

ROLES AND  
RESPONSIBILITIES  
OF GOVERNMENT  
CHIEF NURSING AND  
MIDWIFERY OFFICERS:  
A CAPACITY-BUILDING MANUAL



World Health  
Organization



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## ABBREVIATIONS

CNO	chief nursing officer
GAG	Nursing and Midwifery Global Advisory Group
GCNMO	government chief nursing and midwifery officer
GLC	Global Leadership Collaborative
HLA	Healthcare Leadership Alliance
IOM	Institute of Medicine
MDGs	Millennium Development Goals
NAJ	Nurses Association of Jamaica
NCJ	Nursing Council of Jamaica
NCHL	National Center for Healthcare Leadership
TWG	technical working group
SDGs	Sustainable Development Goals
UHC	universal health coverage
UHI	universal health insurance
WHA	World Health Assembly
WHO	World Health Organization
WHOCC	World Health Organization collaborating centre
WPRO	World Health Organization Regional Office for the Western Pacific

# FOREWORD

Responding to global, regional and national needs requires a well-prepared health workforce at all levels of the health system. As a technical and normative organization, WHO works through Member States' ministries. Government chief nursing and midwifery officers in these health ministries have been key stakeholders in driving nursing and midwifery workforce strategies in collaboration with WHO. Through their policy and management functions they provide an invisible backbone for health systems. Availability, competence, responsiveness and productivity are key to ensuring an effective health workforce. However, there are inputs to making this happen including job descriptions, norms and codes of conduct, supervision, appropriate skills matched with tasks. Furthermore, there needs to be a support system that ensures adequate remuneration, information, communication, infrastructure and supplies. All these should occur in an enabling work environment that promotes lifelong learning, teamwork and management responsibility with accountability. These functions are part of the responsibilities of GCNMOs. Therefore, transformative strategies in leadership and management, education and practice, implemented in an enabling environment, are critical factors in facilitating the effectiveness of GCNMOs.

It is with the conviction that GCNMOs have accepted the challenge and opportunity to make a real difference in the way they execute their functions as leaders in their respective governments that this document has been developed. This document has been developed in a collaborative manner indicating a collective expression of commitment firmly grounded on proper governance and management of the nursing and midwifery workforce, putting quality and competence as central to nursing and midwifery leadership. At a time when the world is rallying behind global mandates and commitments such as the Sustainable Development Goals (SDGs) and universal health coverage (UHC), GCNMOs can contribute to equitable population access to promotive, preventive, curative, rehabilitative and palliative health services by fostering proper policies, management and supervision for the nursing and midwifery workforce.

The information contained in this document is a strong basis for significant improvements in the skills of GCNMOs to ensure that well-qualified and motivated nurses and midwives are in the right place at the right time to deliver health-care services.

The preparation of this document takes into account that the roles and responsibilities of GCNMOs differ from country to country. However, there are commonalities, which this document offers as a starting and reference point.



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## BACKGROUND

As part of capacity building, since 2004, WHO has held a global forum for GCNMOs every two years. Each forum has addressed a specific theme related to World Health Assembly (WHA) priorities and resolutions. The GCNMOs are at the policy level of ministries of health where they can influence policy and support governments in strengthening the nursing and midwifery workforce. Through the forums it became evident that the roles of GCNMOs needed be strengthened. Forum participants in 2008 recommended the development of a manual on roles and responsibilities and since it is critical that GCNMOs are efficient and effective in their task of moving the priority health agenda beyond 2015, that request has been met. The aim of this publication is to provide a capacity-building document for GCNMOs.

This document was prepared with the input of a TWG composed of GCNMOs, recognizing that a practical and relevant document could be realized by working directly with the target audience in the preparation.

The following tasks were carried out in developing this publication.

1. Review of existing literature on roles and responsibilities (based on grey literature and published materials);
2. Formation of a technical review group;
3. Development of an outline on roles and responsibilities;
4. Preparation of a draft version integrating input from the 2014 forum;
5. Working with the TWG to review and revise the draft;
6. Circulation of the draft to a wider audience of GCNMOs and other experts in the field; and
7. Integration of final revisions, comments and recommendations.

The work undertaken included: review of literature on nursing and midwifery, GCNMOs' roles and responsibilities, related leadership and management studies and selected literature on competencies and competency frameworks, review of previous work on roles and responsibilities as a result of the GCNMO forums and the work of the Global Leadership Collaborative (GLC), forming a technical group, developing terms of reference and engagement of a larger group of GCNMOs in reviewing the document.

The document covers definitions of roles and responsibilities, description and discussion of these roles and responsibilities and expansion of the consensus statement developed by GCNMOs in WHO global forums as well as reflections on country case studies in relation to GCNMO roles and responsibilities. It also presents the competency framework with descriptions of its components. A schematic presentation of the framework is also included.

This publication also identifies suggested uses of the competency framework, such as in improvements to the recruitment of GCNMOs, providing and promoting a common language for the roles and performance of GCNMOs, and assistance in the application of knowledge and effective behaviours at work, as well as in identifying flexible and appropriate learning opportunities. A self-assessment tool on identified competencies is included in Annex 1.

# INTRODUCTION

Current World Health Organization statistics reflect an improvement in a number of international health-related goals. According to WHO (2014a), there are still a great number of health issues and challenges facing many countries. Dedicated efforts are needed to achieve the Millennium Development Goals (MDGs) and to ensure UHC to provide all people with access to quality health services. It is recognized that in order to achieve UHC, countries should build efficient health systems that meet population health needs and ensure that citizens receive the needed care without financial hardship. One important requirement for such systems is the availability of a trained and motivated health workforce including nurses and midwives (WHO 2014a). The *State of the World's Midwifery 2014* report (UNFPA et al, 2014) shows that much effort is being made in the 73 countries studied. For example, 33 of the 73 (45%) countries studied report vigorous attempts to improve health workforce retention in remote areas since 2011. Twenty countries (28%) have started to increase recruitment and deployment of midwives, 13 countries (18%) have prepared plans to establish regulatory bodies, and 14 (20%) have a new code of practice or regulatory framework. Most of these countries, (71%), have made substantive improvements in workforce data, information and accountability (UNFPA et al, 2014). Although much progress has been made, there is still much more to be done.

An empowered and effective nursing and midwifery leadership is essential to mobilize appropriate resources, motivate and inspire practising nurses and midwives, and inform and shape health policy and strategy directions. WHA resolution 54.12: Strengthening Nursing and Midwifery (WHO, 2001) called upon governments to create GCNMO positions and empower existing ones. This was in recognition of the increased demand – to have sufficient nurses and midwives both in numbers and quality to meet the health-care needs of individuals, families and communities around the world as stipulated in the MDGs. Nurses and midwives constitute the largest proportion of the health-care workforce. This proportion continues to expand, and the demand for their services increases as new health-care problems and diseases emerge (WHO, 2012).

The GCNMOs have recognized their role in taking a holistic approach in the implementation of strategies towards UHC and in leading and supporting changes in the management of the nursing and midwifery workforce to ensure sufficient numbers of appropriately qualified staff are available at all levels of the health-care delivery system. However, they feel that they are not adequately prepared or supported to meet the challenges of their jobs. They have identified the requirement to develop a clear consensus statement on roles, responsibilities and competencies for GCNMOs (WHO, 2014b).

WHO has spearheaded several initiatives to engage GCNMOs in addressing this requirement. The creation of the Global Forum for Government Chief Nursing and Midwifery Officers in 2004 provided an important platform to bring together nursing and midwifery leaders of the world biennially to move the nursing and midwifery agenda forward globally. Several of the WHO global forums have addressed this issue of roles and responsibilities in achieving the health goals of both the GCNMOs' respective countries and globally.

The 2006 global forum discussed the roles, competencies and mechanisms required to assist the work of GCNMOs in partnership with their governments in moving global health priorities forward (WHO, 2006). Roles and competency models were introduced and country experiences were shared. In 2008 further discussions took place to clarify the role of GCNMOs and the rationale for their inclusion at decision-making tables (WHO, 2008). During the subsequent forums, GCNMOs' inputs and recommendations were compiled into a consensus statement, which was then endorsed by the Nursing and Midwifery Global Advisory Group (GAG). The WHO

Collaborating Centre (WHOCC) for Nursing, Midwifery and Health Development, Sydney, Australia and the WHO Regional Office for the Western Pacific (WPRO) further developed the consensus statement and adopted a self-assessment tool, which was originally created by Professor Jill White (WHO, 2014b).

The 2014 global forum reflected on existing documents on roles and responsibilities, the competency framework and the self-assessment tool and recommended that they be revised. It was also recommended that a capacity development manual identifying the roles and responsibilities and providing a competency framework for GCNMOs be created in the context of current global and health challenges.

The information contained in this document builds on and has benefited from previous work in this area. It delineates and describes the responsibilities and competencies of GCNMOs necessary to the effective performance of their roles in their respective countries in support of global health mandates. The proposed competency framework could be utilized to assist:

- Governments in understanding the roles, responsibilities and contributions of GCNMOs.
- GCNMOs to reflect on their roles, expertise and the required competencies to be effective in carrying out their responsibilities and in contributing to their professional development.
- Government officials in the health sector, educational institutions providing leadership courses and programmes, human resources departments, nursing and midwifery professional associations, and regulatory councils and authorities establishing professional development programmes.

# LITERATURE REVIEW

In 1895, the Government of New Zealand appointed Grace Neil as the most senior nurse (Huffman-Splane and Splane, 1994). This was the first time in the history of modern health-care systems that a chief nurse position at government level was established. A few other countries had created similar positions in their ministries of health by 1940. Despite this long history of the existence of this position, the complexity and requirements of such a position are still not recognized and understood by many health-care professionals including nurses and midwives, or by government officials. Several studies described the role of chief nursing and midwifery officers (CNMO) as having variability in titles, responsibilities and placement across countries (Salmon and Rambo, 2002; Hennessy and Hicks, 2003).

Chief nursing and midwifery officers often are faced with broad issues and challenges. Salmon and Rambo (2002) conducted a study examining their roles and responsibilities, skills and knowledge and the key challenges and issues they face. The study showed that chief nursing officers (CNOs) have to deal with a broad range of issues such as workforce, health system changes, nursing and midwifery education, regulation, financing of nursing and midwifery services and chronic, communicable and emerging diseases. CNOs in this study considered all these issues as important and recognized their responsibility towards dealing with them.

Hader (2010) suggests that the corporate CNO position requires the ability to be visionary, establish nursing governance structures, ensure quality nursing and midwifery care, provide strategic management, foster staff development, foster open communication and collaboration, and provide financial oversight. In order to assume these roles and responsibilities the corporate chief nurse usually occupies the highest position in the corporate nursing structure. Similarly the strategic position of GCNMOs must be at the highest level of government to be able to carry out the required roles and responsibilities.

## Roles and responsibilities

The roles and responsibilities of GCNMOs are directed primarily at achieving national health goals for better health of individuals, families and communities. These roles, however, vary from country to country. They may lie close to service delivery at ground level or they may relate to nursing and midwifery policy and planning oversight. The global forums have discussed four models of the GCNMO's role: executive, advisory, nurse dispersal and chief nurse programme (WHO, 2006). In general, these roles provide opportunities for nursing and midwifery to influence government policies and decisions in relation to population health and health-care provision (Hughes, 2002).

Nursing and midwifery leaders are often required to work in international organizations or have an international focus in their roles and responsibilities to contribute to the global efforts in attaining health. Kim et al (2006) conducted a qualitative descriptive study using structured interviews with 17 nurse leaders from 8 countries in 5 continents to understand the competency requirement of nurse leaders working at global or international level. They found that these nurse leaders learned from their mentors, sustained productive results, and exhibited leadership potential early in their general and professional education. This study indicates the need for structured preparations that include training for global competencies and exposure to international experiences in addition to formal and informal education. The outcome of this study introduces the requirements of the global and international role that nurse leaders such as GCNMOs assume.

## Leaders' attributes

Researchers have described the attributes and characteristics of leaders in the literature. Leadership attributes have received much attention as they are considered an essential requirement for organizational survival and success. At the same time, defining and developing leadership attributes that move organizations and programmes forward has been a challenge and a concern of many researchers and scientists in business as well as health-care settings.

Leadership, as described by (Stefl, 2008), is the ability to create a shared vision and inspire individuals and organizations to achieve strategic goals. In addition, it encompasses the ability to successfully manage change and performance.

Zenger and Folkman (2013) reported that when IBM asked 1 700 CEOs in 64 countries what they want from their leaders they found that the ability to focus on customer needs, to collaborate and to inspire were the three leadership attributes that mattered most.

Developing leaders with appropriate attributes is a challenge. Intagliata et al (2000) have noticed that efforts directed towards the development of leaders did not achieve the desired outcome. They believed that developing a leadership brand, which is linked to business results, is needed. They have concluded that using leaders' competencies and competency models can yield a leadership brand because they:

- Provide direction;
- Are measurable;
- Can be learned;
- Distinguish and differentiate the organization; and
- Help integrate management practices.

In nursing, the challenge of identifying leadership attributes, is also of concern. Hennessy and Hicks (2003) conducted a Delphi study in 22 European countries to identify the most important attributes of effective CNOs. The study highlighted diversity in CNOs' roles and responsibilities and variation in the required attributes. Many CNOs in this study lacked some of the competencies needed for their roles. For example, in only a few countries in Europe are nurses in general, including CNOs, able to make policy decisions at all levels of health-care services.

In this study, 16 themes covering the identified attributes were described (p. 444):

- Political astuteness;
- Leadership;
- Communication;
- Strategic thinking;
- Conflict resolution;
- Good management;
- Professional credibility;
- Research skills;
- Decision making/problem solving;
- Physical characteristics;
- Decency/integrity;
- Personal qualities;
- Innovation;
- Promotion of nursing;
- Team working; and
- Information handling.

## Competencies

Attributes and characteristics are used in the literature to refer to competencies and included in the definition of competencies are knowledge, skills and behaviours as main components. For example the Institute of Medicine (IOM) defined professional competence as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individuals and community being served”. The IOM also proposed five core competencies for health-care clinicians. These competencies include: providing patient centred care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and utilizing informatics (IOM, 2003).

The National Center for Healthcare Leadership (NHCL, USA) competency framework is a relevant example for health-care leaders. The framework was developed based on findings from the literature on leadership and management competencies and was adapted and utilized in many health-care settings. It contains three competency domains including: transformation, people and execution (Ross Baker, 2003; Calhoun et al, 2002; NHCL, 2006).

Stfel (2008) described the Healthcare Leadership Alliance (HLA, USA) efforts in developing common competencies for all health managers. The HLA is a consortium of six major professional membership organizations. Based on research findings and experiences of these organizations, five competency domains, common among all practising health-care managers, were identified. These domains include: communication and relationship management, professionalism, leadership, knowledge of the health-care system and business skills and knowledge.

As the competency models of NHCL and HLA have a high degree of congruence, they provide relevant competency sets to inform the development of a competency framework for the roles and responsibilities of GCNMOs.

# ROLES AND RESPONSIBILITIES

The responsibility of the GCNMO is to assist the government to achieve the health goals of the country through nursing and midwifery, by provision of expert advice based on timely accurate local data and national and international evidence, and through professional networks of influence and professional understanding.

Based on the literature review and outcomes of the GCNMO forums, the roles of the GCNMO may be categorized under:

- Leadership and influence;
- Policy advice;
- Planning and delivery of health systems and services; and
- WHO programmes for health status improvement.

## Leadership and influence

In their national capacity, GCNMOs are responsible for providing authentic leadership in nursing and midwifery. They provide strategic direction and objectives for action to achieve strategic goals with a clear focus on achievement of outcomes for the benefit of patients through the nursing and midwifery profession. They create and communicate a credible and shared vision, deliver and measure a strategy, mobilize team members, motivate and empower them, and provide support and guidance. They demonstrate true commitment in leading and developing nurses and midwives to deliver professional practice to their full potential. The leadership role of GCNMOs is critical because of its impact on influencing and shaping nursing and midwifery practice.

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### GCNMO RESPONSIBILITY

- Setting and evaluating shared and appropriate nursing and midwifery strategic direction, objectives and plans and ensuring appreciation of the resources required to facilitate implementation, with outcomes clearly focused on patient benefit.
- Introducing, influencing, managing and evaluating innovative change programmes to achieve strategic objectives.
- Identifying and developing national nursing and midwifery capacity and capability to deliver positive patient outcomes.
- Establishing liaison, collaboration and networking with the professions of nursing and midwifery, and other health professionals and organizations.
- Establishing appropriate partnerships and facilitating collaboration with both the private and public sectors and academic institutions.
- Representing and advocating nursing and midwifery interests and contribution nationally and internationally.
- Advocating involvement of patients, families and communities in health-care decisions.
- Advocating consideration of the health of the population in public policies and services.
- Leading the establishment of governance structures for nursing and midwifery at national and institutional levels to provide overall leadership and direction.
- Engagement of nursing and midwifery in setting shared annual strategic goals and programmes, including effective workforce planning.

## Policy advice

An important role of the GCNMO is to provide policy advice to government and to participate in health agenda setting. Policy activity enables the nursing and midwifery voice to be heard at policy development level and to reliably inform national policy for both the present and the future. This role also facilitates the influence of the GCNMO as an advocate for the health of the population when strategies and practices are determined.

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### GCNMO RESPONSIBILITY

- Providing advice and credible professional opinion on nursing and midwifery's contribution to meeting population health goals and the development of national health plans.
- Providing advice on nursing and midwifery workforce capacity, capability and skill mix.
- Providing strategic advice to the minister of health and the government on nursing and midwifery.
- Recommending policies and initiatives to support government health objectives relating to quality, safety and best practice.
- Recommending professional regulation and policy in relation to the nursing and midwifery profession and professional practice.
- Providing advice on educational programmes standards, accreditation and funding.
- Engaging communities, organizations and other sectors to identify key components of effective policy to promote health in the context of nursing and midwifery and the wider health arena.
- Identifying and collaborating with partners in addressing public health issues.
- Advising on the effectiveness of health policies in relation to nursing and midwifery, to include recommendations on further policy direction in this regard.

## Planning and delivery of health systems and services

In addition to leadership and policy advice roles, GCNMOs may have operational roles in terms of planning and delivery of health systems and services. Regardless of the level of direct or indirect engagement in service delivery, GCNMOs need to understand and influence management principles and practices such as financial management, human resources for health, governance, safety, access, equity, appropriate use of technologies and community engagement.

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### GCNMO RESPONSIBILITY

- Establishing national nursing and midwifery standards for quality and patient safety.
- Promoting the implementation of appropriate laws regulating nursing and midwifery education, practice settings and practising professionals.
- Promoting safe, effective and economically sustainable models of care.
- Overseeing nursing and midwifery service delivery processes.
- Enhancing nursing and midwifery productivity, capacity and capability through learning and development opportunities.
- Utilizing information systems and technologies to improve efficiency and quality of services.
- Coordinating emergency preparedness and crisis response.



## Programmes for health status improvement

In countries where there is a significant WHO presence and in the context of WHO priority programme areas such as: family and community (ageing, gender, reproductive health, making pregnancy safer), health action in crisis, health security and environment, HIV/AIDS, noncommunicable diseases, mental health, and health systems and innovations, the GCNMO has a number of responsibilities.

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### GCNMO RESPONSIBILITY

- Coordinating nursing and midwifery input into priority health programmes.
- Acting as a liaison between the ministry of health and WHO on nursing and midwifery.
- Facilitating multidisciplinary teams for the implementation of health interventions in the country.
- Contributing to the health status assessment of the country.
- Planning, implementation, coordinating and monitoring of health programmes

Recent evidence has shown the need for service integration and a multidisciplinary, interprofessional approach in the planning and operation of these programmes. This immediately places nursing and midwifery leadership in a central position in the execution of these programmes as nurses and midwives constitute the largest segment of the health workforce.

# COMPETENCY FRAMEWORK

The following competency framework developed for this publication is based on the literature findings and on the consensus statement on GCNMOs' roles and responsibilities resulting from the WHO global forums.

The National Center for Healthcare Leadership model (NHCL, 2006) and the Healthcare Leadership Alliance model provided evidence-based core sets of competencies for health-care leaders. Both of these models have informed the development of the GCNMOs' roles, responsibilities and competency framework. This framework, also, has taken into consideration the four areas of influence which reflect the GCNMOs' roles and responsibilities as indicated earlier.

At the centre of the framework is the circle of national health goals towards communities, families and individuals representing the primary or key responsibility of the GCNMO. The three competency domains of leadership, policy and management are positioned around the circle of national health goals with arrows representing the continuity and interrelatedness of the domains and outline the knowledge, skills and behaviours needed by GCNMOs in carrying out their roles and responsibilities. The maximum benefit is achieved if all domains are considered to determine the identified GCNMOs' roles and responsibilities.

The schematic representation of the framework contains the list of competencies under each domain and GCNMOs' responsibilities on one side and roles on the other – providing a summary of all the essential components of roles, responsibilities and related competencies in diagrammatic form (see Figure 1).

**Figure 1. CGMNO competency framework**



A competency is the capability to use a set of related knowledge, skills and behaviours to successfully perform identified jobs, roles or responsibilities.

Knowledge is defined as the theoretical or practical understanding of a subject gained through formal education or practical experiences.

Skills are abilities to perform a job well. They could be cognitive, technical or people skills, such as communication, interpersonal and problem-solving skills.

Behaviour is the way or manner in which we act towards ourselves or others.

Skills and knowledge are technical competencies and are developed through technical training and/or formal education, while personal traits, motives, self-image and similar characteristics are behavioural competencies, and these are either innate to the person or are learned (Garman, 2006; Epstein and Hundret, 2002).

## Competency domains

GCNMOs, through the global forum meetings, have identified the following three domains under which skills, knowledge and behavioural competencies are categorized:

- Leadership;
- Policy; and
- Management.

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### LEADERSHIP DOMAIN

The leadership domain includes the following competencies:

**Change management:** the ability to identify, introduce, sponsor, manage and support innovative change. It includes the ability to adapt and work effectively in uncertain or changing situations, and with diverse individuals and groups from within the profession and outside. It involves empowering team members and helping them understand why change is needed, what is in it for them and providing continuing guidance and support to maintain enthusiasm and commitment to the change process and develop them as change champions. It also involves the use of effective authentic leadership to facilitate change and overcome resistance.

**Communication:** the ability to present confident and articulate evidence-based arguments, ideas, policies and practices to a variety of audiences on behalf of the government and the profession. It is the ability to use oral and written communication in communicating health-care goals and disseminating information to various parties at various levels. It includes the ability to listen actively and carefully, and involve others.

**Professionalism:** a perceived value. It results from personal characteristics and values such as integrity, decency, ethical conduct, professional credibility, compassion, empathy, confidence, adaptability, critical thinking, emotional intelligence and humility.

**Talent development:** the ability to align talent development objectives with the health strategy through the establishment of national talent development plans that ensure continuous feed to the nursing and midwifery leadership. This includes the ability to provide mentorship and career counselling to the top talent so they may develop required skill sets. It also includes succession planning and coaching.

**Team leadership:** the ability to work with and lead internal and external teams and groups to achieve health objectives, fostering an environment that appreciates diversity, partnership, communication and collaboration with others. It includes the ability to collaborate with sector-wide health-care workers in multidisciplinary health-care teams. It also includes the ability to anticipate, recognize and manage conflict.

**Strategic thinking:** the ability to anticipate and foresee future changes, opportunities and challenges, risks and benefits; create various alternative scenarios for the possible futures; understand the available options; choose and create a common organizational mission and vision, strategic objectives; decide the strategic direction; and be able to share the vision.

**Decision making:** the ability to make responsible, wise and timely decisions based on data, information and intuition and follow them through.

**Networking and partnerships:** the ability to develop, promote and manage essential partnerships and networks with a variety of stakeholders (i.e. nurses and midwives, administrators, professional organizations, regulatory authorities, educational institutions, private and public sectors, etc.) nationally and internationally to achieve national health-care objectives.

**Inspirational:** the ability to inspire individuals and organizations to achieve strategic goals.

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## **POLICY DOMAIN**

The policy domain includes the following competencies:

**Public policy knowledge:** the knowledge of public policies, priorities and services and their impact on health and the knowledge and access to public policy process relating to health-care priorities and resources.

**Political astuteness:** the ability to recognize, analyse and understand political processes in health-care environments and work within these processes or influence them to achieve health goals. It also includes knowledge and application of principles of emotional intelligence; i.e. knowing and controlling oneself and knowing and influencing others, awareness and knowledge of the environment, and ability to build relationships and alliances.

**Policy development:** the ability to identify, analyse and develop appropriate policies to meet national health objectives. It is also the ability to evaluate the outcomes and make further policy recommendations to ensure translation into practice.

**Research utilization:** the knowledge of epidemiology, research and evidence-based health-care and the ability to interpret and use research findings and evidence in recommending health-care policies. It is also the ability to recognize the necessity for new research evidence in areas of practice to support informed decision making.

**Professional regulation understanding:** the understanding of the importance of regulation in promoting the ability of nurses and midwives to respond to societal needs for health-care services, including understanding the definition of the profession and its members, the scope of practice, standards for education for ethical and competent practice, and systems of accountability and responsibility.

**Health-care environment understanding:** the understanding of the context, status and development of health, health care and nursing and midwifery. It also includes understanding of social and cultural determinants of people's health and understanding of the political processes and government engagement in health systems and services nationally and internationally.

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## **MANAGEMENT DOMAIN**

The management domain includes the following competencies:

**Financial management:** the knowledge of principles of finance and budgeting, understanding and use of financial information and statements and understanding and management of health-care budgets.

**Resource allocation:** the knowledge of principles of appropriate and effective resource allocation for health services according to population health priorities and fairness in resource allocation to meet health needs.

**Data and information management:** the knowledge of information and communication technologies and their application in health care and health-care management to improve efficiency and achieve health-care objectives and the knowledge and skill in analysing and using data and information to identify trends and support decision making.

**Planning:** the ability to develop shared strategies in line with the health-care vision and priorities and translate those strategies into operational plans with clear deliverables, timelines and budgets; use of other resources and performance indicators.

**Human resources development:** the knowledge of human resources policies in the country and the knowledge of principles and best practices in nursing and midwifery human resources management in recruitment and retention, professional development, performance management, succession planning, talent development, and positive work environment requirements and standards.

**Quality management:** the knowledge of the principles and best practices of quality management, standards and patient safety and the commitment to quality in health service delivery.

**Occupational health and safety:** the knowledge of occupational health and safety policies and procedures in order to identify health and safety concerns, anticipate danger and take the necessary steps to ensure the development of policies and standards to promote a culture of safety including risk management.

**Programme management:** the ability to evaluate the feasibility of a programme, conduct resource planning, economic analysis and review programme performance. It is the ability to acquire, mobilize and utilize resources within budgetary constraints and manage programmes effectively to ensure timely and cost effective delivery of programme objectives. It is the ability to prioritize between demanding objectives and tasks and choose the best course of action. It is also the ability to leverage information technology tools and other techniques for programme analysis and management.

## Competency framework utilization

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### BENEFICIARIES

- Governments in understanding the roles, responsibilities and contributions of GCNMOs.
- GCNMOs to reflect on their roles, expertise and the required competencies to be effective in carrying out their responsibilities and in contributing to their professional development.
- Government officials in the health sector, educational institutions providing leadership courses and programmes, human resources departments, nursing and midwifery professional associations, regulatory councils and authorities in establishing professional development programmes.

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### POSSIBLE USES

- Selection, recruitment and promotion to the position of GCNMO.
- Development and performance evaluation of GCNMOs and potential GCNMOs.
- Self-assessment by GCNMOs or potential GCNMOs.
- Development of educational and professional development programmes.
- Communication and awareness of the position, its importance and implications.

## Self-assessment

The competency framework could be used for self-assessment. GCNMOs or nurse leaders in similar positions could assess their level of competence against any or all of the identified competencies in the framework. This could help them understand their strengths and identify areas for improvement and development.

Professor Jill White developed a self-assessment tool for GCNMO competencies (WHO, 2010). This self-assessment tool was presented and adopted by GCNMOs at their 2010 forum. The tool reflects the roles and competencies as described in this document. It contains the identified three domains and the 23 competencies (see Annex 1).

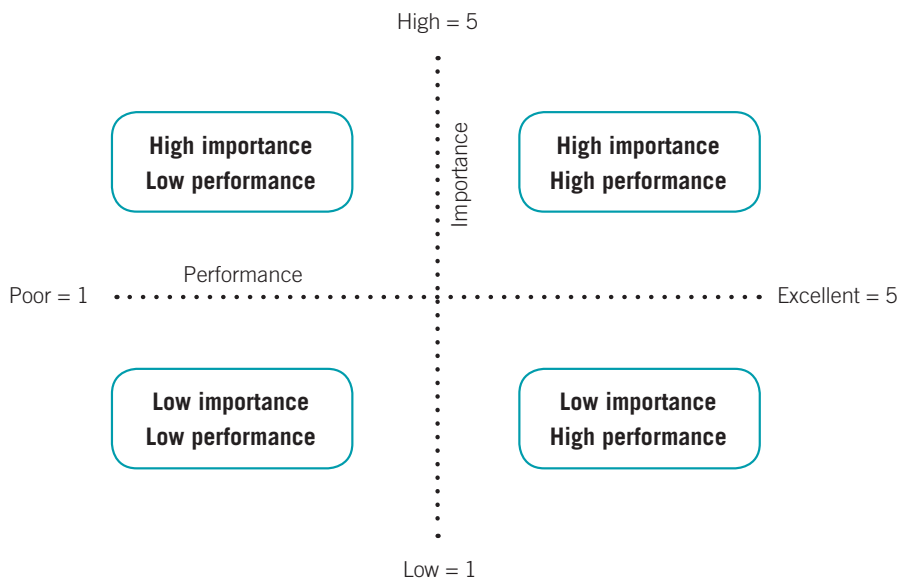
This tool has been constructed using dual Likert scales for each competency so that GCNMOs score themselves on the importance of the competency to them in their context from (1 = low) to (5 = high) and score their level of performance in the competency from (1 = poor) to (5 = excellent).

The reason for the use of dual scale is that it enables the GCNMOs to plot their outcome within the following four quadrants:

1. Competencies of high importance and high performance
2. Competencies of high importance and low performance
3. Competencies of low importance and high performance
4. Competencies of low importance and low performance

This enables GCNMOs to identify those areas in the top left quadrant (low performance/high importance) and target these areas for improvement. It also allows them to identify those areas in which they have strengths in high importance areas where they are in a strong position to act as a mentor/leader/teacher (see Figure 2).

**Figure 2. Competency rating quadrants diagram**



Source: Developed by Professor Jill White

The GCNMOs' roles will vary from country to country and may lie close to service delivery at ground level or may be more abstract and relate to policy and planning oversight. Whatever the level of direct or indirect engagement in service delivery there will be issues that the GCNMO needs to understand and influence ranging from finance, to human resources for health, governance, safety, access, equity, appropriate use of technologies and community engagement. When self-assessing it is important that GCNMOs rate their personal abilities regardless of the country context constraints within which they work.

## LESSONS FROM THE FIELD

The following case studies reflect successes and challenges in relation to GCNMOs' roles and responsibilities in a number of countries. They provide examples of competencies that enabled GCNMOs to influence government health policies, mobilize resources, engage partners and manage change.

### Australia: The case for networking, partnerships and communication

GCNMO: Rosemary Bryant

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#### BACKGROUND

Australia has a federal system of government comprised of six states, two territories and the Australian Government. The Constitution of Australia determines to a large extent the responsibilities at each tier of government. Responsibility for most aspects of nursing and midwifery rests with the states and territories and there is a CNMO in each jurisdiction. Nevertheless over recent years, it has been recognized that nursing and midwifery are national resources and that there is a need for a nursing and midwifery presence in the Australian Government. Thus in 2008 the position of a government CNMO was established.

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#### NURSING AND MIDWIFERY IN AUSTRALIA

As the Australian Government has no direct responsibility for nursing and midwifery, the role of the CNMO had to be carefully crafted to enable the incumbent to develop relevant national policy and then negotiate its implementation with the states and territories. National consistency of policy development in all aspects of nursing and midwifery is critical for a workforce of 360 000 in a country of 23 million people.

Nursing and midwifery stakeholders are numerous and, while the state and territory governments are key players, there are also many other groups. These include nursing and midwifery professional associations and unions, the regulatory agencies and educational bodies. Additionally there is a plethora of speciality nursing associations numbering more than 60. Coordinating policy change and communicating with such a large group, many of which have differing goals, can be variable and at times tortuous.

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#### THE NURSING AND MIDWIFERY STAKEHOLDER REFERENCE GROUP

When the CNMO position was established, a decision was taken to implement a stakeholder reference group, known as the Nursing and Midwifery Stakeholder Reference Group (the Group), with the aim of facilitating the exchange of information and advice between stakeholders and the Australian Government. It was decided to limit the Group to a manageable size and to liaise with speciality organizations on a case-by-case basis.

The Group is composed of nursing and midwifery associations including the larger speciality groups, academics, regulatory bodies, a representative of the state and territory governments and a consumer.

The terms of reference for the Group are:

- Facilitate the exchange of information and advice on nursing and midwifery education and workforce issues between the Department of Health and the Group.

- Facilitate the exchange of information and advice on national nursing and midwifery policy and programmes between the Department of Health and the Group.
- Enable the Group to provide advice to the Department of Health on specific nursing and midwifery issues as they arise and as requested by the Department.

The Group meets four times a year. It is well attended by both stakeholders and Australian Government Department of Health staff.

It provides an opportunity for Australian Government Department of Health officers to explain key government policies such as budget initiatives and interpret their likely effect on the nursing and midwifery workforce. At times governments make decisions which are not particularly palatable to some. Happily, the Group is not seen as a forum where political posturing takes place. It also provides an opportunity for the CNMO to receive advice on key issues as determined by the professional organizations.

The terms of reference include focusing on communication between stakeholders and bureaucrats and this function has indeed been useful. However, over time communication between stakeholders themselves has emerged as a key function. This means that there is the opportunity to discuss key policy developments, which has enriched the debate and at times resulted in better policy outcomes.

Finally, the value of facilitating a forum for networking cannot be underestimated as face-to-face informal communication can also serve to break down barriers between professional organizations and the bureaucracy.

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## CONCLUSION

A formal evaluation of the Group has not been attempted but after six plus years of operation the informal view is that it is a useful space for communication and debate. It also adds to the transparency of Australian Government initiatives. At this time of significant change in the health system, unity and cohesion are vital for nursing and midwifery in a country which is so geographically dispersed. The Group contributes not only to government operation but also to ensuring that nursing and midwifery organizations understand each other's goals and policy positions on specific topics.

## Ghana: The case for change management

GCNMO: George Kumi Kyeremeh

In the recent times, the Ghana Ministry of Health (MoH) has undergone reforms which have resulted in separation of functions. The mandate of the MoH was reduced to policy formulation, planning, monitoring, evaluation and resource mobilization. Service delivery was mandated to the implementing agencies of the MoH, notably the Ghana Health Service (GHS). The reform no doubt has some advantages for the MoH and its agencies, such as focusing on their core mandate, but has also brought some challenges to the office of the GCNMO.

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## PRE-REFORM

During the pre-reform state the office of the GCNMO was a whole directorate located at the MoH. There were four reporting officers: education, nursing and midwifery, psychiatry and public health. The system had an added advantage for effective and efficient coordination of nursing and midwifery activities throughout the country. The GCNMO was in full control and was in the driving seat as far as the administrative machinery of the profession was concerned. She also fitted into the organogram of the MoH and had direct access to the office of the Hon. Minister of Health for policy issues and matters involving nursing and midwifery.



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## POST REFORM

The functions of the GCNMO still remained strategic and operational but the terrain had changed. This change was not objectively appreciated and adequately addressed through a robust policy change to meet current challenges. The reforms moved the service provision component of the office of the GCNMO to the agency level, notably the GHS, which is headed by the Director-General.

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## ROUGH EDGES

Some agitating and nagging questions remain unanswered as far as the current situation is concerned. For example, where exactly should the GCNMO's office be located to oversee nursing and midwifery activities in all the agencies of the MoH – at the ministerial or agency level (such as GHS)? In this case how can the GCNMO exert influence and authority over staff in other agencies? To whom does the GCNMO report – the Hon. Minister of Health or the Director-General of GHS? In the latter case, how will that facilitate efficient and effective functional formal relationships with the other agencies of the MoH such as teaching hospitals, private and quasi-private facilities?

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## CURRENT SITUATION

The current situation presents a number of challenges in the discharge of the duties of the GCNMO. It would be useful to learn from the experiences of others in similar situations. Despite the above challenges, the experience has been that existing strengths and opportunities are continuously tapped into in order keep moving forward.

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## STRENGTHS

- Designated office for GCNMO at ministerial level; and
- Competent, hardworking and highly motivated staff.

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## OPPORTUNITIES

- High-level political will and supportive environment;
- Friendly and cooperative directors of the MoH;
- Supportive national association and regulator; and
- Open-minded GHS and other agencies for dialogue.

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## WAY FORWARD

The way forward is to continue to use the strengths to seize the opportunities for advocacy for the GCNMO position to be formalized at ministerial level. This will enable the office to perform its strategic and operational functions effectively and efficiently. Country specific differences exist; the role of the global GCNMO forum in coming up with clear policy direction to help push the establishment of GCNMOs at ministerial level is both timely and appropriate.

## Ireland: Nursing and midwifery at the top table

GCNMO: Dr Siobhan O'Halloran

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### CONTEXT

Ireland is a small island nation with a population of just over 4.5 million. The current government programme promises the most fundamental reform of health services in the history of the state as outlined in *Future Health – A Strategic Framework for Reform of the Health Service 2012–2015*. The core of the government's health reform programme is a single-tier health service, supported by universal health insurance (UHI). There are four key interdependent pillars of reform: health and well-being, service reform, structural reform and financial reform. There is no doubt that the scale of reform required, combined with the country's financial and economic circumstances, will present many challenges over the coming years.

There are approximately 64 000 nurses and midwives registered with the Nursing and Midwifery Board of Ireland. Nursing and midwifery are considered to be two separate professions as set out in recent legislation: the Nurse and Midwives Act 2012. Nurses and midwives are essential members of the health-care team accounting for 34% of the overall health workforce in Ireland. There are seven distinct divisions across the professions: general, mental health, intellectual disability, public health, children's, midwifery and nurse teaching.

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### THE DEPARTMENT OF HEALTH

The Department Health provides strategic leadership for the health service and ensures that government policies are translated into actions and implemented effectively. The department, through a civil service structure, supports both the minister and ministers of state in the implementation of government policy and in discharging the governmental, parliamentary and departmental duties. These duties include:

- Advising on the strategic development of the health system including policy and legislation;
  - Evaluating the performance of the health and social services; and
  - Working with other sectors to enhance people's health and well-being.
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### CATALYST FOR CHANGE

A number of catalysts for change have strongly shaped the development of nursing and midwifery over the last 20 years. Demands on the health service are growing rapidly due to an ageing population, a high birth rate and a greater prevalence of chronic disease. Other factors include economic turbulence, technological developments, advances in scientific understanding and globalization of the workforce, to mention but a few.

Of particular significance in Ireland was the emergence of general dissatisfaction and industrial disquiet during the late 1990s. A Commission on Nursing was established by the Minister for Health in 1997. The commission examined and reported on the role and professional development of nurses, the education of nurses and midwives and the promotional opportunities including a career pathway for nurses and midwives. This blueprint for the future of nursing in Ireland led to many initiatives that are now benefiting the health services.

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### EMERGENCE OF THE ROLE OF CHIEF NURSE

The Commission on Nursing recommended the appointment of a chief nurse officer (CNO) in the Department of Health. The role of the first CNO was to strengthen the central planning and strategic development of nursing and midwifery, strengthen workforce planning, and provide professional leadership and quality assurance functions. This appointment was supported by

nursing and midwifery advisers from the health services which culminated in the development of a Nursing Policy Division in the Department of Health headed by a senior civil servant with the CNO acting as the authoritative source of nursing and midwifery advice in relation to the broad health agenda. The role was mainly an advisory one to the civil service and the political system.

A number of significant developments were driven by the government and the Nursing Policy Division during this period. These included the transition of nursing education from the health sector to the third level sector and the establishment of an undergraduate programme as the entry level to nursing; the introduction of clinical nurse specialist and advanced nurse practice; the establishment of the Council for the Professional Development of Nursing and Midwifery; and the introduction of regional nursing and midwifery planning and development units. During this decade and a half three CNOs were appointed sequentially.

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## **DEVELOPMENT OF THE CNO ROLE**

In 2013 the Irish Government took a decision to re-grade the CNO to assistant-secretary level and include the post as part of the Management Advisory Committee of the Department of Health. The CNO is now accountable to the Secretary-General and has executive responsibility for all policy matters related to nursing and midwifery as well being the authoritative source of this advice across government. This represented a profound change in the mechanism for ensuring that nursing and midwifery is central to health reform. The appointment at this level is designed to ensure that a nursing and midwifery perspective is brought to bear on the development of policy at the highest level of the political system.

The CNO's office plays an important strategic and leadership role. It provides professional opinion, policy direction and evidence-based advice. The CNO is supported by specialist nursing and midwifery expertise from three deputy CNOs. The three general areas for which the deputy CNOs have respective responsibility are women's health and primary care services; nursing and midwifery policy and legislation; and clinical governance and practice.

The office undertakes the full range of corporate duties including parliamentary and general interdepartmental support to the business of the Department of Health to achieve cross-government health policy initiatives. It does this by working collaboratively through a unique model of partnership which engages both civil servants and clinicians collectively focused on strengthening the nursing and midwifery contribution to health policy.

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## **FUTURE STRATEGIC DIRECTION**

The CNO has developed a strategy entitled *The Point of Truth – The Point at which the Person Touches the Service*. This title is a declaration of the office's focus and ultimate goal, i.e. all of its activities are based around the most important person, the health service user, and lead up to the point where that person interacts with nurses and midwives.

The goal of the CNO's office is to transform nursing and midwifery so that when people are seeking care they are also focused on the quality of that care. We want all people to recognize the importance of nursing and midwifery expertise so that our hospitals and health-care settings become known as places where one goes to receive excellent nursing and midwifery care guided by the three values that underpin nursing and midwifery — care, compassion and competence.

**Vision mission and strategic objectives:** the vision of the CNO's office is to achieve national public health goals through nursing and midwifery. Public good is the end, the person is central, nursing and midwifery is the means, nursing and midwifery metrics are the proof. The mission is to maximize the capacity of nursing and midwifery to strengthen the health system and optimize service provision in the interests of people, their families and the wider community. This can be achieved through the promotion of high quality, safe and economically sustainable models of care. Four strategic objectives designed to guide the journey include to:

- Provide expert policy direction to support government priorities and to maximize public investment in the health system;
- Strengthen the role of nurses and midwives by challenging regulatory, cultural and organizational barriers to maximize the scope of practice across the health service;
- Enhance productivity, stability, capacity and capability through learning and development opportunities, the utilization of robust data intelligence and promoting the impact of nurses and midwives; and
- Enable nurses and midwives to serve as full partners in health-care design and improvement by enhancing leadership competency and opportunities.

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## AT THE TOP TABLE

In creating and bringing to life this vision, nursing and midwifery came to take a place at the top table in the Department of Health. The identity of nursing and midwifery at senior policy level is a double-edged sword. This new visibility as a profession poses new challenges related to demonstrating outputs and impact on patient care and the health services. Nursing and midwifery can attest to the values of care, compassion and competence but demonstrating added value, return on investment and accountability for safe, effective and efficient care are new challenges.

A critical tension exists between the role of the CNO as a public service leader with corporate identity and responsibility and a nursing and midwifery leader who is an agent for transformation. I believe it is in the tension between these two roles that we can set realizable goals for the future of nursing and midwifery in Ireland.

The possibility of strengthening the largest component of the health-care workforce – nurses and midwives– to become partners and leaders in improving the delivery of care and the health system is a significant opportunity for nursing. Accessible to high quality care cannot be achieved without exceptional nursing care and leadership. By working together nurses and midwives can bring more credibility and visibility to issues, help develop the strategic capabilities of clinical leaders across the country and place nursing and midwifery at the very heart of strategic decision making in government and across the health service.

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## LESSONS LEARNED/CONCLUSION

There are advantages to being a small country – it is relatively easy to bring about streamlined coordinated change as a whole when compared with larger nations. The key ingredients to successful change initiatives in Ireland have included a government committed to the development of the professions and interested in innovation, pioneering nursing and midwifery leadership and strong partnerships across major stakeholders including staff associations, the regulatory bodies and the higher education sector amongst others.

Outlining how nursing and midwifery came to earn a seat at the top table is as much about having a unified a vision, developing resources and people, planning and astute management as it is about opportunism and political confidence. Hindsight is a wonderful lens but utilizing every opportunity and demonstrating value to the national agenda is the main lesson. Difficulty in recruitment in the early 1990s, a European Union directive that increased the educational requirements, an industrial relations issue, the Commission on Nursing with 205 recommendations, and a supportive political system, along with hard work on the ground by many nurses culminated in the current developments. Strong leadership underpinned by values that guided the vision, with an ability to bring people along, resulted in a neophyte office that is currently working to make its mark.

## Jamaica: The case for networking and partnerships

GCNMO: Marva V Lawson Byfield

The present incumbent assumed the role of CNO in March 2013, having been involved in nursing education for many years. Her predecessor expressed concerns about the relationship with the Nurses Association of Jamaica (NAJ) and the Nursing Council of Jamaica (NCJ). Collaborating with the NAJ and NCJ is a key function of the CNO as specified in the job description.

With this in mind, during orientation, the new CNO met separately with the NCJ Chairman and Registrar and the President of the NAJ followed by a combined meeting. Both encounters were collegial and well received, which made it easy to introduce the purpose of convening tripartite meetings (CNO, NAJ, NCJ). Collaboratively, the three bodies would provide effective leadership and policy direction to strengthen the nursing and midwifery workforce. This would also provide an opportunity to discuss the critical challenges affecting nursing and midwifery services.

It was suggested to rotate the venue of the meetings as all offices were in close proximity; facilitating sharing of responsibility. Although the NCJ and NAJ are accountable to the CNO, each body is responsible for hosting the quarterly meetings in turn. The meetings have paid big dividends, and in May 2014 all three parties attended the global forum in Geneva. The mantra of the CNO is, “If the three heads of nursing (policy, regulation and advocacy) cannot get it right, no one else can.”

## Lesotho: The case for human resources development and political astuteness

GCNMO: Makholu Nthabiseng Lebaka

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### MISSION OF NURSING AND MIDWIFERY SERVICES

The mission of nursing and midwifery services in Lesotho is to provide equitable, accessible, competency and evidence-based nursing and midwifery care to all the people of Lesotho, in line with the policies of the Lesotho Ministry of Health and decentralization reforms. The vision of Lesotho nurses and midwives is to be visible, professional, viable and responsive to the needs of the people of Lesotho.

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### BACKGROUND

Lesotho is a small mountainous country completely landlocked within the Republic of South Africa. It has a population of 1.8 million. The Ministry of Health adopted a decentralization of health services to fulfil its mandate of access, equity and universal coverage. Some of its partners contributed with improved infrastructure to facilitate this goal. Due to the extremely mountainous terrain some health facilities are hard to reach making it difficult to attract health workers. Important to note is that primary health care provision in Lesotho is nurse led, and it was even more challenging to deploy nurses to hard-to-reach areas where there was no access to communication, no network, no access roads and no schools for their children. In simple terms life is very difficult in such places.

The partners who erected new and refurbished old buildings to make them more habitable started complaining to the Ministry of Health that the beautiful buildings had become “white elephants”. It was arising from this concern and that of the mal-distribution of skilled nurses coupled with extremely high maternal and neonatal mortality rates (MMR 1 155/100 000) that an innovation to attract nurses to work in these hard-to-reach places was developed. An incentive package was drawn up and sold to other partners. Negotiations took time but were eventually

fruitful, and “buy in” was sought from parliamentarians as they had to commit to sustaining the plan (which also endorsed their authority). To sell this to the nurses, job fairs for graduating nurses both at high school and nursing college level were held. These job fairs showed nurses the benefits of working in the hard-to-reach areas, enable them to make choices after graduation.

The incentive package includes but is not limited to:

- Furniture – to cut down the expense of buying and transporting furniture;
- Television and satellite dish to ensure reception wherever they are;
- A gas fridge – to store food (which is challenging as shops are extremely far) and a 48-kg gas canister;
- A four-burner gas stove to facilitate cooking and a 48-kg gas canister;
- A gas heater as most parts of Lesotho are very cold in the mornings and evenings all year round and a 48-kg gas canister;
- Airtime allowance to contact their families and other facilities for support; and
- Transport allowance to facilitate travel when they are off duty.

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## LESSONS LEARNED

Nurses volunteered to go to these hard-to-reach areas where health services were limited. Now 95% of these hard-to-reach facilities have a minimum staff complement of three midwives and two nursing assistants from a starting point of zero. They offer comprehensive primary health care services. Over and above the services provided they conduct deliveries which is a major stride towards reducing the maternal and neonatal deaths due to inaccessible health facilities. Nothing is impossible if those who make the effort tell convincing true stories to appropriate stakeholders, e.g. partners and the parliamentarians.

## Sultanate of Oman: The case for strategic thinking and policy influence

GCNMO: Dr Majid Al Maqbali

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### BACKGROUND

Advanced nursing practice was introduced as a response to changes in the health-care delivery system and consumer demands. Some of the driving forces that led to this innovation include shortfalls in doctors both in numbers and specific areas of expertise, emerging health problems due to lifestyle changes, increase in life expectancy, and the global trend of moving care closer and deeper into the community. Nurses currently working in the primary health care centres of Oman are functioning in advanced practice roles without any formal educational preparation and often in the absence of medical supervision during evening shifts and weekends.

My role as GCNMO started by gathering evidence to inform policy to support the development of such a role through a national situational analysis. This process was supplemented by collaborating with stakeholders; exerting influence to win their support through evidence. The evidence gathered proved that Oman is in a strong position to introduce this role. This led to high-level strategic planning for the project in terms of human and financial resources, education and training, regulatory mechanisms, a career path for progression, and a defined scope of practice. Networking with international experts such as WHO technical experts and other GCNMOs and offering expert opinion in benchmarking the proposed innovation with other countries was essential. Visits were made to other countries to find opportunities for training nurses for this role. However, when the plan for developing this role was ready there was some resistance from the other professions. Local and international evidence on patient outcomes and access to health-care services enabled other professions to be convinced about the importance of this role. The project was then presented to His Excellency, the Minister for Health, for approval and, following this, the project moved into the implementation phase.

This case study documents the critical role the GCNMO plays in influencing national health policy and in assisting the government to achieve the health goals of Oman.

## Zambia: The case for understanding the health-care environment and human resources development

GCNMO: Emily S Chipaya

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### MISSION OF NURSING AND MIDWIFERY SERVICES

To provide cost effective, quality nursing and midwifery services as close to the family as possible in order to ensure equity of access to health service delivery and contribute to the human and socioeconomic development of the nation.

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### BACKGROUND

For decades, nursing and midwifery services in Zambia have faced many challenges in the delivery of quality services. The major contributing factor is the human resource crisis brought about by a high attrition rate, resulting from:

- The Voluntary Separation Programme (VSP) introduced by the health reforms of 1991 that gave nurses an option to leave public service early. Many nurses accepted the early retirement option because it gave them a chance to do other things outside nursing or an opportunity to work in the private sector;
- Many nurses left the country (nurse migration) or joined NGOs for better wages; and
- The HIV/AIDS epidemic.

The above factors left the health sector with a brain drain of experienced nurses and midwives including those in leadership positions. As a result inexperienced nurses and midwives were promoted to leadership positions and the lack of experience impacted staff development, patient care quality and safety, and the ability to implement change. Furthermore, the ministry of health underwent a restructuring process where health workers, including nurses and midwives, were placed in various leadership positions. A number of the nurses and midwives who were promoted to leadership positions had no formal or informal leadership or management training. This was confirmed by inadequate supervisory and leadership skills exhibited by most of the nursing and midwifery leaders in the health facilities and training institutions.

In response to this, capacity-building workshops have been established to equip nurse leaders with supervisory and leadership skills. One of the activities of these workshops is the development of action plans to improve nursing and midwifery care in their respective health facilities. The workshops are followed by supportive visits to provide on-site guidance to nursing and midwifery leaders on supervision of nursing and midwifery care. During visits a review of the implementation of the action plans developed during the workshop is done and any necessary technical support provided. So far, the capacity-building workshops and supportive visits have been conducted in nine of the ten provinces in the country.

This intervention has increased the performance of nursing and midwifery services. There has been some improvement in planning for nursing activities, supervision and documentation. It has been noted that in some facilities nursing and midwifery leaders are able to develop audit tools, conduct their own audits and plan how to improve in the areas where gaps are noted. For example, one team identified gaps in medical equipment required for the provision of nursing and midwifery care and these were duly procured. The capacity building has helped in changing the mind-set of the nurses and midwives positively.

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## LESSONS LEARNED

- Capacity building and supportive supervision can increase performance and improve the quality of nursing and midwifery care.
- Frequent supervisory visits help supervisors to regularly audit the care and this results in nurses and midwives adhering to the principles of care provision.
- Nurses and midwives were happy to be visited by their supervisors. This was motivational as they felt cared for as the team helped solve some of the challenges they faced during practice.



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## ANNEX 1. SELF-ASSESSMENT TOOL

	IMPORTANCE					PERFORMANCE				
	Least		Most			Poor		Excellent		
	1	2	3	4	5	1	2	3	4	5
<b>LEADERSHIP DOMAIN</b>										
1. Change management										
2. Communication										
3. Professionalism										
4. Talent development										
5. Team leadership										
6. Strategic thinking										
7. Decision making										
8. Networking and partnerships										
9. Inspirational										
<b>POLICY DOMAIN</b>										
1. Public policy knowledge										
2. Political astuteness										
3. Policy development										
4. Research utilization										
5. Professional regulation knowledge										
6. Health-care environment understanding										
<b>MANAGEMENT DOMAIN</b>										
1. Financial management										
2. Resource allocation										
3. Data and information management										
4. Planning										
5. Human resources development										
6. Quality management										
7. Occupational health and safety										
8. Programme management										



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