifery journals are available in less than half of the countries. Some countries even have different peer-reviewed journals on particular areas of interest. One instance of a scientific journal that reserves two volumes per year for nursing research is reported. Written forms of dissemination include textbooks, monographs, complete research reports, newsletters and the inclusion of research results into clinical guidelines.

The second way of dissemination used almost all over the Region is the presentation at conferences or seminars. This also includes dissemination during courses for continuing education. Organizations such as WHO and ICN are mentioned as main disseminators of research. The Internet is mentioned as a new source of information and getting access to research results. Only one instance of appearance in the public media is reported.

7.5. Is there a government level of funding available for nursing research? Is it coming from government or from private sources, nongovernmental organizations or commercial companies?

There are still many countries where governmental funding for nursing research is not available. Mostly this results in no funds at all for nursing and midwifery research. On the other hand quite a lot of countries have general funds for research or health care research, and nurses and

midwives are free to apply for these grants. This is not often accessed due to lack of information on the funding and lack of an adequate number of nurses and midwives with the appropriate knowledge and skills to write research proposals.

In other countries there are funds available explicitly for nursing research (this is not true for midwifery). Usually those funds have a particular focus, such as long-term care, nursing education or quality of care. Only limited evidence of general nursing research funds has been reported. In addition to governmental funding many foundations are active in inviting grant applications from nurses on various subjects.

7.6. *Are there plans or measures established for the evaluation of nursing and midwifery services? If so, could you give examples?*

Only a few countries report regular evaluation of nursing and midwifery services, but where they are done they are usually based on previously defined indicators. Evaluation may include patient views and patient satisfaction on the one hand and professional performance on the other.

There is growing awareness that evaluation of nursing and midwifery services needs to be developed. The discussions take place on very different levels, starting with nurses being concerned about documentation of their own actions to make themselves visible to governmental discussions on appropriate indicators that might serve for adequate evaluation of services.

Some countries have developed standards and guidelines for nursing and midwifery for ensuring quality of services. When there are no formal evaluation standards, guidelines may serve as means of defining a desired level of quality.

Summary

Similar to the area of basic education a lot is happening with regard to building a knowledge/evidence base for nursing and midwifery. Although national research strategies are still the exception, many examples of nurses and midwives conducting own research projects or participating in interdisciplinary research are reported. The state of nursing and midwifery research is closely related to options for study programmes with a nursing and midwifery focus. Governmental funds for research are only available in some countries. In general research funds are limited, if existing at all. Links with other professional groups do exist such as WENR, ICN and Sigma Theta Tau International. All countries report opportunities of disseminating research results via professional journals. The evaluation of nursing services seems too be in the very beginning. Where it occurs it is usually done according to predefined indicators.

8. Initial and continuing education and higher education

Table 10: Responses from question 8.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
8.1.	44	27	16	27	17
8.2.	40	26	15	26	14
8.3.	39	25	14	23	16
8.4.	38	25	15	24	14
8.5.	40	25	14	24	16

8.1. *Have university departments/faculties/schools been established to provide the full range of professional education for nurses and midwives (pre-registration, post basic, continuing education, master's and PhD level)? How do such departments fit in within the national educational and health care system?*

The answers to this question are not always clear. Except in the case of Slovenia, all countries reply positively to the existence of the full range of professional education. However, the answers reveal quite strong differences in so far as it is not always clear whether nursing and midwifery education really fits into the national educational system. For some countries this is definitely true, while others have special educational offers for nurses and midwives, particularly in the area of continuing education.

The answers are mostly related to initial and continuing education, and it may be assumed that the full range of academic degrees is not available. This is especially true for the master's degree and the PhD. For midwives the situation seems worse than for nurses, as midwifery degrees are a real exception.

Educational systems vary and so do options for nurses and midwives. This may be highlighted from options for continuing education. While in some countries the whole range from specialization, higher qualification, updating courses and special interest courses is available, other countries spend their resources on priority areas such as family health nursing. Continuing education is only to a limited extent subject to receiving degrees. Depending on the national educational system, universities offer nursing and midwifery programmes mainly on their own initiative or due to national priorities.

8.2. *Were any of the above educational programmes in place prior to the Munich Declaration?*

Most of the programmes were in place prior to the Declaration. In countries where recent reforms have taken place the influence of the Declaration has not been stated. Reforms were more a matter of general considerations within the educational or health care system. Recent reforms without regard to Munich have taken place in Denmark, Germany, Ireland, the Netherlands, and Lithuania. The former Yugoslav Republic of Macedonia and the Republic of Moldova state that none of the educational programmes that exist now have been in place prior to Munich. In these two instances an influence of the Declaration may be assumed.

8.3. *What steps have been taken since the Munich Conference to meet the terms and spirit of the Declaration regarding: post secondary school/undergraduate (initial) education? higher education? continuing education?*

Despite the fact that many steps in the area of education have been taken (adoption of curricula, raising qualification level for teachers of nursing, more opportunities for continuing education),

most countries report only limited impact of the Declaration on these processes. Particularly the EU accession countries had to different reforms that do not contradict the Declaration, but rather are initiated by EU requirements and aimed at harmonization with existing EU regulation. In the area of education the Bologna Process and its requirements also had a significant impact.

Countries where reforms have actually been initiated on the basis of the Declaration such as Belarus, Latvia, Moldova, The former Yugoslav Republic of Macedonia and Uzbekistan report several achievements, such as making public health nursing a national priority, introducing university-level education, developing and implementing educational standards and developing programmes of initial and continuing education. In one instance a discontinuation of this process due to a change in the Ministry of Health is reported

8.4. In your judgement (and on what grounds) do you see a satisfactory take-up of places for these programmes and successful completion of programmes?

The overall answer to this question is a clear “yes”. In most countries take-up of the places and completion of the programme is successfully. Limited evidence shows higher demand than supply of places. However, some countries state that it is too early for evaluating the effects and for evaluating sufficient numbers on participation and completion of new educational programmes. A lack of practical learning opportunities was expressed as a concern for future development.

In countries where programmes have been recently established there is an expectation of improving the quality of nursing care by having better prepared nurses from these new programmes.

8.5. In your judgment (and on what grounds) will the health sector’s needs for university-educated nurses and midwives be met? What proportion of nurses and midwives should be educated to this level? What are the current proportions?

There is no clear indication that the health sector’s needs will be met. Very different numbers are provided for estimating the numbers of university-educated nurses to be achieved. Some countries aim at an all-graduate nursing workforce, meaning that all nursing education takes place at universities. Some countries already achieved this level. Other countries do explicitly reject the idea of all nurses having university degrees. What they have in mind is a particular proportion of nurses with a master’s degree or PhD or the respective highest degree the educational system of the country has to offer. Numbers to be achieved vary from 5% to 30% with most statements in favour of 5% to 10%. Reality reveals actual figures of nurses with a master’s degree and/or PhD of less than 1% to 3%. Nevertheless there is the optimistic expectation that a sufficient percentage will be achieved the near future, because most academic programmes have been implemented just recently. Slovenia is the only country where they estimate to develop a proportion of 20 master’s degree-prepared nurses for every 100 000 of the population.

Summary

Reforms in nursing and midwifery education have been undertaken in many countries during the past years, although only some of these reforms were initiated because of the Declaration. The full range of professional education for nurses and midwives is an exception, but many options for continuous professional development are offered in countries. There is no shared understanding of the health sector’s need for university prepared nurses and midwives, but most statements refer to a number of 5–10% of nurses with master’s degrees and PhDs.

9. Joint learning opportunities

Opportunities for nurses, midwives, and physicians to learn together

Table 10: Responses to question 9.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
9.1.	44	27	15	26	18
9.2.	40	26	15	24	16

9.1. *Are there any existing opportunities to learn together in the country? If so, at what educational level and with what scope or focus?*

Most countries actually report various existing opportunities for joint learning. Most of these opportunities take place at post-graduate level, either in master's or PhD programmes or within different types of continuing education. Joint learning at this level is more facilitated by the educational sector in general than a matter of health care. Continuing education is often located within health-care facilities and it needs to be distinguished between obligatory and voluntary participation. Conferences on various topics are also mentioned as good opportunities for joint learning.

Joint education between nurses, midwives, and physicians within the initial education is a rare phenomenon. There are hardly any statements on structured opportunities. It is more a matter of interdisciplinary health care facilities where students from all disciplines come and work together and therefore joint learning opportunities are offered. Despite the lack of formalized opportunities there seem to be an increasing number of initiatives and experiences in practice settings reflecting the need and the commitment of health care professionals.

Particular practice areas are mentioned as locations where joint learning and interdisciplinary working takes place including: psychiatry, paediatrics, neonatal care, family medicine, palliative care and geriatric departments.

In the area of quality and assurance, several opportunities have been reported. The same is true for health care management positions. The opportunities in these areas may be part of a national strategy or may be due to institutional requirements on the qualification of applicants for particular posts.

Although many countries have reported positive examples and initiatives it has to be stressed that not in all countries such opportunities exist. This is true for Armenia and The former Yugoslav Republic of Macedonia.

9.2. *Has any difference in entry requirements for nursing, midwifery and medical training been an obstacle or a reason for not pursuing joint learning possibilities?*

The majority of countries state "no" to this question. The fact that most of joint learning opportunities are located in institutions of higher education implies that entry requirements are according to the educational system, no matter the individual professional background.

It is also a fact that initial medical and initial nursing and midwifery education takes place at different educational levels in most, if not all countries. This implies structural limitations for joint learning.

In addition the lack of adequate programmes, different funding procedures for nursing and medical schools, historical developments and the search of professional disciplines for having their own faculties and programmes do all limit opportunities for joint learning.

Summary

Joint learning possibilities are an exception and occur at post-graduate level or at clinical sites where nurses and midwives work together with physicians. As in other areas the educational level is the key for progress in this area.

10. Partnership with all relevant bodies

Table 12: Responses to question 10.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
10.1.	42	26	16	26	16
10.2.	42	26	16	26	16
10.3.	38	24	15	25	13
10.4.	36	26	15	22	14

10.1. What partnerships have been established with the relevant ministries and other bodies (statutory and nongovernmental, within the country and internationally) and for what particular purpose?

Partnerships have been established in all countries. The most common ones were national partnerships between Ministries and professional associations. Usually Ministries of Health and Ministries of Education were involved, sometimes Ministries of Labour and Social Issues. Purposes of these partnerships were twofold. On the one hand they had a particular focus such as developing or reviewing educational programmes and standards with the aim of improving nursing and midwifery education and practice, or negotiating working conditions. Other countries have set up these partnerships to institutionalize exchange and discussion of shared interests. General concerns about the quality of care or public health policy debates promote the establishment of these gatherings. They may occur on a permanent basis or within a limited time frame.

Partnerships between different professional associations or chambers are another form of partnerships. They mainly serve the purpose of exchanging ideas and developing joint activities that will be promoted together.

International partnerships also include a range of different ways. Membership in international organizations is mentioned as one. Organizations include ICN, International Confederation of Midwives (ICM), European Midwives Association (EMA), European Forum of National Nursing and Midwifery Associations (EFNNMA) and the Standing Committee of Nurses of the EU (PCN). Partnerships occur related to different projects, e.g. under the auspices of the United Nations Children's Fund on child health and development.

Especially in some eastern European countries partnerships include projects that have been initiated externally or are funded externally, and they are usually related to some kind of developmental work on a particular area, often strengthening nursing and midwifery. Partnerships in this area have been established with different organizations within and without the United Nations system including nongovernmental organizations from the United States of America or Japan. They also occurred as bilateral projects between two countries.

10.2. Have any partnerships been established by nurses and midwives themselves?

Many of the above mentioned partnerships have been initiated and established by nurses and midwives. The associations mostly took a proactive approach in initiating partnerships.

10.3. Have any twinning projects been implemented? If so, in what fields and for what purpose?

The question was not clear to many respondents. Twinning between two countries was mentioned only a few times. Existing examples include twinning between the Danish Nurses Organization (DNO) and the Lithuanian Nurses Organization, the DNO and Kyrgyzstan on the Family Health Nurse, the Royal College of Midwives and Romania (in preparatory stage), the Royal College of Nursing, Yorkshire region with the Krakow region of the Polish Nurses Association.

10.4. Has the necessary information been made widely available as to which potential internal and external partners would be useful, proactive and available to provide information, advice and other forms of support?

Also on this question it was not quite clear what information exactly was asked for. Some countries simply state a 'no' while others refer to information provided on websites, via professional journals, booklets, textbooks. It is referred to information material from WHO as well as material from Ministries of Health and NN/MAs.

Summary

A range of national and international partnerships has been reported, but they were derived from a different understanding of partnerships. They included formalized agreements of working together on particular issues on the one hand and being a member of international organizations on the other. NN/MAs have been proactive in developing partnerships. Twinning arrangements between countries were an exception.

11. Workforce planning strategies

Table 13: Responses to question 11.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
11.1.	41	26	15	24	17
11.2.	40	27	16	24	16
11.3.	40	25	13	23	17
11.4.	42	24	13	26	16
11.5.	37	25	14	23	14
11.6.	30	19	11	17	13
11.7.	36	23	14	22	14

11.1. How many trained nurses and midwives there are in the country?

Some countries do not have data on questions 11.1 and 11.2. Nevertheless many numbers have been provided, which are presented in the table below. Sometimes numbers from Ministries of Health and National Associations differed. If there was a considerable difference, both numbers are provided. If different sources were stated, the most recent one is presented below.

Table 14: Numbers of trained nurses and midwives.

Countries	Number of nurses	Source/Comments	Number of midwives	Source/Comments
Armenia		Ministry of Health: only data of current workforce available		
Belarus	71 926	NNA, National Midwives Association (NMidA)		
Croatia	30 000	Ministry of Health: 20 000 second level/ 10 000 first level nurses	3 000	NNA
Czech Republic	82 890	Ministry of Health	4 420	Ministry of Health
Denmark	52 597	Members of NNA, constitute 96% of all		
Georgia	27 000	NNA		
Germany		not known, because of no registration	17 000	NMidA
Greece	25 000	Ministry of Health	4 000	Ministry of Health
Hungary				
Ireland	59 000	NNA		
Israel	35 000	Ministry of Health	1 500	Ministry of Health
Lithuania	22 280	NNA: nurses and midwives		
Latvia	17 612	Ministry of Health, data from January 2004	755	Ministry of Health
Malta	5 000	Ministry of Health, NNA states 3 500	365	Ministry of Health
Netherlands	222 000	NNA, NMidA states 226 000	2 835	NMidA, NNA states 2 700
Norway				
Poland	180 000	Ministry of Health	22 000	Ministry of Health
Republic of Moldova	16 805	NNA: 6 578 Higher category, 5 489 1st category; 4 738 2nd category		
Russian Federation				
Slovakia	40 000	NNA, estimated	1 800	NNA, estimated
Slovenia	3 408	Ministry of Health	120	Ministry of Health
Sweden	117 854	Ministry of Health and NNA	7 777	Ministry of Health and NNA
Switzerland	110 000	NNA estimation 100 000–120 000		
The former Yugoslav Republic of Macedonia				
Turkey		Ministry of Health: 79 nursing and 30 midwifery schools		
United Kingdom	550 000	NNA	27 000	NMidA, 47 000 educated
UK-England				
UK-Northern Ireland	20 968	Ministry of Health	1 265	Ministry of Health
UK-Scotland	54 572	Ministry of Health: Nurses and midwives		
Uzbekistan		Ministry of Health: workforce planning strategies in progress		

11.2. *How many nurses and midwives constitute the current workforce?*

For a better overview the answers to this question are also provided in a table. The general remarks on the numbers from question 11.1 apply to the numbers here, too.

Table 15: Current workforce of nurses and midwives.

Countries	Number of nurses	Source/Comments	Number of midwives	Source/Comments
Armenia	9 741	Ministry of Health	1 023	Ministry of Health
Belarus		all work		
Croatia	28 000	Ministry of Health		
Czech Republic	80 724	Ministry of Health: data from 31 December 2003	4 387	Ministry of Health
Denmark	73 645	NNA-Members, who constitute 96% of all	1 400	NMidA
Georgia	27 000	NNA		
Germany	790 000	Ministry of Health: whole-time equivalents, and/or appr. 70 000 nursing assistants	10 000	Ministry of Health, NMidA states 14 000–15 000
Greece	20 000	Ministry of Health	3 850	Ministry of Health
Hungary				
Ireland	60 000	Ministry of Health: data from 2002, NNA states 40.000	2 500	Ministry of Health
Israel	35 000	Ministry of Health	1 500	Ministry of Health
Lithuania	22 280	NNA: nurses and midwives		
Latvia	13 009	Ministry of Health: data from January 2004	548	Ministry of Health, data from Jan 2004
Malta	2 050	Ministry of Health: data from 2004	130	Ministry of Health, data from 2004
Netherlands	222 000	NNA	1 825	NMidA
Norway	60 000	NNA		
Poland	188 507	NNA, Ministry of Health states 90% of those stated under 11.1	22 272	NNA, Ministry of Health states 90% of those under 11.1.
Republic of Moldova	24 460	NNA		
Russian Federation				
Slovakia	37 265	NNA	1 500	NNA
Slovenia	3 408	Ministry of Health	120	Ministry of Health
Sweden	98 960	Ministry of Health	7 126	Ministry of Health
Switzerland	59 833	Ministry of Health, according to Census 2000	2 033	Ministry of Health, Census 2000
The former Yugoslav Republic of Macedonia	7 000	NNA, in addition 2 400 unemployed		NNA
Turkey	75 879	Ministry of Health	41 158	Ministry of Health
United Kindgom	550 000	NNA	27 000	NMidA
Uzbekistan	256 182	Ministry of Health		

11.3. According to estimates, how many nurses and midwives are needed currently and in the future in the health care system?

Answers to this question were given from different perspectives. While some countries refer to vacant nursing posts others based their answer on prospective assessments. Specific numbers were the exception and when they were given they were related to needs per year or general needs. A more detailed figure is given in the table below.

Table 16: Need for nurses and midwives in the future

Countries	Number of nurses	Source/Comments	Number of midwives	Source/Comments
Armenia		Ministry of Health: no need		
Belarus		NNA: need is decreasing		
Croatia		Sufficient capacity		
Czech Republic		Sufficient capacity		
Denmark	1 000	NNA, according to recent study, greater need in the future	100	NMidA: immediate need
Georgia				
Germany		Ministry of Health; NNA; NMidA: Need is recognized, but not quantified		
Greece	50 000	Ministry of Health	1 000	Ministry of Health
Hungary				
Ireland	675	Vacancies, according to Ministry of Health, need of 1 000 according to NNA		
Israel		Ministry of Health: no major changes expected		
Lithuania		NNA: no national workforce planning strategy		
Latvia	250–300	Per year according to Ministry of Health and NNA		
Malta		Ministry of Health: difficult to assess		
Netherlands		NNA: 7%, but only 2% expected		NMidA: a study is in progress
Norway		NNA: impossible to predict, but shortage is acknowledged		
Poland		Ministry of Health: workforce in line with need		
Republic of Moldova	1 500	NNA: greater need in the future		
Russian Federation				
Slovakia				
Slovenia	250	Per year, Ministry of Health		Ministry of Health: in line with need
Sweden		Ministry of Health, right now quite balanced, but greater need expected		
Switzerland				
The former Yugoslav Republic of Macedonia				
Turkey		225 000 nurses and 123 000 midwives are needed		
United Kingdom	50 000	NNA	10 000	NMidA
UK-England				
UK-Northern Ireland				
UK-Scotland	5 000	Ministry of Health		
Uzbekistan		Ministry of Health: 3%		

11.4. *Is there a workforce policy based on explicit assumptions about future needs?*

11.5. *Is there a workforce planning strategy in the country?*

Because many countries gave their answers to these two questions in a similar way, the answers are summarized together. In general there are not many countries that have a particular workforce policy or workforce planning strategy in place. Where there is such a policy it is based on estimations of future health care needs of the population and the capacity of educational opportunities for nurses and midwives.

Workforce policies and strategies are mentioned that have been developed between Ministries of Education, Ministries of Labour and Ministries of Health. Nursing and midwifery are part of broader workforce policies.

The constitutions of particular countries do not allow for national strategies, but have regional or state responsibilities for that. The need for workforce planning seems to be recognized as there are some countries in which a planning process is under way, studies are undertaken and a search for appropriate mechanisms has been started.

11.6. Are there any problems with workforce planning strategies?

The answers on problems with workforce planning strategies have been quite detailed. Four different aspects have been stated:

- lack of financial resources to develop and implement workforce planning strategies;
- overall lack of sufficient data on future needs and developments, and without sufficient data and information an appropriate strategy cannot be developed;
- difficulty predicting future health care needs of the population, in particular needs for nursing care), and no agreed upon assessment of what constitutes the need for nursing care; and
- difficulty assessing long-term needs in a constantly changing health care environment.

11.7. Are policies and programmes established which ensure healthy workplaces and quality of the work environment for nurses and midwives?

Almost all countries report policies and programmes that ensure healthy workplaces and quality of the work environment. Mostly these programmes are part of a general occupational health policy that applies to people in the workforce. For the health care sector often particular programmes are in place, e.g. monitoring of risk factors and prevention of needle-stick injuries. While these programmes have a longstanding history in some countries, they are recent developments in others.

Summary

Despite some contradictions in the numbers provided it can be stated that within the countries that responded to the questionnaire 2.9 million nurses and midwives constitute the current workforce. Only in few countries a targeted workforce strategy has been implemented. Unlike other areas here the reasons are more or less the same across the Region: lack of data, lack of assessment of future needs for nursing care and financial limitations.

12. Fair rewards, recognition and opportunities for career advancement

Table 17: Responses to question 12.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
12.1.	44	28	17	26	18
12.2.	42	27	16	25	17
12.3.	42	26	15	26	16

12.1. *What is the salary of nurses and midwives in relation to other professions and the national average wage (where known)? What has been the trend over the past five years?*

It is nearly impossible to summarize the answers on this question in a reasonable way. This is due to very diverse levels of the answers. Some countries provide absolute figures in US\$, Euro, British Pounds and local currencies. These figures stretch between salaries of US\$ 20 and £ 2800 per month depending on employment status, position and national economic situation.

Even when considering answers on the comparison between the salary of nurses and midwives and average national salaries, the situation remains very diverse. There are many examples of nurses' and midwives' salaries being below the national average or on a comparable level, but there are also examples of nurses' and midwifery salaries above the national average. It may be assumed that the latter is the result of active lobbying of unions and associations and the result of successful presentation on the value of nursing and midwifery.

Some countries report formal career and pay structures. This occurs when there is a differentiated system for nurses and midwives with positions on different levels and payment is related to the actual performance.

There are only two statements that explicitly mention women in disadvantaged positions in terms of payment and reflected in nurses' and midwives' salaries. Compared to physicians' salaries, nurses' and midwives' salaries are considerably lower, but in most statements physicians' salaries are not taken as comparable numbers. Finally, there are several statements on plans for increasing salaries or reports of recently increased salaries for nurses and midwives.

12.2. *What career prospects are available within nursing and midwifery? Is there a formal pay and career structure? Are there gender issues related to the pay and career structure?*

Most countries report the existence of formal pay and career structures. Two countries report the absence of such structures (Armenia, Republic of Moldova). Career prospects exist mainly in nursing itself such as leadership positions on wards, nursing care facilities and the like. The next level is management of health care institutions. Management positions are linked to higher education. In addition, management and leadership career prospects exist in education, mainly as teachers in initial education, but also on university or higher education level. The third area for career prospects is that of specialization, be it as a clinical nurse specialist or by gaining particular competencies in a given area.

The pay structures usually use the same pattern of educational level, position and experience of working years to contribute to the level of payment. An interesting comment was made from Sweden where career prospects formally exist, but a recent study reports that only 10% of nurses

understand their prospects. Where it exists the private sector seems to play an increasingly important role, as there is a tendency toward better payment and career opportunities there.

12.3. Is there any trend for nurses and midwives to seek better career prospects outside their professions? Has there been a net gain or loss to the workforce of trained nurses and midwives over the past five years?

The trend for nurses and midwives to search for better options outside their profession does exist to a small extent. Countries report that better education offers more options, and nurses and midwives do take them. They leave into the private sector, into pharmaceutical business and search for degrees in other disciplines. Although this trend exists, it does not seem to be significant. The conclusion, however, that better education results in more leavers from nursing and midwifery cannot be drawn as there are also examples that better education attracts more applicants to a career in nursing and midwifery.

This phenomenon is mostly judged as nurses and midwives leave the profession. From Germany and Switzerland another judgement is made, that nurses with higher qualifications enter new areas and find jobs that could not be obtained by them some years ago.

Estimations of net gain and loss seem hard to give as in most countries there is a lack of sufficient data. Countries report net gain and net loss of qualified nurses and midwives as well. Net gain in one instance was reported as a result of international recruitment.

Especially in eastern Europe the problem of emigration remains. Nurses and midwives search for better opportunities by leaving their country.

Summary

Salaries of nurses and midwives cannot be compared across the Region, because the economic situation in countries is too diverse. Concerning average salaries in countries the salaries of nurses and midwives have been reported to be below, above and according to the national average of comparable professions. Physicians' salaries haven't been considered as comparable. Pay structures usually follow the same pattern and that is: level of education, actual position and experience in terms of working years.

13. Strategic guidance from WHO

Table 18: Responses to question 13.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
13.1.	41	27	17	25	16
13.2.	34	26	17	19	15
13.3.	28	22	14	16	12
13.4.	37	25	15	24	13

13.1. *Has the guidance that you need been made available?*

Most answers state a simple “yes” to this question. This indicates that most Associations and Ministries of Health have received the WHO materials on the Declaration. A “yes”, however, does not clarify whether all documents have been received or if the recipients had an overview over the materials available. From the Irish Nurses Organization and the Royal College of Nurses it is mentioned that the sending of materials was quite poor during the last two years and not occurred at all the last year. The German Nurses Association points out that materials have only been received to a limited extent. The Hungarian Nurses Association states that it was difficult to find the materials.

From the Ministry of Health of Armenia it is commented that there was a delay in the reception of materials and that they unfortunately had been in English. From the Czech Nurses Association difficulties are reported in obtaining the document from WHO headquarters *Strategic directions for nursing and midwifery 2002–2008*. A “no” answer for the availability of guidance documents is stated by the Danish Midwives Association and by the Royal College of Midwives.

13.2. *How useful has WHO guidance been?*

The overall feedback on WHO guidance is positive. Most countries state that the materials have been useful. They have been used in developing or reforming the following areas: education, community health nursing development, developing a nursing research strategy, strategically on safe maternity care, for reasoning purposes in negotiations with decision-makers, planning of nursing and midwifery services. Education was the predominant aspect. Beyond that it is stated that the materials are a valuable source of information and provide a comprehensive overview over the field of nursing and midwifery. Another positive comment on the materials was that they allow self-development for the professions while at the same time pointing to areas where negotiations with decision-makers are needed.

Limitations of the usefulness arise from individual national circumstance requiring adaptation, language issues such as non-availability of material in Russian or too advanced English. From one country it is reported that the materials have not all been useful given their already well-established structures and processes. Only one country gave a negative feedback that the materials are too extensive and too complicated.

13.3. *What specific impact has it made (how and where)?*

The answers confirm and expand the answers on 13.2. Education is the area where the most significant impact is reported. The impact on education is stated on the curriculum and the role of nurses. For some countries WHO guidance has had an impact on their legislative efforts in the development of new regulatory frameworks.

Understanding of particular issues and having a framework of orientation were two other aspects mentioned. The implementation of particular projects was influenced by the Declaration and WHO guidance. Even initiatives with no special regard to nursing and midwifery such as the Health Promoting Hospitals were addressed. As in 13.2 the guidance has had an impact in discussions and negotiations with other stakeholders and decision-makers.

13.4. What support would be helpful in future (e.g. drawing up regulatory/legal frameworks or curriculum planning; or more general assistance to help with raising the profiles of nursing and midwifery)?

Despite the impact on education and legislation these are still the main areas where support is asked for. It is explicitly asked for support in developing midwifery curricula. Another important request is on raising the image and profile of nursing and midwifery. Several countries see the development of nursing research, the creation of databases with sufficient data on nursing and examples of evidence-based practice as a means to achieve this goal. WHO support is asked for in terms of organising international seminars and providing opportunities for exchange. The provision of best practice examples is also suggested.

Some countries explicitly ask for support in their negotiations with governments. This may occur via direct communication from WHO to Ministries of Health on nursing and midwifery or via constantly reminding Ministries of Health of their commitment expressed in the Declaration.

Additional aspects are to address the issue of recruitment and retention, direct WHO Partnership in country projects, reports of successful implementation of the Declaration, quality development, creating evidence for the effectiveness of midwifery, increasing the financial aid for WHO presence in particular regions and keeping up the support provided via the European Forum of National Nursing and Midwifery Associations (EFNNMA) and the regional advisor for nursing and midwifery.

Summary

The WHO guidance has been made available to most of the respondents. Some critique is stated on less guidance during the past two years and on the fact that documents have been sent out in English. It is asked for documents in Russian, where they are needed.

WHO guidance in general has been very useful, in particular the area of education and continuing education. Useful support is stated in the areas of developing research and databases on nursing and midwifery, the development of midwifery curricula, and in terms of supporting negotiations with Ministries of Health on the implementation of the Declaration.

14. Coordination mechanism for working in partnership

Table 19: Responses to question 14.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
14.1.	40	26	15	26	14
14.2.	33	21	13	22	11

14.1. *What mechanisms have been set up that have been helpful in strengthening international collaboration and ties with counterparts in other countries?*

Almost all countries report international collaboration either as permanent members of International Organizations or on particular subjects and occasions. The establishment of EFNNMA is considered helpful and valuable by most of the respondents. It is followed by International Organizations such as ICN, ICM, and the Government Chief Nurse Network of WHO. Other organizations mentioned are the EMA, the PCN and the WHO Global Network of Collaborating Centres.

Beside the attendance of regular meetings of the above mentioned organizations it is suggested to add topics and experts to the existing collaboration, meaning that the existing networks are to be used for new issues coming up and expand their focus. Although the EFNNMA is mentioned the most there are some critical remarks on it. One concerns an extension for self-regulating bodies as they are considered more powerful as associations and might be useful for them. Another comment is a concern that the Forum meetings without adequate representation of a WHO Regional Advisor for Nursing and Midwifery are not that powerful any more.

International collaboration takes place beyond the international organizations. Examples are university networks, the WHO Lemon Project, the European NEXT study, bilateral agreements (Slovakia-Germany; Malta-United Kingdom), and the EU exchange programmes. Without particular reference, various international project meetings are also mentioned.

The most structured way of international collaboration is, however, the regular participation and/or membership in the international organizations. The internet and modern communication is seen as a means of strengthening international collaboration and staying in contact.

14.2. *In what areas has international collaboration been particularly useful, and how could it be made even more effective in future? What organizations have been most helpful? Have you any advice about such collaboration that could be disseminated to other countries?*

A part of this question was already included in answers on 14.1, but many additions have been made. Areas where international collaboration was considered useful include: Nursing development, Midwifery development, education, research, best practice examples, legislation, development of national and international strategies, dissemination of information.

In addition to the organizations mentioned in 14.1, the following organizations were mentioned as being helpful: ILO (International Labour Organization), Workgroup of European Nurse Researchers (WENR), International Confederation of Free Trade Unions (ICFTU), European Federation of Trade Union Confederation (EPSU), Nordic Nurses' Federation (SSN), The Swedish East Europe Committee of the Swedish Health Care Community (SEEC), Catholic Organization for Relief and Development (CORDAID), Soros Foundation Network and the United States Alliance on Health Care.

There is no clear advice on a particular way of collaboration and its dissemination, but there are different suggestions for international collaboration. These include the international development of standards of practice (in nursing as well as in midwifery), joint work on protocols and statements to improve practice and to influence policy, educational seminars and creating opportunities for international educational placements.

In terms of procedures the following suggestions have been made:

- collaboration on a particular topic should always have a leading partner responsible for taking it forward;
- particular areas of concern could be identified by several countries signing an agreement to take on the work in international partnership; and
- annual meetings on the implementation of the Declaration where success stories are presented that would serve as motivation for other countries.

15. Reports to the Regional Committee

Table 20: Responses to question 15.

Question number	Total responses	Number of countries	BCA countries	NN/MAs	Ministries of Health
15.1.	33	23	12	22	11

15.1. *What particular implementation issues should be emphasized, and information given on specific matters, e.g. on “initiatives taken in improving career development opportunities, joint learning with physicians, workforce planning, etc.?”*

The examples given in the question reflect most of the answers. Career prospects, workforce planning and joint learning opportunities are the most mentioned aspects. Career aspects are mentioned in the broadest sense on the one hand, but they are also linked to the establishment of university education for nurses. Establishing nursing research in general and national nursing research institutes, including funding for nursing research are mentioned as other issues. Educational issues included plans for curriculum development.

Countries ask for networking opportunities for several purposes: to learn from each other, to exchange ideas and to obtain external expertise. One statement considers this aspect as the most important for WHO and sees it in favour of the above mentioned.

Other issues of high relevance for particular countries were mentioned: staffing levels and skill-mix, contributing to legislative frameworks, nurses’ retention and international recruitment issues, formulation of health policy, addressing an adequate salary for nurses, establishing a nursing register, benchmarking between countries on the basis of determined quality indicators and involvement in policy-making.

Finally, some countries addressed their collaboration with WHO directly by stressing the valuable support by Anna Fawcett-Hennessy, by asking for more “consumer-friendly” documents and by asking for better and clearer communications around implementation issues.

Conclusions

The analysis of the 2004 questionnaire to track the implementation of the Declaration reveals that many countries are in a process of working on the role of nurses and midwives. Many positive steps have been taken since 2001. Unlike in 2001 the responses from 2004 allow for a better insight into the situation of midwives, which is characterized by a huge diversity between countries. The examples of good practice and a well established framework for midwifery are a good starting point for countries to reconsider the situation of midwifery and to act on ensuring a better midwifery contribution to health care. For nurses and midwives the importance of the legislative framework and an appropriate education was stressed throughout the responses.

The WHO Regional Office for Europe has launched the educational strategy for nurses and midwives in 2000. The strategy is accompanied by a monitoring process using the Prospective Analysis Methodology (PAM). Results of the latest survey are available and it will be important in the future to link the results from the PAM with the results from the Declaration follow-up process. By doing so the situation in nursing and midwifery education in the European Region

will become more evident and support on implementing appropriate programmes can be more tailored.

The multi-national study on the implementation of the WHO Family Health Nurse concept will also contribute valuable evidence to the role of nurses and midwives in health care systems. After a slow start of the multi-national study for several reasons many countries now started the implementation process and results will be available in not too far a time.

WHO will continue its work on monitoring and supporting the implementation of the Declaration and contribute to realising the contribution of nurses and midwives so that they will be a real force for health.

References

European Commission Education and Training (2000): *The Bologna Declaration on the European Space for Higher Education: An explanation*, <http://europa.eu.int/comm/education/policies/educ/bologna/bologna.pdf> (accessed 02 March 2005)

WHO (2002): *Nursing and Midwifery Services*. Strategic Directions 2002–2008, Geneva

WHO Regional Office for Europe (2000): *The Munich Declaration: Nurses and midwives: a force for health*, Copenhagen

WHO Regional Office for Europe (2001): *Moving on from Munich: A reference guide to the implementation of the Declaration*, Copenhagen

WHO Regional Office for Europe (2003): *Progress report on implementation of the Munich Declaration on Nursing and Midwifery: a Force for Health (draft)*, Copenhagen

WHO Regional Office for Europe (2003): *Government Chief Nurse Meeting, Madrid, Spain, 13 March 2003, Report on a WHO Meeting*, Copenhagen

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WHO also would like to thank Maggy Wallace and Deborah Hennessy for their valuable contributions to the amendments of the questionnaire from the 2001 to the 2004 version. Elena Galmon and Britta Hanson contributed enormously by translating the questionnaires and inserting the data into a database.

Finally WHO likes to thank Ainna Fawcett-Henesy for initiating the whole process of tracking the implementation of the Declaration.

Annex 1

QUESTIONNAIRE FOR MINISTRIES OF HEALTH

Tracking Implementation of the Munich Declaration
Country Progress Report 2004
(Ministries of Health)

In completing this proforma, you may wish to refer to the WHO document *Moving on from Munich* (document EU/ICP/OSD 631AS 00, 5019309), which provides the context for the issues raised here.

Please return this proforma to the WHO Regional Office for Europe (for the attention of the Director of Country Support) by 31 May 2004.

Purpose

1. The need for a tracking process for implementing the Munich Declaration is two-fold. First, and fundamentally, it is the trigger for a learning process, which is based on self-assessment of progress as measured against the objectives and political commitments in the Declaration. Second, it is a necessary means for preparing progress reports for the Regional Committee.
1. The purpose is not to put “ticks in boxes” or collate routine statistics to generate supporting “evidence” of progress. It is for Munich implementation partners to ask questions of themselves and each other and then to reflect on those answers, and to go on to decide what further action is required or whether changes need to be made to the strategy followed so far.
2. The tracking process will also facilitate international cooperation. It can be used to help identify issues for the exchange of information and experience with countries in similar circumstances (e.g. culture, experience, demography, resources available to the health sector, etc.) or for benchmarking progress through comparison with selected countries in those features of their nursing and midwifery services that are more developed.
3. The intended end result of Ministers’ policies is better health for all, which will be achieved through addressing the major public health challenges and the improvement of health services. In the terms of the Declaration, success will hinge to a significant extent on nurses and midwives being enabled to fulfil the roles now expected of them and spelt out in the Declaration. This in turn hinges on action being taken within countries and by WHO.
4. These developments specified by the Declaration may be referred to as “intermediate outcomes”. These outcomes can be used as markers to assess progress towards ensuring that nurses and midwives contribute fully in addressing the public health agenda. The same applies to action taken on the political commitments made by ministers and on commitments of support made by WHO (in other words, are the right health system conditions being put in place)

5. Open-ended questions are posed below under each of the objectives and political commitments in the Declaration. The purpose is to prompt reflections on actions taken and their results and consequences. These reflections can then be formulated as answers, which will provide indications of the measure of progress achieved.

Note: the paragraph references in parenthesis against each Declaration objective relate to the document Moving on from Munich (document EU/ICP/OSD 631AS 00, 5019309), which was sent out from the Regional Office in June 2001.

Nurses and midwives

1. Reviewing and amending legislation and professional regulation to ensure that nurses and midwives can work to their full potential as independent and interdependent professionals (paragraphs 33–39)
 - How is the role of a nurse and/or a midwife defined (by legislation, custom or practice)?
Your response:
 - In your judgement, do nurses and midwives work to their full potential? Have you any examples where nurses and midwives are doing this?
Your response:
 - What prevents nurses and midwives from doing so at present? What changes have to be addressed and what action has been taken so far?
Your response:
 - How widely understood is the contribution that nurses and midwives can make to the health system (e.g. provision of health promotion, care and treatment)?
Your response:
 - Are nurses and midwives themselves generally aware of their potential?
Your response:
2. Contribute to decision-making at all policy levels (paragraphs 40–45)
 - How are nurses and midwives acknowledged to be relevant stakeholders at the different levels by government, by national and subnational health administrations, etc.?
Your response:
 - What is the current nursing and midwifery input into the policy-making decision process on health related issues?
Your response:
 - What strategies do nurses and midwives themselves adopt to ensure that they contribute? How do nurses and midwives contribute at each level of policy and decision-making in the country?
Your response:
 - How are the contributions of nurses and midwives received by the relevant authorities at these levels? Are they seen to be taken into account in policy formulation?
Your response:

- How does the involvement of nurses and midwives in decision-making compare with the involvement of other interests in the health sector?

Your response:

3. Play a role in public health action and community development (paragraphs 46–56)

- What contributions do nurses and midwives make to public health and community development? (e.g. are they contributing to debates on public health priorities at governmental level? Are they contributing to public health programmes at regional and community level?)

Your response:

- Do nurses and midwives receive any specific training in public health and public health policy? If so, how is it structured? If not, what changes in their education and training are required or would be desirable to enhance their public health activity work?

Your response:

- What legislation or other measures are required to establish/consolidate a public health and community-oriented role for nurses and midwives?

Your response:

4. Provide family-focused community programmes and services (paragraphs 57–67)

- Are there any family-focused community programmes or services established? Where are they based and how are they structured?

Your response:

- If none, what are the reasons that no programmes and services have been established?

Your response:

The Government and WHO provide the right health system conditions

5. Legislative and regulatory frameworks (paragraphs 33–39)

- What frameworks are currently in place at all levels of the health system and are they sufficient according to the Munich Declaration?

Your response:

- Have the existing national legislative and regulatory frameworks been reviewed in the light of the recommendations of the Declaration? Are there any plans for action on that and if so, what are the anticipated time-scales?

Your response:

6. Obstacles, such as those relating to gender and status issues (paragraphs 7–27, 109–113)

- Is there a national recruitment and retention policy in place? Is it gender-sensitive?

Your response:

- Do recruitment policies of other countries have an impact on the situation of nurses and midwives, such as the effect of Western Europe attracting nurses from eastern European countries?

Your response:

- What is the public perception of nurses and midwives in the country? Does it appear to be changing? Have any activities been initiated to promote nursing and midwifery?

Your response:

- What is the approximate ratio between women and men: (a) within the nursing profession and (b) within the health care system as a whole? Are these now changing? If so, what might this indicate?

Your response:

- What opportunities do nurses and midwives have to be heard in public debate on policy issues outside their own defined professional boundaries?

Your response:

7. Strengthened knowledge/evidence base for nursing and midwifery practice (paragraphs 68–69)

- Is there a national nursing and midwifery research strategy? What institutions exist to support nursing and midwifery research?

Your response:

- Do nurses and midwives have the opportunity to study for research-based degrees in their field of practice or are such opportunities only available in other subject areas, such as education or psychology or do nurses and midwives have to go outside the country in order to pursue research training and careers? What research questions are research students interested in; are they building the foundations of knowledge?

Your response:

- If nursing research facilities do not yet exist, are there any links with other countries that do provide research training, or with other professional groups within the country for the purpose of developing research capacity?

Your response:

- How are research results disseminated in the country? Are there journals for the dissemination of research results?

Your response:

- Is there a government level of funding available for nursing research? Is it coming from government or from private sources, nongovernmental organizations or commercial companies?

Your response:

- Are there plans or measures established for the evaluation of nursing and midwifery services? If so, could you give examples?

Your response:

8. Initial and continuing education and higher education¹ (paragraphs 70–91)

- Have university departments/faculties/schools been established to provide the full range of professional education for nurses and midwives (pre-registration, post basic, continuing education, Master and PhD level)? How do such departments fit in within the national educational and health care system?

Your response:

- Were any of the above educational programmes in place prior to the Munich Declaration?

Your response:

- What steps have been taken since the Munich Conference to meet the terms and spirit of the Declaration regarding:
 - post secondary school/undergraduate (initial) education?
 - higher education?
 - continuing education?

Your response:

- In your judgement (and on what grounds) do you see a satisfactory take-up of places for these programmes and successful completion of programmes?

Your response:

- In your judgment (and on what grounds) will the health sector's needs for university-educated nurses and midwives be met? What proportion of nurses and midwives should be educated to this level? What are the current proportions?

Your response:

9. Opportunities for nurses, midwives and physicians to learn together (paragraphs 86–91)

- Are there any existing opportunities to learn together in the country? If so, at what educational level and with what scope or focus?

Your response:

- Has any difference in entry requirements for nursing, midwifery and medical training been an obstacle or a reason for not pursuing joint learning possibilities?

Your response:

10. Partnerships with all relevant bodies (paragraphs 92–99)

- What partnerships have been established with the relevant ministries and other bodies (statutory and nongovernmental, within the country and internationally) and for what particular purpose?

Your response:

- Have any partnerships been established by nurses and midwives themselves?

Your response:

¹ Indicators on this are included in the Prospective Analysis Methodology (PAM) tool for the WHO European Strategy for Nursing and Midwifery Education (document EUR/01/5019304), which will be used for the longitudinal study on education strategy. The same will be done according to the principles of the strategy on continuing education (in process of being developed).

- Have any twinning projects been implemented? If so, in what fields and for what purpose?

Your response:

- Has the necessary information been made widely available as to which potential internal and external partners would be useful, proactive and available to provide information, advice and other forms of support?

Your response:

11. Workforce planning strategies² (paragraphs 100–115)

- How many trained nurses and midwives there are in the country?

Your response:

- How many nurses and midwives constitute the current workforce?

Your response:

- According to estimates, how many nurses and midwives are needed currently and in the future in the health care system?

Your response:

- Is there a workforce policy based on explicit assumptions about future needs?

Your response:

- Is there a workforce planning strategy in the country?

Your response:

- Are there any problems with workforce planning strategies?

Your response:

- Are policies and programmes established which ensure healthy workplaces and quality of the work environment for nurses and midwives?

Your response:

12. Fair rewards, recognition and opportunities for career advancement (paragraphs 100–114)

- What is the salary of nurses and midwives in relation to other professions and the national average wage (where known)? What has been the trend over the past five years?

Your response:

- What career prospects are available within nursing and midwifery? Is there a formal pay and career structure? Are there gender issues related to the pay and career structure?

Your response:

- Is there any trend for nurses and midwives to seek better career prospects outside their professions? Has there been a net gain or loss to the workforce of trained nurses and midwives over the past five years?

Your response:

² This set of issues is closely related to the issues of recruitment policies, rewards and career advancement.

Strategic guidance from WHO (paragraphs 116 and 117)

- Has the guidance that you need been made available?

Your comment:

- How useful has WHO guidance been?

Your comment:

- What specific impact has it made (how and where)?

Your comment:

- What support would be helpful in future (e.g. drawing up regulatory/legal frameworks or curriculum planning; or more general assistance to help with raising the profiles of nursing and midwifery)?

Your comment:

Coordination mechanisms for working in partnerships (paragraphs 118–121)

- What mechanisms have been set up that have been helpful in strengthening international collaboration and ties with counterparts in other countries?

Your comment:

- In what areas has international collaboration been particularly useful, and how could it be made even more effective in future? What organizations have been most helpful? Have you any advice about such collaboration that could be disseminated to other countries?

Your comment:

Reports to the Regional Committee (paragraphs 122–129)

- What particular implementation issues should be emphasized, and information given on specific matters, e.g. on “initiatives taken in improving career development opportunities, joint learning with physicians, workforce planning, etc.?”

Your comment:

Annex 2

QUESTIONNAIRE FOR NATIONAL NURSING AND MIDWIFERY ASSOCIATIONS

Tracking Implementation of the Munich Declaration
Country Progress Report 2004
(National Nursing and Midwifery Associations/WHO Collaborating Centres)

In completing this proforma, you may wish to refer to the WHO document *Moving on from Munich* (document EU/ICP/OSD 631AS 00, 5019309), which provides the context for the issues raised here.

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3. The tracking process will also facilitate international cooperation. It can be used to help identify issues for the exchange of information and experience with countries in similar circumstances (e.g. culture, experience, demography, resources available to the health sector, etc.) or for benchmarking progress through comparison with selected countries in those features of their nursing and midwifery services that are more developed.
4. The intended end result of Ministers’ policies is better health for all, which will be achieved through addressing the major public health challenges and the improvement of health services. In the terms of the Declaration, success will hinge to a significant extent on nurses and midwives being enabled to fulfil the roles now expected of them and spelt out in the Declaration. This in turn hinges on action being taken within countries and by WHO.
5. These developments specified by the Declaration may be referred to as “intermediate outcomes”. These outcomes can be used as markers to assess progress towards ensuring that nurses and midwives contribute fully in addressing the public health agenda. The same applies to action taken on the political commitments made by ministers and on commitments of support made by WHO (in other words, are the right health system conditions being put in place)

6. Open-ended questions are posed below under each of the objectives and political commitments in the Declaration. The purpose is to prompt reflections on actions taken and their results and consequences. These reflections can then be formulated as answers, which will provide indications of the measure of progress achieved.

Note: the paragraph references in parenthesis against each Declaration objective relate to the document Moving on from Munich (document EU/ICP/OSD 631AS 00, 5019309), which was sent out from the Regional Office in June 2001.

Political will and commitment

1. Government statements made “on the record” that can be taken as a clear commitment to implement the Declaration and especially specific proposals in the Declaration (paragraphs 1–32)
- Have any such statements been made and to what audiences?
Your response:
 - Were there any explicit statements of intended action and, if so, what action has followed?
Your response:
 - Have the national Nursing and Midwifery Associations made any moves to secure government commitment? How have they done this?
Your response:

Nurses and midwives

2. Reviewing and amending legislation and professional regulation to ensure that nurses and midwives can work to their full potential as independent and interdependent professionals (paragraphs 33–39)
- How is the role of a nurse and/or midwife defined (by legislation, custom or practice)?
Your response:
 - In your judgement, do nurses and midwives work to their full potential? Have you any examples where nurses and midwives are doing this?
Your response:
 - What prevents nurses and midwives from doing so at present? What changes have to be addressed and what action has been taken so far?
Your response:
 - How widely understood is the contribution that nurses and midwives can make to the health system (e.g. provision of health promotion, care and treatment)?
Your response:
 - Are nurses and midwives themselves generally aware of their potential?
Your response:

3. Contribute to decision-making at all policy levels (paragraphs 40–45)

- How are nurses and midwives acknowledged to be relevant stakeholders at the different levels by government, by national and subnational health administrations, etc.?

Your response:

- What is the current nursing and midwifery input into the policy-making decision process on health related issues?

Your response:

- What strategies do nurses and midwives themselves adopt to ensure that they contribute? How do nurses and midwives contribute at each level of policy and decision-making in the country?

Your response:

- How are the contributions of nurses and midwives received by the relevant authorities at these levels? Are they seen to be taken into account in policy formulation?

Your response:

- How does the involvement of nurses and midwives in decision-making compare with the involvement of other interests in the health sector?

Your response:

4. Play a role in public health action and community development (paragraphs 46–56)

- What contributions do nurses and midwives make to public health and community development? (e.g. are they contributing to debates on public health priorities at governmental level? Are they contributing to public health programmes at regional and community level?)

Your response:

- Do nurses and midwives receive any specific training in public health and public health policy? If so, how is it structured? If not what changes in their education and training are required or would be desirable to enhance their public health activity?

Your response:

- What legislation or other measures are required to establish/consolidate a public health and community-oriented role for nurses and midwives?

Your response:

5. Provide family-focused community programmes and services (paragraphs 57–67)

- Are there any family-focused community programmes or services established? Where are they based and how are they structured?

Your response:

- If none, what are the reasons that no programmes and services have been established?

Your response:

The Government and WHO provide the right health system conditions

6. Legislative and regulatory frameworks (paragraphs 33–39)
 - What frameworks are currently in place at all levels of the health system and are they sufficient according to the Munich Declaration?
Your response:
 - Have the existing national legislative and regulatory frameworks been reviewed in the light of the recommendations of the Declaration? Are there any plans of action on that and if so, what are the anticipated time-scales?
Your response:
7. Obstacles, such as those relating to gender and status issues (paragraphs 7–27, 109–113)
 - Is there a national recruitment and retention policy in place? Is it gender-sensitive?
Your response:
 - Do recruitment policies of other countries have an impact on the situation of nurses and midwives, such as the effect of Western Europe attracting nurses from eastern European countries?
Your response:
 - What is the public perception of nurses and midwives in the country? Does it appear to be changing? Have any activities been initiated to promote nursing and midwifery?
Your response:
 - What is the approximate ratio between women and men: (a) within the nursing profession and (b) within the health care system as a whole? Are these now changing? If so, what might this indicate?
Your response:
 - What opportunities do nurses and midwives have to be heard in public debate on policy issues outside their own defined professional boundaries?
Your response:
8. Strengthened knowledge/evidence base for nursing and midwifery practice (paragraphs 68–69)
 - Is there a national nursing and midwifery research strategy? What institutions exist to support nursing and midwifery research?
Your response:
 - Do nurses and midwives have the opportunity to study for research-based degrees in their field of practice or are such opportunities only available in other subject areas, such as education or psychology or do nurses and midwives have to go outside the country in order to pursue research training and careers? What research questions are research students interested in; are they building the foundations of knowledge?
Your response:
 - If nursing research facilities do not yet exist, are there any links with other countries that do provide research training, or with other professional groups within the country for the purpose of developing research capacity?

Your response:

- How are research results disseminated in the country? Are there journals for the dissemination of research results?

Your response:

- Is there a government level of funding available for nursing research? Is it coming from government or from private sources, nongovernmental organizations or commercial companies?

Your response:

- Are there plans or measures established for the evaluation of nursing and midwifery services? If so, could you give examples?

Your response:

9. Initial and continuing education and higher education³ (paragraphs 70–91)

- Have university departments/faculties/schools been established to provide the full range of professional education for nurses and midwives (pre-registration, post basic, continuing education, Master and PhD level)? How do such departments fit in within the national educational and health care system?

Your response:

- Were any of the above educational programmes in place prior to the Munich Declaration?

Your response:

- What steps have been taken since the Munich Conference to meet the terms and spirit of the Declaration regarding:
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 - higher education?
 - continuing education?

Your response:

- In your judgement (and on what grounds) do you see a satisfactory take-up of places for these programmes and successful completion of programmes?

Your response:

- In your judgment (and on what grounds) will the health sector's needs for university-educated nurses and midwives be met? What proportion of nurses and midwives should be educated to this level? What are the current proportions?

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Your response:

- Has any difference in entry requirements for nursing, midwifery and medical training been an obstacle or a reason for not pursuing joint learning possibilities?

Your response:

11. Partnerships with all relevant bodies (paragraphs 92–99)

- What partnerships have been established with the relevant ministries and other bodies (statutory and nongovernmental, within the country and internationally) and for what particular purpose?

Your response:

- Have any partnerships been established by nurses and midwives themselves?

Your response:

- Have any twinning projects been implemented? If so, in what fields and for what purpose?

Your response:

- Has the necessary information been made widely available as to which potential internal and external partners would be useful, proactive and available to provide information, advice and other forms of support?

Your response:

12. Workforce planning strategies (paragraphs 100–115)

- How many trained nurses and midwives there are in the country?

Your response:

- How many nurses and midwives constitute the current workforce?

Your response:

- According to estimates, how many nurses and midwives are needed currently and in the future in the health care system?

Your response:

- Is there a workforce policy based on explicit assumptions about future needs?

Your response:

- Is there a workforce planning strategy in the country?

Your response:

- Are there any problems with workforce planning strategies?

Your response:

- Are policies and programmes established which ensure healthy workplaces and quality of the work environment for nurses and midwives?

Your response:

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- What is the salary of nurses and midwives in relation to other professions and the national average wage (where known)? What has been the trend over the past five years?

Your response:

- What career prospects are available within nursing and midwifery? Is there a formal pay and career structure? Are there gender issues related to the pay and career structure?

Your response:

- Is there any trend for nurses and midwives to seek better career prospects outside their professions? Has there been a net gain or loss to the workforce of trained nurses and midwives over the past five years?

Your response:

Strategic guidance from WHO (paragraphs 116–117)

- Has the guidance that you need been made available?

Your comment:

- How useful has WHO guidance been?

Your comment:

- What specific impact has it made (how and where)?

Your comment:

- What support would be helpful in future (e.g. drawing up regulatory/legal frameworks or curriculum planning; or more general assistance to help with raising the profiles of nursing and midwifery??)

Your comment:

Coordination mechanisms for working in partnerships (paragraphs 118–121)

- What mechanisms have been set up that have been helpful in strengthening international collaboration and ties with counterparts in other countries?

Your comment:

- In what areas has international collaboration been particularly useful, and how could it be made even more effective in future? What organizations have been most helpful? Have you any advice about such collaboration that could be disseminated to other countries?

Your comment:

Reports to the Regional Committee (paragraphs 122–129)

- What particular implementation issues should be emphasized, and information given on specific matters, e.g. on “initiatives taken in improving career development opportunities, joint learning with physicians, workforce planning, etc.?”

Your comment:

