

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC**



REPORT

**WORLD HEALTH ORGANIZATION WESTERN PACIFIC REGION,
NURSING AND MIDWIFERY LEADERSHIP SUMMIT, 2006
*BUILDING LEADERSHIP CAPACITY AND DISEASE PREVENTION IN
THE WESTERN PACIFIC REGION***

**28-30th November 2006
Sydney, Australia**

**Sydney, Australia
January 2007**

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NURSING AND MIDWIFERY LEADERSHIP SUMMIT, 2006
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THE WESTERN PACIFIC REGION***

Convened by:

FACULTY OF NURSING, MIDWIFERY & HEALTH, UNIVERSITY OF TECHNOLOGY,
SYDNEY

WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR THE WESTERN PACIFIC

Sydney, Australia
28-30th November, 2006

SPONSORS

The organisers would like to thank the sponsors of this Summit. These were World Health Organization (WHO) , Australian Agency for International Development (AusAID) and International Centre for Excellence Asian Pacific Studies (ICEAPS)

NOTE

The views expressed in this report are those of the participants in the Summit on *Building Leadership Capacity and Disease Prevention in the Western Pacific* and do not necessarily reflect the policies of WHO, AusAID or ICEAPS.

Delegates would like to recognise the contribution to this Summit of Professor Aileen Plant who sadly died in March 2007 while working in Indonesia.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Members States in the Region and for Summit participants.

SUMMARY

A Summit on *Building Leadership Capacity and Disease Prevention in the Western Pacific* was held at the Faculty of Nursing, Midwifery & Health, University of Technology, Sydney, Australia from 28-30th November, 2006. The Summit was attended by 33 Chief Nurses including deputy chief nurses; eleven representatives from various WHO Collaborating Centres (and representatives from two proposed WHOCCs) and 30 other delegates from a range of organizations relevant to the Summit objectives. From the total group of delegates 20 were also speakers. The Summit consisted of key presentations and feedback sessions involving all the Summit delegates.

The aims of the Summit

1. To facilitate the refinement and operationalization of a World Health Organization, Western Pacific Region (WHOWPRO) **Regional Strategic Plan For Nursing And Midwifery** (presented at the 57th WHO Regional Committee for Western Pacific Region held in New Zealand, September, 2006). This plan covers the following areas:
 - Information management systems for Human Resources for Health (HRH) data collection;
 - Workforce needs;
 - Improving the quality of education programs;
 - Strengthening health workforce governance and management.
2. To facilitate the sharing of experiences of **disaster and pandemic preparedness** both in the aftermath of SARS and the current avian influenza threat.
3. To consider workforce capacity issues (HRH) in this context and proposed interventions to address workforce shortages.
4. To develop **leadership capacity** and succession planning for chief nurses within the region.
5. To strengthen regional governmental networks to improve crisis communication, crisis management and leadership in the face of threats within the region.

The main focus of the Summit was to garner feedback and comments from regional nurse leaders on the draft World Health Organization, Western Pacific Region (WHOWPRO) Regional Strategic Plan For Nursing And Midwifery. The plan consists of objectives, indicators and an action plan in relation to: information management systems for human resources for health (HRH) data collection; health workforce needs and strengthening health workforce governance and management; and improving the quality of education programs. The formation of a working group who will meet via teleconference and email, to further refine aspects of the plan was also an important outcome in this regard.

The Western Pacific region consists of a complex mix of developed and developing countries. Following the SARS Summit held at UTS in 2004, it was

SUMMARY

imperative to continue to share and build on nursing experiences on pandemic and disaster preparedness as nurses are on the front-line, being both the key defense against the spread of diseases and involved in the care of those affected by disasters. They are also the most vulnerable to the risk of disease as they perform the procedures involving the highest viral load. The Summit provided the opportunity to exchange information and to hear from experts on pandemic and disaster preparedness. In this context, it was also instructive to learn of interventions to address the region's workforce shortages which contribute to inadequate pandemic preparedness.

The Summit also focused on nursing leadership and sought to encourage delegates in the region to consider succession planning for senior nurses in their countries in the light of current health workforce shortages. Presentations on nursing leadership and succession planning were delivered by experts and those with experience of nursing leadership in their countries.

The Summit consisted of technical and country presentations and provided the opportunity for discussions and feedback relating to the key areas of interest. All presentations were made available to the delegates on a USB mass storage device to enable easy and effective dissemination in their own countries. The list of delegates is in Annex 1 and 3 and the timetable for the Summit in Annex 2.

Building on regional nursing and midwifery leadership, including strengthening regional relationships in line with AusAID's designated policy for Australian development assistance in health '*Helping Health Systems Deliver*' (AusAID 2006) was identified at the Summit as critical to the coordination and management of health issues faced by the region. The delegates committed to the further development of the strategic plan and working groups were formed. It was agreed that the Strategic Plan will provide a tool for developing nursing and midwifery in the region and will be adapted at local levels.

As well as refining the Strategic Plan, the Summit has contributed to an improved understanding of pandemic preparedness and disaster management amongst key health personnel in the region and has fostered the continuing development of a regional network of CNOs. The Summit recognizes the urgency of ensuring an adequate and well-trained health workforce that can provide care in the event of disasters or pandemics. Discussions were held on the process for developing a schedule of CNO meetings ideally coinciding with other events such as ICN.

KEY WORDS

Disaster preparedness/ Pandemic preparedness/ Succession planning/ Nursing leadership/ Strategic planning /Western Pacific/ Human Resources for Health/ Infection control/ Public Health legislation

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1. INTRODUCTION

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The Summit was convened to provide a forum for the Chief Nurses of the Western Pacific Region to participate in the refining of the Regional Strategic Plan for Nursing and Midwifery and also to build on the CNO network established at the 2004 SARS Summit held at UTS to improve crisis communication, crisis management and leadership in the face of health threats in the region. In addition, it provided an opportunity for CNOS, experts on pandemic preparedness, disaster management, human resources for health and infection control and WHOCC representatives to share information and contribute to the objectives of the meeting.

1.1 Objectives

1. To facilitate the refinement and operationalization of a World Health Organization, Western Pacific Region (WHOWPRO) **the Regional Strategic Plan for Nursing and Midwifery** (presented at the 57th WHO Regional Committee for Western Pacific Region held in New Zealand, September, 2006). This plan covers the following areas:
 - Information management systems for Human Resources for Health (HRH) data collection;
 - Workforce needs including strengthening health workforce governance and management;
 - Improving the quality of education programs.
2. To develop **leadership capacity** and succession planning for chief nurses within the region.
3. To facilitate the sharing of experiences of **disaster and pandemic preparedness** both in the aftermath of SARS and the current avian influenza threat.
4. To consider interventions to address workforce shortages.
5. To strengthen regional governmental networks to improve crisis communication, crisis management and leadership in the face of threats within the region.

1.2 Opening remarks

1. INTRODUCTION

Co-convenor of the Summit, Professor Jill White, Dean of the Faculty of Nursing, Midwifery & Health opened the Summit explaining the purpose, significance and program of the Summit. An outline was given of the processes to be used for discussion to ensure that all voices were heard and that everyone had the opportunity to speak. For Day 1, the meeting was restricted to CNOs and representatives from WHOCCs to consider the regional strategic plan. On Days 2 and 3 those from peak nursing and midwifery organizations and other individuals (experts, observers, speakers) were present to participate in sessions on pandemic and disaster preparedness and infection control (Day 2) and nurse leadership (Day 3).

Delegates were invited to introduce themselves and describe what they hoped to achieve from the Summit.

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2.1 Day 1 – Regional Strategic Plan for Nursing and Midwifery

Morning session facilitated by Mrs Pelenate Stowers, Assistant Chief Executive Officer, Performance & Quality Assurance Nursing & Midwifery, Western Samoa

2.1.1 Refinement of Regional Strategic Plan for Nursing and Midwifery, Ms Kathy Fritsch – WHO WP Regional Nursing Advisor

Ms Kathleen Fritsch, Regional Nursing Advisor for WHO within the Western Pacific Region, gave an overview of the objectives of the morning session. She spoke of the role of WHO in the region and also the importance of nursing being able to respond to emerging diseases and disasters in the region.

Ms Fritsch summarized the context and content of the Regional Strategic Plan for Nursing and Midwifery (previously distributed to delegates). The importance of the development and refinement of indicators for demonstrating the effectiveness of nursing was stressed.

Member states had reviewed an earlier draft produced in 2005. The Regional Plan is linked to HRH issues via the WHO document Working Together for Health. Delegates were requested to share priority needs relating to Human Resources for Health (HRH).

The following issues were identified as being priorities:

- Addressing workforce shortages;
- Upgrading skills (postgraduate training to increase skills);
- Financial recognition;
- Addressing the competition with the developed world in terms of working conditions and pay;
- Improving working conditions and wages to improve retention rates;
- Addressing the maldistribution of health workers;
- Addressing small workforces and inadequate disaster and pandemic preparedness.

It was noted that there will be variability in the emphases each country will give to aspects of the Plan. For example, in the Pacific there is strong public health nurse leadership. It was acknowledged that each country will implement the plan concurrently with building consensus within countries on the Plan's objectives. It is probable that each country will select from the plan the objectives that best fit national

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context and objectives.

Delegates were then invited to comment on the draft plan.

General feedback and suggestions for inclusion in the plan:

- It was noted that the objectives are generic (that is, applicable to all healthworkers) and that there will be essential differences between countries on, for example, educational frameworks;
- There will be country-specific needs which may not be reflected in the generic objectives; some adaptation of objectives and indicators may therefore be required;
- A section on succession needs to be included and the leadership component strengthened;
- It should be stated that in many countries nursing is not adequately reimbursed;
- To implement the plan successfully commitment and partnerships are required – teamwork and education should be emphasized;
- Implementers of the plan should form partnerships between nurses and health planners and encourage CNOs and CMOs to work together on the Plan's objectives;
- The benefits and disadvantages of migration should be stated;
- Statements about transcultural nursing and how this may affect the quality of care are required (this will relate to Action Plans 2 and 4);
- The type of data required for workforce planning decisions in the light of changing systems, roles and models of care should be stated;
- Regulation requires a higher profile as it impacts on scope of practice;
- Current IT systems may be inadequate for HRH planning and data collection. Developing a database applicable to all countries requires careful planning;
- A statement of how the plan will impact on population health is needed;
- Acknowledgement that each country will translate the Plan into their own national plans rather than override national plans is required;
- The most important objectives of the Plan should be emphasized: 1) recruitment and migration; 2) how to improve the image of nursing;

Feedback on each of the objectives was recorded and forwarded to the WHOWPRO.

The main outcomes from the morning session of Day 1 were:

1. All agreed that the plan should be developed and that once completed, it will make a difference to nursing in the region when implemented;
2. Nominations to take the work forward with a one-year deadline for completion were obtained;
3. Each country will implement the plan concurrently with building consensus on the plan's objectives. It is likely that those objectives from the plan that best fit the national objectives of each country will be prioritized for

implementation.

**Afternoon session facilitated by Mrs Bibi Florina Abdullah,
Director of Nursing, Malaysia**

**2.1.2 Ms Monica Fong, Pacific Islands Forum Secretariat, Fiji –
*Overview of the Pacific Plan Initiative***

Ms Fong delivered an overview of the Pacific Plan highlighting that the Pacific Plan was endorsed by Leaders at the Pacific Islands Forum meeting in October 2005. The Plan is the result of work undertaken by the Pacific Plan Task Force with oversight by a core group of leaders and identifies initiatives within an implementation framework that extends to ten years. It captures broad-based feedback from Member countries and other stakeholders (including non-state bodies and development partners). It has been enhanced by additional analytical and strategic planning work carried out by the Pacific Islands Forum Secretariat with assistance of some partners. The Pacific Plan is based on the concept of regionalism, which under the Plan, does not imply any limitation on national sovereignty as it is not intended to replace any national programs, only to support and complement them.

Ms Fong then presented the outcomes of a concept paper presented at a meeting in Apia in September 2006. In terms of Initiative 7.2 of the Pacific Plan (enhancing and standardizing regional training programs in nursing), informal discussions had taken place with key regional nursing personnel. However, progressing this initiative has been difficult mainly because any regional training program must be of national benefit and take into account the quality of education and quality of practical skills needed locally; that the level of education and training should reflect the practice of nurses in-country; and that any standardized approach adopted should allow each country to design its curricula to suit its own needs while remaining cognisant of an overall agreed regional approach with similar competencies.

Key points from resolutions at the meeting in Apia were that the:

- South Pacific Chief Nursing Officers Alliance resolved to work with the Pacific Islands Forum Secretariat, supported by WPRO, to investigate the potential for enhancing and standardizing regional training programs in nursing;
- A preliminary exercise in mapping current educational provision and standards required for registration in member countries was required as an essential first step in the process;
- Such a mapping exercise would provide necessary information from which to move forward to further consideration of harmonization of educational standards across the region;
- The Common Competencies for Registered Nurses in the WPSEAR (Kuala Lumpur 2004) are used as a reference point for the mapping exercise.

Ms Fong acknowledged Expected outcome 3.1 of the Nursing / Midwifery Draft Strategic Action Plan for the WPR - *Mapping needed as a critical part of*

broader educational improvements, to establish output of Pacific schools of nursing in order to create possible steps and stairs to enable maximum upgrading to international standard without individuals leaving their country and highlighted how this expected outcome linked in with the proposed mapping exercise.

Calls for tenders for mapping will occur during Jan 2007. It is envisioned that a report on mapping exercise will be presented to the 2007 Leaders Forum with a report presented to SPCNOA in 2008, which will determine the further progression of this Pacific Plan initiative. Currently, terms of reference are being drawn up and will be discussed with WPRO – as per Resolutions from the 2006 SPCNOA.

Comments received from the floor included:

- A suggestion to obtain AusAID funding to support the project;
- Using the information included in the ANMC Country Profiles resource relevant to the mapping;
- Whether the South Pacific Chief Nursing Officers Alliance is recognized by Pacific leaders.

2.1.3 Ms Sue Kelly, Director Pacific Health, Education and Environment Section, AusAID – *Strengthening Networks*

Ms Kelly gave an overview of the Australian Government White Paper (2006) on aid funding. The White Paper supports the Pacific Plan and also outlines initiatives for Pacific Aid Programmes which aim to accelerate growth, promote stability and cooperation and which draw on appropriate regional solutions. Examples are the land mobilization programme, the Australian Technical College, building stronger leadership within countries, enhancing emergency response capacity, investing in people, health, education, supporting pandemic preparedness and an increased number of Australian scholarships. Potential partners in development include multinational banks and generating their interest in supporting regional interests. The Australian Government aims to double aid funding by 2010.

Ms Kelly noted that those countries integrated into the global economy are experiencing economic growth at a faster rate compared to other countries. In addition, countries which experience a growth boom that only benefits a few people for the short-term are not performing well. The quality of governance within countries is a critical factor in achieving sustained growth and successful long-term management. Growth is more likely if conflict is managed and social benefits are aligned with economic benefits. For countries that are dealing with stagnating economies and emerging from conflict, a different approach is required. Although aid provides assistance, it is not the complete answer.

By 2010, AusAID will be implementing different models of aid programmes. Some of these will be sector-wide and will collaborate with other donors to support government national plans. Accordingly, there will be less contracting out and an increased emphasis on transparency and effectiveness.

The Pacific health program assist countries to reduce vulnerability to diseases such as HIV. Eight million dollars are being provided for pandemic preparedness. The importance of nurses' roles in health education, communicating risks and implementing community-wide measures is recognized by Ausaid. In the light of this, Ms Kelly said that it would be beneficial for nursing organizations, Ausaid and regional groups to share communication channels and keep each other in the loop in terms of relevant developments.

The issue of aid coordination among donor communities was discussed. Ms Kelly commented that a new approach was needed to 'small island states'. The Pacific Island Forum has established a small island state unit with a focal point in each country. It was suggested that donor organisations need to communicate with each other and to include key players such as nurses in relevant discussions. It was also suggested that nurses need to adopt an assertive position and communicate to aid agencies about what is required from the latter to address the problems being discussed at the Summit. Ms Kelly suggested that such messages would have more of an impact if they were put in a letter from CNOs.

Ms Kelly concluded by saying that overall there have been improvements in the region and that there is better linking of aid programmes with national budget priorities. This makes it easier for donors to target resources.

Professor Jill White closed the day at 4.40pm by summarizing the day's achievements.

2.2 Day 2 – Pandemic Preparedness and Human Resources for Health (HRH)

Morning session facilitated by Ms Lata Malu, Chief Nursing Officer for Tonga

Professor Jill White welcomed delegates attending Days 2-3 and gave an overview of the day's program which was focused on pandemic and disaster preparedness and human resources for health. Professor White explained that the previous day's proceedings were concentrated on the refinement of the Regional Plan for nursing and that the delegates consisted of CNOs and WHO CCs. Peak nursing and midwifery organization representatives and others had joined the meeting for Days 2 and 3.

Professor White introduced Ms Joan Tranter from the UTS Equity and Cultural Diversity Unit, who provided an Acknowledgement to Country. Ms Tranter spoke of the traditional owners of the land and also of the meaning of language and culture within a broader and changing cultural environment.

The Vice Chancellor of UTS, Professor Ross Milbourne, then addressed the

meeting. He spoke of the important role of nurses in developing countries in which nurses often comprise the entire health workforce. It is therefore beneficial to hold forums such as the Summit which provide opportunities to give information on pandemic and disaster preparedness and to share experiences.

This was followed by opening remarks by the NSW State Parliamentary Secretary of Health, Mr Paul McLeay on behalf of the Minister of Health. Mr McLeay welcomed delegates to NSW and outlined common concerns across countries such as chronic workforce shortages and the need to foster networks of knowledgeable, well-informed health leaders to undertake the planning required to manage the aftermath of large-scale disasters and to prevent disease transmission. Hearing and learning from people with experiences of SARS and avian flu is an essential component of good leadership. Mr McLeay commended the Regional Strategic Plan for Nursing and Midwifery.

2.2.1 Professor Aileen Plant, Australian Biosecurity Cooperative Research Centre for Emerging Infections Disease, Curtin University, Perth – *Overview of Pandemic Preparedness*

Professor Plant spoke of the challenges in managing pandemics and the benefits of planning for disease outbreaks with reference to the recent outbreaks of avian influenza viruses. Professor Plant explained that avian influenza viruses mutate, can swap genetic material with other influenza viruses and can become adapted to humans. Most flu viruses come from birds and it is highly likely this was the case in the pandemic of 1918. There were three pandemics during the twentieth century: 1918-19; 1957-58; 1968-69. Each reflected changing patterns in terms of spread and mortality. For example, the spread was slower and there was lower mortality associated with the 1960s pandemic. It is inevitable that there will be future pandemics.

In terms of the recent avian flu outbreaks, there were more sick and dead birds than had been previously seen and many more countries were affected. About eighty (80) per cent of infected humans had been exposed to sick poultry. Although about 50% of individuals infected with avian flu so far have died, the virus is not spread efficiently. From the information available it is difficult to predict future patterns of this disease. It is likely that individual cases but not big clusters have been missed. The risk of pandemic flu for any given time is low but the consequences are high.

Professor Plant outlined the different options for prevention and control, including plans for containment and plans for maintenance. She said there are three main points of intervention:

- Stop birds being infected;
- Decrease human-chicken interaction;
- Decrease human spread .

Biosecurity (stopping interaction between wild birds and poultry; faeces disposal etc.) or vaccination are the main options in preventing birds being infected. Vaccination is difficult due to cost and practicalities (for example, 90% of birds are sold in wet markets which are viral 'swap shops'). Implementation of pandemic management plans may also be hindered by economic considerations. For example, the chicken plays a role in national economies like Vietnam, providing both food security and livelihood.

Decreasing the chance of human infection mainly depends on anti-virals, infection control and surveillance systems. However, in most countries the vaccine for humans is prohibitively expensive.

There have been improvements in surveillance systems as a result of the provision of funding, better availability of laboratory diagnostics, guidelines, pandemic planning and workshops. Many of these improvements have been spearheaded by the Pacific Public Health Surveillance Network.

Important features of flu pandemics that affect planning include:

- The unpredictable nature of severity or burden of a pandemic mean it is best to plan for a severe pandemic;
- The spread is potentially rapid;
- 15-40 year olds had the most mortality in the 1918 pandemic;
- The first wave is usually mild, with subsequent waves being more severe;
- Influenza is different from SARS, because with influenza the individual may be infectious for 1-2 days yet remain asymptomatic, whereas with SARS no-one appeared to be infectious prior to symptoms .

To maintain momentum in coping with pandemics, the following are critically important:

- Ensuring surge capacity for key functions;
- Identification of key functions and availability of several people competent to carry them out;
- Sufficient staff for routine functions – this is important as the epidemic is unlikely to be over quickly like SARS;
- Consideration of bed capacity to accommodate probable length of stay;
- Having adequate food, transport and accommodation;
- Placing emphasis on the importance of pre-planning;
- Regular briefings.

There are opportunity costs to both over or under-planning. Without a plan there is a risk that either too little or too much will be done. In many countries, there is a risk of too much vertical activity rather than integrated activity because of the organizational features of health care bureaucracies. To ensure adequate preparation, planning needs to occur at different levels within the country and within the health

care system.

Professor Plant noted that in many countries infection control is inadequate. This is related to a lack of training (and no maintenance of the skills learned) and planning. Health care workers need to ask what can be done that is achievable and then concentrate on those objectives. Achievable infection control actions include barrier nursing and physical barriers. Reliance should not be placed on retrovirals as there is only weak evidence for their effectiveness once infection has occurred.

Professor Plant stated that nurses as front-line workers in a pandemic, need to be invested with sufficient authority. For example, nurses must have the right to demand the proper execution of infection control procedures, the right to adequate equipment and must also have access to and input into preparedness plans. However, this authority will only be bestowed through effective leadership and lobbying. Professor Plant concluded her talk by advising nurses to contribute to pandemic preparedness by:

- Participating at all levels;
- Working in partnership;
- Offering skills and being involved at an early stage;
- Making sure that nursing skills are understood and valued;
- Understanding planning processes;
- Facilitating responses;
- Influencing resource allocation.

2.2.2 Miss Ang Beng Choo, Chief Nursing Officer, Singapore – *Pandemic Preparedness in Singapore*

Miss Ang Beng Choo shared the lessons learnt from Singapore's experience with preparing for an avian flu outbreak. A critical factor in Singapore's response was teamwork between the government and the general population. This was crucial in addressing outbreaks in a dense population of 4.5 million, with 70 per cent living in apartments.

Miss Ang said it is reasonable to assume when preparing for pandemics, that there will be two or more waves in the same year and that the second wave may be worse than the first. Each wave lasts about six weeks.

The objectives during the outbreaks were:

- Response and impact mitigation (main aim to minimize disruption and to vaccinate the entire population);
- To ensure essential services continue;
- To minimize social and economic disruption;
- To integrate all relevant government agencies so that coordination occurs;
- To prevent unnecessary fear.

The Regional Emerging Disease Intervention (REDI) centre was tasked with the following:

- Joint monitoring of avian flu with USA in Indonesia;
- Assist Indonesia in manpower capability building;
- Train the trainer in infection control.

Miss Ang explained the key strategies used to manage the epidemic. The main strategies include surveillance and early detection. The MOH ordered approximately 10 million doses of avian influenza vaccine. A colour-coded risk management approach was implemented and cases were ring-fenced by isolation and quarantine. Other strategies included: public education; creation of a flu website; internet schooling; stocking up on two weeks' food supply; avoidance of crowded places. A business continuity plan for each alert level was also developed which focused on operating with minimal face to face interaction.

One of the lessons learnt from SARS was the need to increase hospital capacity and to set up additional health care facilities such as isolation rooms. Also necessary were the development of manpower training and contingency plans; the development and rehearsal of emergency drills (Exercise Sparrow-Hawk); the testing of crisis procedures and processes; and stockpiling of Tamiflu.

Miss Ang concluded by illustrating other strategies such as banning imports from affected countries; stepping-up inspection procedures; implementing biosecurity measures; establishing notification systems; implementing culling plans; and providing compensation for affected businesses.

2.2.3 Professor Thomas Wong, Faculty of Health and Social Science, Hong Kong Polytechnic University – *Pandemic Preparedness, The Hong Kong Experience*

Based on the experiences of Hong Kong in relation to SARS and avian flu, Professor Wong identified several baseline factors necessary for pandemic planning:

- Capacity building and training;
- Staged mobilization;
- Ongoing revision of implementation plans;
- Development and implementation of contingency plans for businesses, schools and hospitals;
- Being alert to and identifying the first outbreak;
- Prophylaxis for health care professionals caring for confirmed cases;
- Cough etiquette procedures;
- Capacity for more than 1400 isolation beds;
- Criteria for surveillance;
- Case identification, in particular the importance of standardized criteria and need for high vigilance;
- Case reporting system for all clinics and doctors;
- Real-time data collection and reporting system;

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- Diagnostic criteria;
- Early sickness detection system for staff (eg., daily temperature check).

Capacity building occurred in Hong Kong through the following:

- The establishment of a Centre of Health Protection;
- Enhancement of professional training;
- Preparation of the entire community through education (posters and factsheets), vaccination (including the development of criteria for vaccination) and the recruitment and training of volunteers;
- The development of information systems.

The Hong Kong contingency plan for the avian influenza pandemic was available on the internet. The development of a response strategy based on stages of the pandemic provided response levels which ranged from alert to emergency. Each response level was associated with a scenario and action. The WHO case identification criteria was used alongside a country-wide case reporting and real-time data collection system.

Within health care settings, strategies included protocols for the use of personal protective equipment (PPE) and on cough etiquette stratified by level of risk of transmission (ie., high risk patient areas and other patient areas). A staff early sickness alert system was implemented to ensure rapid identification of cases amongst health care workers.

Professor Wong provided details of research undertaken to address issues which had arisen during the outbreaks.

- In response to the expense of hospital automatic airlock sealed doors and filters to prevent airborne disease transmission, the adequacy of natural ventilation was tested. It was found that natural ventilation is the cheapest and most practical alternative as measured by ventilation rate and decay of droplet nuclei. An open window and open door gives many air changes an hour, therefore the more expensive alternative is not cost-effective.
- To improve surveillance methods of identification of the first human outbreak a comprehensive approach was developed which included full diagnostic service for influenza; an increase in the number of sentinel clinics – there are now 60 government clinics (only nine existed before 1997); laboratory monitoring; rapid typing of clusters; gathering of public hospital data; and investigation of clusters in aged care facilities.
- The Centre for Infection Control, Hong Kong Polytechnic University examined the effect of personal protective equipment on psychological and physical responses in relation to concerns raised about the effectiveness of the equipment. It was found that inappropriately sized face masks, designed for Caucasian physiognomy, which moved position during a working shift may have caused health care professionals to have caught SARS. Research is now being undertaken to improve the design of Personal Protective Equipment (PPE). This involves establishing a

reference range for different facial configurations. Preliminary findings indicate that on a number of facial variables there are significant differences between the facial configurations of Taiwanese compared to those of Americans and Europeans. PPE products need to be developed taking these variations into account.

- Hand-washing surveillance systems are being trialled to improve adherence to hand-washing protocols. These range from the use of basic checklists to electronic systems which sound an alarm should someone approach a patient's bedside without having washed their hands.

2.2.4 Dr Noriko Katada, University of Hyogo, Japan – *Challenges in Developing a Centre of Excellence for Disaster Nursing, the Japanese Experience*

Dr Katada's presentation was on the development of a centre of excellence for disaster nursing. This form of nursing has been developed in response to the threats to Japan from being located in a zone with a high risk of earthquakes, volcanoes, tsunamis, floods and typhoons. Disasters threaten life and incur insecurity, disruption and mental suffering. Japan is therefore well placed to establish the discipline of disaster nursing spanning preparedness, education and research.

Nurses are at the frontline in disasters alongside police, rescue services and medical workers. Nurses have a role in the management of post disaster health problems: respiratory, circulatory and chronic diseases and post-traumatic syndrome. They are also involved in follow-up care, in advocacy for vulnerable people and in supporting caregivers.

The Disaster Nursing Program aims to develop nursing care strategies based on information provision and self-care strategies to aid recovery from the consequences of disaster. The program has spawned the development of various resources including an information base; internet-based tools; a nursing support network; network building and coordination with other organizations; links with national government and overseas organizations; and the development of care strategies to meet the immediate, mid-term and long-term needs of those affected by disaster.

Preparedness is essential as it is hard to change behaviour and ways of thinking at the time of an emergency. In disaster nursing, preparedness is focused on education/training; the acquisition of core competencies; the development of the disaster preparedness handbook; and the development of Masters and Doctoral Programs in disaster nursing. Research programs in disaster nursing are being developed alongside a research agenda. Additional activities include: international conferences; dissemination of programs; consultations; and dispatching services.

2.2.5 Dr Cho-Ja Kim – *Nursing Leadership in Disaster Management in Korea*

Dr Cho-Ja Kim explained that the role of nurses in Korea has expanded because, like Japan, Korea is a disaster-prone country. Due to geographical and ecological reasons, Korea regularly experiences floods and typhoons and the frequency of earthquakes is increasing. During the last decade (1991-2000), 122 persons were killed, 17,219 persons lost their houses, and there has been 580 million dollars (USD) in property loss per year. Recently, rapid industrialization and lack of safety concerns have caused an increase in manmade disasters. Different disasters result in different illnesses and disabilities. Many survivors of disasters suffer from some form of disablement such as chronic pain and psychological problems. An example of the type of health problems suffered is given by recent floods. Most victims experienced skin problems, the common cold, symptoms of stress and later on depression, agitation and hypersensitivity to rainfall (waterborne communicable diseases such as typhoid, dysentery and cholera were rare).

Dr Kim explained that first-line nursing activities include first-aid; hospital transfers; and working on emergency response and mobile health teams. Nursing continues throughout the recovery phase. After a disaster, public health nurses provide immunizations and surveillance against communicable diseases, and arrange hospital mobile service teams to visit affected areas.

In 2004, the Korean Government established the National Emergency Management Agency. Three nursing scholars are members of the NEMA advisory committee. In addition, there is a 'Disaster Safety Network' involved in disaster preparedness and the Korean Nurses Association is represented on this group. Recently two nursing research groups were funded by the government. One project is to develop a textbook on safety education, while the other is to develop a community-based psychological support system.

While disaster nursing was a new concept in the early 1990s in Korea, the middle of the 1990s saw the establishment of modules on 'Emergency and Disaster Nursing' in 10 nursing colleges. In 1999, a textbook for 'Emergency and Disaster Nursing' was published. In 2004, the graduate schools of nursing offered clinical nurse specialist courses including a master's course specializing in emergency nursing.

There are also three disaster nursing research centres in Korea:

- Center for Global Health and Disaster Nursing Studies Red Cross College of Nursing, Seoul;
- Nursing Research Center, Armed Forces Nursing Academy, Daejeon;
- Seoul Narrative Research Center (interdisciplinary research), Seoul.

Dr Kim concluded her presentation by saying that nursing leadership in disaster management is urgently needed and can be strengthened by:

- Co-operating with government and relief agency initiatives;
- Marketing the unique contribution of nursing in disaster management;

- Encouraging evidence-based research through field study and collaborative international research;
- Training managerial manpower in disaster nursing through systematic training programs.

Afternoon session facilitated by Ms Elizabeth Iro, President of Nurses Association, Cook Islands

2.2.6 Ms Julie Hamblin, partner Ebsworth & Ebsworth Lawyers, Sydney – *Principles for Regulation in Public Health Crises*

Ms Hamblin introduced herself as a lawyer who specializes in health law and policy. She is also a consultant for the United Nations Development Program. The focus of Ms Hamblin's presentation was on law and public health legislation. Because much of her work has been in the area of HIV, she talked about how the HIV epidemic has highlighted the inadequacy of existing public health legislation in many contexts. The experiences around HIV have led to a re-thinking of how public health legislation should be approached and about the appropriate framework for public health legislation.

The notion of public health law is a relatively new phenomenon. There are no universalities - different diseases with different patterns of infection and transmission require different public health interventions and the regulatory framework must be able to accommodate this. The traditional model of public health legislation focused on coercive measures, which can be counter-productive in the context of many public health concerns, such as HIV. Nonetheless, there is a need for public health authorities to ensure they have the necessary legal authority to intervene, where necessary, in response to public health threats.

Ms Hamblin gave an overview of the key regulatory issues. These include: which diseases should be notifiable, and by whom, and what should be the trigger for notification; confidentiality protection (ie whether reporting should be by name or anonymous); delimiting the powers of public health authorities to enter, inspect and close premises; disinfecting or destroying products; ordering others to be tested; counseling and contact tracing; and entitlement to compensation for financial loss caused by public health interventions.

Isolation and quarantine are contentious practices that can be subject to legal challenge. Depriving a person of his or her liberty is an extreme measure than can only be justified if public health authorities can show it is necessary to achieve a legitimate public health objective, and is the only way of achieving that objective. It is preferable, where possible, to implement graded approaches with detention as a last resort. Public health legislation should contain appropriate safeguards to ensure that public health interventions are undertaken fairly and with proper regard for the difference interests involved.

Conclusions:

- Ensuring that appropriate public health legislation is in place is an essential part of pandemic preparedness;
- The legislation needs to give public health officials the necessary legal authority to respond quickly and effectively to threats to public health;
- The legal framework should be sufficiently flexible to deal with different modes of disease transmission;
- Individual rights should be restricted only to the extent necessary to achieve the desired public health outcome;
- Coercion should be a measure of last resort.

2.2.7 Dr Charmaine Turton, Director; Ms Sue Greig, Clinical Nurse Consultant; Mr Philip Melling, Infection Control and Resource Director, Albion Street WHO Collaborating Centre – *WHO Infection Control Toolkit*

The Albion Street Centre was established in 1985 as an ambulatory care centre. It consists of 60 professional staff and 200 volunteers. Dr Turton explained that the Albion Street Centre's goal is to consolidate and strengthen clinical management, counselling, research, prevention and education of people affected by HIV/AIDS, hepatitis and other emerging infectious diseases in order to promote the well being of those affected. It is a multidisciplinary centre consisting of doctors, nurses, psychologists, social workers, pharmacists, dieticians, educators, infection control practitioners, researchers and librarians.

In March 2006, the Albion Street Centre was designated a WHO Collaborating Centre for Capacity Building and Health Care Worker Training in HIV/AIDS Care, Treatment and Support.

Its aims are to:

1. Refine models for the delivery of HIV/AIDS comprehensive care;
2. Adapt, implement and evaluate training programs;
3. Promote capacity building for HIV/AIDS care;
4. Develop and adapt for specific in-country use standard operating protocols;
5. Perform service reviews and design quality assurance activities;
6. Establish an HIV/AIDS Technical Reference Group;
7. Develop and implement tools to enhance health care worker safety in clinical settings within the Region.

Mr Melling outlined the importance of a structured approach to infection control that starts at a basic level. The Centre is currently developing an Infection Control Toolkit for health care users and users in the region. The Toolkit will be able to be adapted to a variety of settings and will allow users to identify gaps in current practice. It will consist of simple strategies that are adaptable to a variety of health care

settings such as audit tools and guidelines on how infection control can be achieved where best practice may not be possible.

An overview was also given of the Safe Hands project that aims to promote health care worker safety in the Asia Pacific region, by highlighting the importance of hand-washing techniques in preventing the spread of infection. This has been funded by AusAID for three years and provides information, support and practical solutions, a website and newsletter. It costs nothing to be a member of the Safe Hands network (Error! Reference source not found.) and resources such as posters are available.

The NSW Infection Control Resource centre can be accessed at Error! Reference source not found.. It includes downloadable information sheets and kits).

2.2.8 Professor Wing Hong Seto, President of the Asia Pacific Society of Infection Control, Hong Kong – *World Alliance for Patient Safety*

Professor Seto gave an overview of the work of the World Alliance for Patient Safety which was established in 2002. The main focus of the Alliance's work is on hand hygiene, a basic tool of patient safety, and in promoting WHO work on this area. The main message of the infection control campaign is 'clean care is safer care.'

Approximately, 1.4 million hospital patients have hospital acquired infection (HAI) at any given time. Much of this could be prevented by a combination of clean hands and by practices, products, environment and equipment that promotes hand hygiene. Hand hygiene is the single most important practice to prevent the transmission of infection and HAI. The WHO have therefore developed guidelines on hand hygiene in health care settings. Professor Seto referred to a recent study that examined the impact of hand hygiene education in a developing country. In the community studied, the results demonstrated decreases in the rate of diarrhea, skin infections, respiratory infections and childhood mortality.

Currently compliance by health care workers with hand-washing requirements is < 40%. The main reason given for this low uptake is that it takes too much time (1.5 minutes is the estimated time) per wash. It has been estimated that hand washing takes up to two hours per working day. However, an alcohol-based hand rub which takes only 10 seconds bypasses the time constraint.

The advent of effective hand rubs, means that hand washing is now an action of the past – the correct term is 'hand hygiene'. The WHO guideline states that only dirty hands need washing – otherwise the gold standard recommendation is to use alcohol-based hand rub in all other clinical situations.

Key changes in practice, as listed below, are needed to ensure that this new practice prevails:

- Broad provision of WHO formula in all settings (as they are cheaper than similar products);

- Gloves to be used for dirty procedures;
- No mixing of handwash and rub;
- Discontinuation of disinfectant detergent (which is not as effective as alcohol);
- Implementation of guidelines using WHO tools.

Professor Seto reported that in Hong Kong a National Committee has been formed to address hand hygiene. The need for pandemic preparedness has been instrumental in enforcing best practice hand hygiene. SARS provided a strong motivation for good hand hygiene practice – if a health care professional failed to wash their hands they would be at high risk of getting SARS.

Professor Seto concluded by saying that adequate infrastructure does not exist for many countries to implement adequate infection control measures. There is a need to deploy adequate full-time infection control personnel and for certified practice and continuing education on this topic.

2.2.9 Professor Jim Buchan, Visiting Professor, Faculty of Nursing, Midwifery & Health, UTS – *Minimum Dataset for Human Resources for Health (HRH)*

Professor Buchan explained that workforce shortages are currently of global concern. The universal challenges include obtaining the best mix of staff, getting the right skills in the right place at the right time, and understanding which incentives are effective in motivating staff. Within regions there are large variations, particularly in the availability of a health workforce and skill mix.

Typical challenges in relation to HRH include: skills shortage; geographic maldistribution; fragmented planning; education-employer linkages; and staff performance (how to achieve improved performance in individuals). The HRH evidence base is drawn from sectors other than health and suggests that effective strategies include:

1. Implementing a range of interventions across different interdependent organizations – there is no single magic bullet;
2. Developing HRH policies appropriate to the organizational objectives and the context in which they are to be applied. This necessitates managing political expectations and dissuading politicians from adopting quick-fix solutions.

The four most important components of any strategy and its associated interventions to address workforce shortages were outlined by Professor Buchan.

1) Workforce planning

Interventions include conducting a needs assessment (see WHOICN.CH website); integrated or aligned planning; linkage with education sector; scenario modeling; and geographical distribution. Requirements are workforce data, planning capacity and stakeholder involvement.

2) Improve recruitment and retention

Interventions include recruiting from traditional resources; recruit from new sources (men, ethnic minorities); improve retention of current staff; and attract returners (if there exists a pool of well qualified personnel that are not currently working). Requirements are marketing of attractive part-time opportunities; a program of return to practice; financial and non financial incentives; career structure; opportunities for continuing practice development; flexible working; safe working conditions; and both involvement in and autonomy in decision-making.

3) Improve skill mix

Interventions include policy decisions on effective skill mix (for example, nurses should not do ward clerk work); regulatory infrastructure; legislative infrastructure; and in-service training. Requirements are strategic management; data on activity/output; job descriptions; financial and other incentives; and involvement in decision making.

4) Improve performance and deployment

Interventions include day to day matching of workload with staff; genuine flexible working (too often lip service is paid to this intervention); shift patterns for 24 hr care; in-service training; offering full or part-time or temporary positions (there are still too many constraints on allowing nurses/midwives to work less than full-time). Requirements are local management; data on activity; financial and non-financial rewards; allocation of necessary equipment; involvement in decision-making.

Aiming for staffing stability is the most cost effective intervention. This requires a long-term and broad based approach to skill mix and distribution as well as financial and non-financial incentives.

Professor Buchan concluded his presentation by giving an outline and overview of the HRH project being undertaken by the University of Technology, Sydney on behalf of the WHO. The project is at Phase 3 and this involves the production of three factsheets which outline the following:- Why HRH is important; Why HRH data is important; and How to use the WHO IMS minimum HRH dataset. Professor Buchan concluded his presentation by inviting delegates to email their comments on the draft Minimum dataset (by December 11, 2007).

The International Centre for Human Resources in Nursing (<http://www.ichrn.org/>) provides resources for generating, collating, promoting and disseminating information, research and data related to nursing HR. There is also the International Centre on Nurse Migration (<http://www.intlnursemigration.org/>) which aims to serve as a global resource for the development, promotion and dissemination of research, policy and information on nurse migration.

2.2.10 Dr Piya Hanvoravongchai, Coordinator, Asia-Pacific Action Alliance on Human Resources for Health (AAAHR) - *Asia-Pacific Action Alliance on Human Resources for Health (AAAHR)*

Dr Piya Hanvoravongchai explained that the AAAHR is a relatively new initiative aimed at formulating and driving action on health workforce planning and management in order to increase access to a skilled and supported health workforce in the region. There are currently 15 member countries with a number of active partners particularly the World Health Organization, both the South East Asia Regional Office and Western Pacific Regional Office.

AAAHR is a flexible, inclusive and non-bureaucratic organization which shares responsibility of work across several focal points on a voluntary basis. The Secretariat is based in Thailand and is responsible for coordinating and facilitating the network. There is a steering committee with representation from six member countries and development partners as well as the World Health Organization. Activities occur at both a country and regional level. AAAHR is also a regional partner of the Global Health Workforce Alliance (GHWA) and receives funding from development agencies including the Rockefeller Foundation.

Currently, there are a number of health workforce challenges faced by this region similar to other regions, including the shortage in health workforce, skill mix imbalances; maldistribution and migration; and negative work environment. There are also regional specific issues including: the risk of pandemics and other health threats; rapid private sector growth; and increasing international trade in health services.

The AAAHR will focus its priority actions in the next two years in five areas:

- Advocacy of HRH importance at country and regional level;
- Coordination of knowledge generation & management;
- Undertaking regional HRH monitoring and supporting in-country information system development;
- Assisting with capacity building;
- Coordinating technical support as requested.

Outputs are a website and monthly newsletter, a web-based discussion, training workshops, a health workforce financing multi-country study, and assisting five priority countries in the development and implementation of their National Health Workforce Strategy and strengthening their HRH information systems. In addition, the AAAHR will work closely with the GHWA on HRH issues. Dr Hanvoravongchai concluded his presentation by inviting delegates to join the network and become involved in the work of the Alliance. (<http://www.AAHR.org>; email secretariat@aaahr.org).

The day concluded with a barbecue and music.

2.3 Day 3 – Leadership capacity

**Morning session facilitated by Michele Rumsey, Executive Officer,
Faculty of Nursing, Midwifery & Health, UTS**

2.3.1 Opening remarks, Debra Thoms, Chief Nursing Officer, NSW Health

Professor Thoms spoke about how Australian state and territory-based CNOs could most productively work with the Summit group and contribute to work in the region. It was agreed that Australian CNOs will attend some of the regional meetings. Professor Thoms remarked on the common challenges between countries, including addressing leadership and succession planning and noted that it is increasingly difficult to nurture and attract good applicants to nursing leadership posts.

2.3.2 Professor Judith Shamian, President and CEO, Victorian Order of Nurses (Former Chief Nursing Officer for Canada 1999-2004) Canada – *Succession Planning in a Leadership Role*

Professor Shamian drew on her experiences as Canadian Chief Nurse to illustrate the challenges in leadership preparation and in managing the complex and multifaceted nature of leadership roles. Professor Shamian said that the primary task of an incumbent CNO should be to understand the parameters of the role and then to develop a work agenda based on stakeholder input and which will influence public policy and action. Relationship building skills are critical for ensuring that the broader health care communities work together. Talent and experience are required for navigating through a system which is different in many respects to nursing.

New leaders need to be aware of misconceptions such as seeing the CNO role as being solely to lobby for nursing. The CNO should provide a perspective based on nursing knowledge and experience but which contributes to public health and social policy.

The basic core functions of the CNO role are:

- Proferring advice;
- Willingness to break through barriers to make changes to policy agendas;
- Developing policy and providing input into the policy agenda;
- Promoting the visible face of nursing;
- Influencing the government agenda;
- Accessing decision-makers;
- Promoting nursing leadership.

Professor Shamian outlined the different CNO models based on the work of Splane & Splane 1994:

- The Executive Model is common in unitary states and is where the CNO exercises authority through a reporting relationship within the upper levels of the health ministry bureaucracy. In this model, the CNO exercises line authority over nurses and nursing services.
- In the Advisory Model, there is no line responsibility for the nursing workforce but reporting relationships at a high level exists. The CNO exercises influence on ministerial policy comparable to that in the executive model. This is a common model in a federated system where there is less bearing on day to day management.
- The Dispersal Model involves no CNO and nurses are dispersed in various programs and may exercise some influence on policy.
- The Program Model is where the CNO manages specific programs such as education and human resources and where there are cross-functional/sector links. The role is one of content expert/manager who influences or manages program level functions.

Over the last 10 years, nursing leadership has been beset with change and flux. Stability is a thing of the past and the pace of change is escalating. Therefore, to be effective in a CNO role, charisma, courage, connections, strong sense of self, stamina, intellect and the ability to talk government, policy and nursing are essential. Both nursing and systems knowledge are needed. The CNO needs to know both roles intimately and be able to explain one to the other. Providing leadership in the stormy context of health and nursing can be vexing. People who have the skills and expertise survive.

Visibility is also essential and occurs by: making regional visits; inviting visiting scholars, attending and hosting workshops and national and international conferences; producing newsletters, and putting yourself forward to advance the cause. Professor Shamian noted that many in government positions hide because of the political structure whereby the elected personnel are the face.

An obvious but overlooked strategy is to engage with key stakeholders. If there is no engagement the CNO will not know the thinking of relevant organizations and know who is passionate about what issue. Using the media provides a strategy for engagement, either through face to face interview or articles and updates. Possessing political expertise to understand the internal and external machinery enables strategic directions to be taken and also creates strategic knowledge. The first six months of the Canadian CNO post was to understand the power structure and how it moves around.

Being a knowledge broker by working with scholars and spearheading an evidence based policy agenda will earn respect. If scientific evidence can inform policy there is scope for making a big difference. People respect science.

Teamwork and partnership are essential to support the work and policy agenda. The ball must start rolling in a strategic way and the right agenda must be implemented at the right time.

Building external relationships may be difficult but are extremely important and must be cultivated and maintained to make a significant difference to public policy and nursing.

Be aware that it may take a decade to move an agenda forward. The case of nurse practitioners provides an example. This model was tried in the 70s, died, but has now been revived and is likely to be maintained because of legislation and funding models.

Professor Shamian said that the following were required to foster future leaders:

- Recognition of and support of emerging leaders;
- Providing opportunities and exposing them to new roles;
- Developing a leadership pipeline which enables leaders to move forward in a structured way;
- Mentoring of potential leaders.

Consider also whether mentoring or coaching is appropriate. The latter is more purposeful while mentoring is broader. There are several different models of mentoring which could be considering to assist with succession planning.

Professor Shamian concluded her presentation by saying that the leadership gap is not just in healthcare. Nursing could lead the way with investigating and trialling methods of succession planning as well as learn how other organizations are overcoming this problem.

2.3.3 Dr Frances Hughes, WHO PIMHnet facilitator and Adjunct Professor, UTS; Immediate Past CNO, New Zealand – *Framework for Political Development- Leading Health*

Dr Hughes introduced herself as the new WHO Mental Health Network Facilitator for the Pacific. She invited delegates to make contact with her in relation to the work of the network and to become involved.

Dr Hughes presented a conceptual framework for understanding political processes which was developed for her doctoral studies. The thesis consisted of applying the conceptual framework to a case study on policy formation in New Zealand. The work illustrated the importance for nurse leaders to understand the political connections and influences of the country in which they work. Frequently there is minimal understanding among health care professionals about the political machinery of their own country. More details are contained in a book authored by Dr Hughes (*Have Your Say – Influencing Public Policy*) which is soon to be published. Dr Hughes recommended the North American model of nurses undergoing intern or post-doctoral programs to obtain political experience and which provides valuable preparation for the role of a nurse leader.

A handout of the framework was distributed and delegates were invited to apply the framework to their own work.

Dr Hughes said that leadership is not just about advancing nursing but using nursing networks to address population health issues. The ICN strategic plan addresses complex issues such as infectious diseases and child labour thus demonstrating a shift away from a specific nursing focus to broader health issues and willingness to engage with broader political debates. Nursing needs to forge a relationship with key players in health such as the Heart Foundation and Diabetes Organizations. Nursing leaders should be aware of possible links between health issue campaigns and work to facilitate the integration of them. An example is mental health and diabetes, as those with mental health problems generally experience a high incidence of diabetes.

A political science model provides a framework for understanding how individuals can help move items up or down agendas. Fundamental to political development is building relationships and coalitions. Nursing must be visible and develop the ability to relate to other groups and assist them to take the agenda forward. Dr Hughes gave an example of nursing getting behind a policy item but without introducing 'nursing' into the dialogue. This related to the police use of tazers which nursing bodies opposed on the grounds that there was no evidence to support their use in the community for the management of violence by psychiatric patients. This position was made public via the media. This resulted in the NZ Medical Association, followed by other key groups, getting behind the issue.

Dr Hughes concluded the presentation by saying that while approximately 20 per cent of policies are based on evidence, most are based on politics. It is therefore incumbent on nursing leadership to understand the political context in which they operate in order to influence health policy.

2.3.4 Professor Pat Brodie, Professor of Midwifery Research & Practice Development, Faculty of Nursing, Midwifery & Health, UTS and Sydney South West Area Health Service. National President, Australian College of Midwives – *Building Professional Alliances With Women, Collaborative Practice, Strategic Partnership And Community Engagement*

Professor Pat Brodie's presentation focused on the political and strategic development of midwifery in New South Wales. Professor Brodie explained that as midwifery moved beyond political self-interest into the broader sphere of strategic alliances and partnerships it was able to influence the standards and the quality of midwife education. In doing so, midwife leaders had to face and overcome barriers to developing new service models such as the medical dominated 'illness' system of childbirth; patriarchal structures; and the lack of a clear understanding of the inter-relationship between midwifery and medical responsibilities.

Key factors in developing midwifery included: the regulation of midwifery and adoption of regulatory reforms separate from nursing; involvement of consumer groups (who can now be members of the Midwives Association); lobbying for funding; and evidence-based reform of service models. Informing the media about changes in provision of maternity care also raised the profile of midwifery within the broader community and within health care systems.

Competency standards for midwives have been established and soon there will be a Code of Conduct and Ethics. These tools, as well as guidelines and standards, ensure a strong and accountable workforce whose practice is evidence-based.

Professor Brodie enumerated the remaining challenges in developing the profession:

- Workforce reforms (ie. ensuring that adequate numbers of midwives are in the right places);
- Determining what should be the skill mix and complementary roles;
- Developing new models of midwifery care in the public sector;
- Changing the culture of care from the medical model to a public health and woman focused model;
- Fostering a research, education and practice development agenda;
- Understanding the parameters of the 'new midwifery' and balancing midwife autonomy with clinical governance.

The essential skills for addressing these challenges include the ability of professional leaders to understand and learn new frameworks; to move beyond navel gazing; to set standards and communicate them; to be politically aware and maintain the vision; to work with local women; and to engage in collaborative relationships and learn to negotiate.

In summarising her presentation, Professor Brodie advised that to ensure a secure and feasible future for nursing and midwifery there is a need for skilful leadership willing to engage in collaborative relationships and strategic partnerships at the local and systemic level. Leaders also need to invest in self care and support for each other as well as to nurture and encourage future leaders. Finally, there needs to be a realization that there is strength in unity, in building professional capital and in engaging with the community.

Afternoon session facilitated by Ms Frances Prescilla Cuevas, Chief Health Program Officer, Philippines.

2.3.5 Professor Mary Chiarella, Professor of Clinical Practice Development & Policy Research, Faculty of Nursing, Midwifery & Health, UTS; Nursing and Midwifery Office, NSW Health – *Fostering Nursing Leadership In Times Of Political Flux*

Professor Chiarella commenced her presentation with the following questions that had on previous occasions been put to her: *Couldn't a nursing perspective be supplied in some other way? They don't have to be nurses to do that, do they? What is it that makes nursing work? Would health care delivery be different if there were no nurses?*

Such questions demand an exploration of the notion and function of nursing leadership. Professor Chiarella explained the current political landscape as it affects nursing and nursing leadership in NSW. Each area health service region has a Director of Workforce which is a multidisciplinary operational position. Each Area Director of Nursing has professional responsibility for nursing but may have no line management. Some senior hospital nursing positions are maintained only because of union pressure. Some of these positions may cover two sites and do not necessarily have an operational function and therefore neither line responsibility nor budget. There is currently a push from the Opposition party in NSW for nurse education to be more hospital-based, a policy which has been developed with the assistance of some senior nurses. There is also a call for greater scope of practice for unregulated workers in the aged care sector.

The combination of two factors could be argued to jeopardize the potential for developing future leaders in nursing: 1) Depletion of senior nursing leadership; 2) Use of itinerant workers to fill nursing shortages.

Professor Chiarella outlined the unique qualities associated with nursing practice. These include the care of sick people and the tending of the entire environment in which care happens (Dier, 2004). Nursing 'humanises the system at the point of contact...' (from Pearson, 2000) and is a craft that draws on clinical skill and the giving of professional compassionate care. Nursing offers a unique perspective that stems from prolonged and intimate contact with patients.

The benefits of retaining an adequately skilled nursing workforce include:

- A strong round the clock operational perspective;
- An understanding of the key issues that affect patients;
- A clear-eyed understanding that life is neither rational or fair;
- An ability to comfort, listen and advise on intimate and/or difficult issues;
- A knowledge that ordinary people are capable of greatness.

However, as previously stated, the question has recently been posed as to whether that perspective could be offered by others such as unregulated health care workers, consumers or carers. To respond to such challenges nursing needs to clearly articulate its objectives. These could consist of:

- Improving care, safety and quality;
- Using the best available evidence in order to speak with authority;
- Developing a strong and resolved value base;
- Demonstrating empirically that skilled nursing care makes a difference;
- Articulating on key health issues;
- Feeling entitled to have the nursing voice heard.

To operationalize these objectives leaders need to 1) advocate that nurses are well placed to manage health care as well as nursing and 2) participate in debates around health care as well as nursing. Leaders need to speak authoritatively on how best health care could be organized and delivered and consult about clinical and political issues on a 'bottom up' as well as top down basis. Political awareness and competence should be a central part of nursing education and culture.

The fostering of a healthy workplace culture is essential to encourage future leaders to come forward and to grow leaders using a 'bottom up' approach. This requires the dismantling of militaristic styles of workplace management which see debate and/or disagreement as mutiny and insubordination. In addition, there is a need to address the Tyranny of Niceness (Walker, 1993) where Walker argues that a 'nice' nurse is perceived as a good nurse. An ethos of collegial generosity which celebrates curiosity and fosters the young to take their place in debate and strategy should be embraced alongside a perception that nursing is entitled to be at the tables that matter.

Professor Chiarella concluded by saying that in order to assume a strong and active leadership role in the health care arena, nursing needs to reconceptualise what future leaders might look like and to adopt effective political strategies and manoeuvres to achieve goals.

2.3.6 Lady Jocelyn Keith C.B.E, former Head of Department of Nursing Studies, Victoria University of Wellington and of the Department of Public Health, Wellington School of Medicine, Otago University, New Zealand – *Leadership in Nursing: Are We Promoting Nursing Or Are We Promoting Health*

Lady Keith urged nurse leaders to focus on improvements in health and not just on concerns specific to nursing. She spoke of their leadership in three domains: administration, the academy and clinical practice.

She said that Florence Nightingale had provided modern nursing with a model of administrative leadership - charismatic, bold, creative, informed and persistent. She invented modern nursing specifically to respond to human health and to enable health. Moreover, she urged the academy to ensure that nursing knowledge focus on nursing the sick, not on nursing the sickness and that nursing was both an art and a science.

In clinical practice, effective nurse leaders use their knowledge and relationship skills to assist the development of individuals and to influence the care and health of communities. Lady Keith quoted from the work of Patricia Benner and her associates who set out the commonalities:

- first, effective nurse leaders in clinical practice are authoritative knowledge workers, using their knowledge of the sciences and practice;
- second, they have developed relationship skills, such as teaching and coaching that enable them to assist in the development of others and

- finally, they influence the care and health of individuals, groups and communities. (Clinical Wisdom and Interventions in Critical Care: A Thinking-In-Action Approach, 1998. Benner, P, Hooper-Kyriakidis P, Stannard D.)

Lady Keith then used some of the current challenges to the health of people in the Asia Pacific Region to illustrate where she saw opportunities for active nursing leadership. This region, which contains two-thirds of the world's population, including the populous countries of China, India and Indonesia as well as sixteen of the smallest island states, is the most disaster-prone area of the world. Three-quarters of all deaths from disasters occur in this region.

She outlined the most recent assessment of progress in the region towards the achievement of the United Nations Millennium Goals and suggested the following areas where she believed Nursing could make a significant contribution.

Modest progress has been made towards reducing child mortality (Goal 4) but most countries in the region would miss the target without renewed effort. In terms of improving maternal health (Goal 5), progress is poor and the likelihood of achieving the target is low. Modest progress has also been made in combating HIV, malaria and other communicable diseases (Goal 6) but again the target will only be achieved if countries invest in prevention, treatment and rehabilitation. While progress towards the goal of achieving environmental sustainability (Goal 7) has been modest, the likelihood of halving the proportion of people without ongoing access to safe drinking water is unlikely.

The skills nurses have can provide a firm foundation for leadership in promoting health. They score highly on empathy, trust and emotional intelligence. They have been shown to be the profession best able to manage difficult conversations within the health team. But nurse leaders must also build networks and learn how to navigate through political minefields to be truly successful because, as Lady Keith concluded, "Health is a very political affair. We delude ourselves if we try to think otherwise."

Open session

As non-nurses who work extensively with nurses and nursing issues, Professor Buchan and Plant were invited by Professor White to offer their perspective on nursing and leadership.

Professor Jim Buchan

The strengths of nursing are clarity about the main business of nursing and ability to communicate those objectives in a jargon-free way to non-nurses. There is scope for nursing to highlight its strengths, for example emphasizing the size and diversity of the workforce and the involvement of nursing across all health care fields. However, it is important also to recognize weaknesses in the profession and to build alliances outside of the profession. Health is about politics and nursing needs to be able to play a political game and to engage with politicians in an influential way. An evidence-base to support arguments in favour of nursing is essential. Much nursing

research has a tendency to stay within its own comfort zone rather than embed itself in the broader concerns of health. Nursing research needs to align with and address national goals for health. Nurses need to engage outside the profession when undertaking research and to form research collaborations that involve other health care professions. Professor Buchan concluded his overview by saying that nursing would be in a much stronger position to influence change if nursing engaged with broader health networks.

Professor Aileen Plant

It is important for nursing to focus on its role within the broader health arena. Although lobbying for nursing is important, more influence is to be had by emphasising what nursing can do for other people. Health leadership should be regarded as a way of achieving outcomes and this opportunity should be exploited as much as possible. The round the clock exposure to patients and carers is nursing's biggest selling point. A priority might be to develop a structure for leadership development for young health care professionals to enable them to systematically influence and contribute to debates, policy and change management and also enable them to become effective leaders in the future.

2.3.7 Refinement of the Regional Strategic Plan for Nursing and Midwifery following Summit discussions – facilitated by Kathy Fritsch

Ms Fritsch explained that by the end of Jan 2007, WHO requires a final version of the Regional Plan. A teleconference will be scheduled to discuss patient safety, infection control and workforce issues. Delegates were invited to make further comments about the Regional Plan and to modify resolutions. These were recorded and forwarded to WHOWPRO.

A new resolution was composed and agreed as follows:

- *Recognizing* that a capable, motivated and supported health workforce is critical to advancing health, improving population health outcomes and achieving internationally agreed health and development goals, including the Millennium Development Goals.
- As nurses and midwives, comprising the largest part of the health care workforce, we *are committed* to improving the efficiency and effective delivery of health services, during this era of new and emerging health threats and continuing health disparities, by addressing continued workforce shortages, inequitable distributions, skill-mix imbalances, employment and working conditions.
- Therefore, as 2006 Nursing/Midwifery Leadership participants, we *endorse* the final drafting and adoption of a *Western Pacific Regional Strategic Action Plan for Nursing/Midwifery Development and pledge to implement* activities aligned with its four strategic objectives, closely linked to the Western Pacific Regional Strategy on Human Resources for Health, 2006 -2015.

3. CONCLUSIONS

3.1 The Way Forward. Panel: Professor Jill White, Rigieta Nadakuitavuki, Director Nursing and Health System Standards, Ministry of Health, Fiji; Neti Herman, Chief Nurse, Cook Islands; Phengdy Inthaphanith, Director of Nursing, Ministry of Health Lao.

Professor White invited the panel to make final comments about the second coming together of Chief Nursing Officers in the Western Pacific region.

Phengdy Inthaphanith

The excellent presentations have highlighted the current strengths and weaknesses in nursing and nursing leadership across the region and in different spheres of nursing. There is much variability between countries in terms of advancement of nursing leadership, pandemic preparedness and training and education of nurses in disaster management. Work needs to be done to strengthen nursing leadership and the Regional Plan will assist this process and should be supported.

Neti Herman

This Summit has provided new and valuable information on the opportunities and challenges inside and outside nursing and health. It has highlighted that future leaders need to be groomed and that regional CNOs should collaborate to make a difference to nursing and the health of communities.

The Summit has provided an overview of what needs to be achieved in the region and proffered ideas for taking this work forward. The opportunity to network with senior nurse leaders and experts in the region was timely. A WHOCC within the UTS faculty will further assist the region, particularly the small island countries, in efforts to improve nursing and midwifery and the role of nursing within health. The partnership that has developed over the years between many of the delegates and participating organizations has been strengthened as a result of the Summit.

Mrs Herman thanked Professor White and her team, WHOWPRO, AusAID and ICEAPS on behalf of the delegates.

Rigieta Nadakuitavuki

The Summit has provide an opportunity of refreshment, learning, enrichment, information exchange and networking. It is a rare occasion that nurses in the region are able to meet and learn from each other and from experts. The range of speakers and delegates has been unparalleled.

From Day 1, it is apparent that the Regional Strategic Plan for Nursing and Midwifery must be adapted to and aligned with a country's health plans. The Regional Plan provides a tangible commitment to quality improvement and risk management and outlines concise, clear and achievable outcomes. It is crucial that nursing

demonstrates how it makes a difference to people's lives and also shows how nursing is different from other professions. The next step is for delegates to consider how the Plan is translated into action in local contexts.

Mrs Nadakuitavuki stated that the work of institutes like UTS, James Cook University and the University of Auckland that are collaborating with some of the developing countries should be recognized and each country should be part of the WHOCC.

From Day 2, the most important message was the vital contribution of nurses in caring for those affected by natural or man-made emergencies. It was instructive to hear of experiences from Korea, China and Singapore and also the research and development programs that have arisen from the work of disaster nurses. The session on human resources for health provided ideas for addressing workforce shortages.

On Day 3, leaders in nursing passed on their hard-won experiences. The important message emerging from most of the speakers was for leaders to be nurtured for their to be cultures that encourage leaders and for nursing to engage in and lead on important health issues not just nursing issues.

In terms of the way forward, nursing must become more visible and have a shared vision. The indicators in the Regional Plan provide a means of measuring the progress of nursing in the region. Mrs Nadakuitavuki spoke of her 15 year experiences as a CNO and involvement in the development of health system standards and multidisciplinary work. In Fiji, a nurse has chaired the national therapeutic drug committee and standards committee. Mrs Nadakuitavuki's final words were 'Experience will take us through. Be focused. Share what you have. Prioritize what your country needs to achieve in health in five years time.'

Professor White then informed the Summit about future meetings. It has yet to be decided if this meeting will be held every second year. It is probable that the next meeting will be in 2009 but there will be opportunities to meet up at other forums.

The Summit then concluded with farewell songs from an indigenous Australian women's singing group.

3.2 Follow-up Activities

This summit will lead to:

- 1) Completion of the Regional Strategic Plan for Nursing and Midwifery;
- 2) Establishment of groups to work on areas of the Regional Plan;
- 3) A teleconference will be scheduled to discuss patient safety, infection control and workforce issues in relation to the Regional Strategic Plan;
- 4) Initiation of implementation planning and building consensus for the Regional Plan within each country;
- 5) Linking of key individuals into international initiatives around patient

- safety, human resources of health and infection control;
- 6) Feedback on the IMS-HRH project from delegates;
 - 7) Strengthening of the CNO and WHOCC network in the region around crisis communication and management in the face of threats within the region as well as on patient safety, infection control and human resources for health;
 - 8) The formation of a network of ex-CNOs/mentors in the region to promote planning of leadership succession;
 - 9) The holding of biennial Summits.

3.3 Serendipitous Summit Meetings

The Summit provided opportunities for many other meetings to take place. These meetings were able to move forward with some of the work presented at the Summit. They were:

1. AusAID Technical College: participants were CNOs of the South Pacific;
2. Infection Control: participants were Ms Kathy Fritsch, Professor Wing-Hong Seto, Professor Thomas Wong; Albion Street WHO CC representatives.

3.4 Evaluation & Media Coverage

Delegates were requested to evaluate each of the presentations, their overall experience of the Summit and to make recommendations for future Summits. An evaluation form was distributed to all delegates and 34 were returned. Each presentation and event was ranked 1-5 with 1=poor and 5= excellent (as shown in table below). There was also provision for open-ended responses. Delegates were also asked to make recommendations for future Summits.

General

Eleven out of 20 evaluated presentations were rated equal to or greater than 4.5. Stand-out presentations included those on Nursing Leadership, Pandemic Preparedness and Infection Control. Only one presentation ranked less than 4 at 3.8. Both evening events scored 4.7 and were welcomed as extending the time for networking and discussions within a social context. Following is a summary of the results for each day.

Day 1-Strategic Planning and presentations

All presentations were rated as greater than 4, with the mean score attained 4.2. Specific comments included that the Day was 'excellent' and 'very well organised'. A comment was made that small group work would have maximised the contribution of delegates and made the session more outcomes focused. One delegate said that they welcomed the overview of the SPCNOA objectives provided in the afternoon session.

Day 2 - Pandemic preparedness, disaster planning and HRH

The mean score for the Day 2 presentations was 4.3. The comments were almost all highly favourable ('excellent'; 'great speakers'; 'learnt a lot'). Comments were made that it would have been preferable to have scheduled the HRH sessions on a separate day to prevent information overload. It was noted that because of the number of sessions on this day it was quite tiring.

Day 3 - Nursing leadership and succession planning

Day three achieved an average ranking of 4.5. Comments included that the day was 'excellent', that there were 'good speakers', that it was 'good to hear from experienced colleagues', and that Day 3 was a 'very productive day'. One delegate mentioned that they would have preferred Day 3 as Day 1 (no reason given).

Comments on organization of Summit

Comments included that the organisation was 'very good', 'well organised', 'fantastic hospitality' and there were many 'excellent' comments for the accommodation, transport arrangements, catering and venue. However, there were a couple of comments that the Summit venue was too remote from the accommodation and that there were some delays in processing due to the tight turn-around time for organization of the Summit.

Overall comments on Summit

Comments included that the Summit was a very productive, informative and significant conference and that the speakers and topics were well-chosen. Opportunities were provided for: networking, getting together so many nurse leaders and experts. Group discussions and the sharing country experiences were seen as particularly valuable. One delegate reported that 'I was proud to have been there'. It was also mentioned that it was valuable to have the opportunity to hear non-nursing speakers. There was a comment that the number of presentations each day meant the Summit was quite demanding.

Recommendations for future Summits

Comments included: increase time to share country experiences, include small group work and include case studies of good practice. Comments on organisation and structure included: have venue closer to accommodation, run sessions from 8am-3pm to enable some free time and to prevent overload.

Media coverage

The Summit attracted substantial press coverage in the Australian national dailies and via numerous radio interviews on pandemic preparedness and building capacity within the region.

ANNEX 1

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ANNEX 2

TIMETABLE

Day 1 – Tuesday 28 November, Regional Strategic Plan

10.00am Welcome address and opening remarks, Professor Jill White
Professor and Dean, Faculty of Nursing, Midwifery & Health, UTS

Facilitated by Pele Stowers (Performance & Quality Assurance, Nursing & Midwifery, Samoa)

10.15am Kathy Fritsch, WHO WP Regional Nurse Advisor
Facilitate the refinement and operationalisation of the WHO/WPR regional strategic plan for nursing and midwifery. Includes discussion of

- > Information management systems for HRH data collection
- > Addressing workforce needs
- > Improvement quality of education program
- > Strengthening health workforce governance and management.

1.00pm Lunch

1.45pm Concurrent sessions
Professor Jill White, Western Pacific Collaborating Centres Meeting.
Kathy Fritsch, Chief Nursing Officers Meeting.

3.00pm Afternoon tea

3.30pm Monica Fong, Pacific Islands Forum Secretariat, Fiji
Update of Pacific Forum Plan
Facilitated by Bibi Florina Abdullah, Chief Nursing Officer, Malaysia

4.00pm Sue Kelly, Director, Pacific Health, Education & Environment
Section, AusAID
Strengthen regional governmental networks to improve crisis communication, crisis management and leadership in the face of threats within the regions.

4.30pm Close for the day

Day 2 – Wednesday 29 November, Pandemic Preparedness and Human Resources for Health (HRH)

10.00am Acknowledgment of Country, Joan Tranter, Manager of Indigenous and Cultural Diversity Programs UTS
The Vice-Chancellor and President, Professor Ross Milbourne, UTS
Opening Remarks, Paul McLeay MP, Parliamentary Secretary for Health, NSW.
Facilitated by Mrs Lata Malu, Chief Nursing Officer Tonga

10.20am Professor Aileen Plant, Australian Biosecurity Cooperative Research Centre for Emerging Infectious Diseases, Curtin University, Perth
Overview of Pandemic Preparedness

11.15am Ang Beng Choo, Chief Nursing Officer, Ministry of Health, Singapore and Registrar, Singapore Nursing Board

11.45am Professor Thomas Wong, Faculty of Health and Social Science, Hong Kong Polytechnic University

Sharing of experiences of pandemic preparedness in the aftermath of SARS and the current Avian Influenza threat.

12.15pm Dr Cho-Ja Kim, President, Korean Nurses Association
Nursing Leadership in Disaster Management in Korea

12.35pm Dr Noriko Katada, University of Hyogo, Japan
Challenges in developing a Centre of Excellence for Disaster Nursing - the Japanese Experience

1.00pm Lunch

Facilitated by Elizabeth Iro, President, Cook Islands Nurses Association

1.45pm Julie Hamblin, Ebsworth & Ebsworth Lawyers, Sydney
Principles for regulation in public health crises

2.15pm Dr Charmaine Turton, Director, International Health Services, Sue Greig, Clinical Nurse Consultant, Philip Melling, Director, Infection Control and Resources, WHO CC Albion Street Centre
WHO Collaborating Centre Albion Street Centre Infection Control Kit

2.45pm Dr Professor Wing Hong Seto, President of the Asia Pacific Society of Infection Control
World Alliance for Patient Safety

3.30pm Afternoon tea

4.00pm Professor Jim Buchan, Visiting Professor, Faculty of Nursing, Midwifery & Health, UTS
Information on broader HRH issues and the WHO/WPR Nursing and Midwifery Minimum Data Set for HRH Indicators Project.

4.45pm Dr. Piya Hanvoravongchai, Coordinator, Asia-Pacific Action Alliance on Human Resources for Health Researcher, Thailand
Asia-Pacific Action Alliance on Human Resources for Health (AAAH)

Day 3 – Thursday 30 November, Leadership Capacity

9.45am Opening Remarks, Adjunct Professor Debra Thoms, Chief Nursing Officer, NSW Health

Facilitated by Michele Rumsey Executive Officer, Faculty of Nursing, Midwifery & Health, UTS

10.00am Professor Judith Shamian, President and CEO, Victorian Order of Nurses, Canada
Succession Planning in a Leadership role

11.00am Professor Frances Hughes, Adjunct Professor UTS and WHO PIMHnet facilitator, New Zealand
Framework for political development-leading health

11.45am Professor Pat Brodie, Professor of Midwifery Research & Practice Development, Faculty of Nursing, Midwifery & Health, UTS; National President, Australian College of Midwives
Building professional alliances with women, collaborative practice, strategic partnership and community engagement

12.30pm Lunch

Facilitated by Ms Frances Prescilla Cuevas, Chief Health Program Officer, Philippines

1.30pm Professor Mary Chiarella, Professor of Clinical Practice Development and Policy Research, Faculty of Nursing, Midwifery & Health, UTS - Fostering nursing leadership in times of political flux

2.15pm Lady Jocelyn Keith C.B.E., former Head of department of Nursing Studies, Victoria University of Wellington, and of the Department of Public Health, Wellington School of Medicine, Otago University, New Zealand
Leadership in Nursing - Are we Promoting Nursing or are we Promoting Health?

3.00pm Afternoon tea

3.15pm Kathy Fritsch, WHO WP Regional Nurse Advisor
Refinement of the Regional Strategic Plan following the discussions within the Summit.

Panel: Professor Jill White; Rigieta Nadakuitavuki, Director Nursing & Health System Standards, Ministry of Health, Fiji; Neti Herman, Chief Nurse, Cook Islands; Phengdy Inthaphanith, , Director of Nursing, Ministry of Health, Lao
Evaluate Summit and way forward.

4.30pm Close of Regional Summit and Musical Farewell

ANNEX 3

**World Health Organization Western Pacific Region, Nursing And
Midwifery Leadership Summit, 2006: *Building Leadership Capacity And
Disease Prevention In The Western Pacific Region*
Hosted by University of Technology, Sydney
28 – 30 November 2006
Sydney Australia**

Organising Committee

Ms Michele Rumsey Australia	Conference Director, Executive Officer, Proposed WHOCC for Nursing, Midwifery and Health Development, Faculty of Nursing, Midwifery & Health, University of Technology, Sydney
Ms Kathleen Fritsch Philippines	Co-convenor, Regional Advisor Nursing, Western Pacific Regional Office World Health Organization
Professor Jill White Australia	Co-convenor, Director, Proposed WHOCC for Nursing, Midwifery & Health Development, Dean, Faculty of Nursing, Midwifery & Health, University of Technology, Sydney
Professor Mary Chiarella Australia	Co-convenor, Professor of Clinical Practice Development and Policy Research, Faculty of Nursing, Midwifery & Health, University of Technology, Sydney
Ms Liz McInnes Australia	Conference Co-ordinator, Project Officer for Policy Research and Development, Faculty of Nursing, Midwifery & Health, University of Technology, Sydney

Chief Nursing Officer Participants

Mrs Koh Sileap Cambodia	Chief Nursing & Midwifery Officer Ministry of Health
Dr Li Zheng China	Dean of School of Nursing Beijing Union Medical University
Mrs Neti Tamarua Herman Cook Islands	Chief Nurse Ministry of Health
Mrs Elizabeth Iro	President

Cook Islands	Cook Islands Nurses Association
Ms Rigieta Nadakuitavuki Fiji	Manager Nursing Ministry of Health
Ms Mamoa Robate Kiribati	Acting Deputy Director of Nursing Ministry of Health & Medical Services
Dr Cho-Ja Kim Korea, Republic Of	President Korean Nurses Association
Mrs Phengdy Inthaphanith Lao	Director of Nursing Ministry of Health
Mrs Bibi Abdullah Malaysia	Chief Nursing Officer Ministry of Health
Ms Che Sayang Long Malaysia	Assistant Chief Nursing Officer Ministry of Health
Mrs Cathelina Antolok Marshall Islands	Chief Nurse Ministry of Health
Mrs Hillia Langrine Marshall Islands	Assistant Chief Nurse Ministry of Health
Mrs Lois Aingimea Republic of Nauru	Chief Nursing Officer Ministry of Health
Dr Elaine Papps New Zealand	Director of Nursing Hawke's Bay District Health Board
Mrs Ketu Fereti Niue	Principal Nursing Officer Department of Health
Mrs Rosa Tuleda North Mariana Islands	Chairperson, CNMI Board of Examiners Board of Nursing
Ms Patricia Maech Palau	QA/CE Co-ordinator Ministry of Health
Ms Frances Cuevas Philippines	Chief Program Officer, Department of Health
Ms Pele Stowers Western Samoa	Performance & Quality Assurance Ministry of Health

Mrs Fulisia Aiavao Western Samoa	Dean of Faculty of Nursing, National University Ministry of Health
Ms Ang Beng Choo Singapore	Chief Nursing Officer & Registrar Singapore Nursing Board, Ministry of Health
Mr Amos Lapo Solomon Islands	National Head of Nursing Services Ministry of Health
Ms Anna Sinapati Tokelau	Health Department
Mrs Latu Malu Tonga	Chief Nursing Officer Ministry of Health
Ms Filoiala Sakaio Tuvalu	Hospital Matron Ministry of Health
Mrs Adeline Welin Vanuatu	Principal Tutor of VCNE Ministry of Health
Mrs Vu Thi Ngoc Vietnam	Ministry of Health
Ms Heather Austin Australian Capital Territory Australia	Senior Policy Officer, Nursing & Midwifery Office ACT Health
Professor Jenny Beutel South Australia Australia	Chief Nursing Officer Department of Health
Professor Belinda Moyes Victoria Australia	Principal Nurse Advisor Department of Human Services
Professor Debra Thoms New South Wales Australia	Chief Nursing Officer NSW Health
Ms Pauline Ross Queensland Australia	Chief Nursing Officer Queensland Health
Ms Fiona Stoker Tasmania Australia	Chief Nursing Officer Department of Health and Human Services

WHOCC Participants

Dr Juliet Fleischl Fiji	Technical Officer, Human Resources and Health Systems for WHO; WHO Representative Office
Ms Kathleen Fritsch Philippines	Regional Advisor in Nursing WHO Western Pacific Regional Office
Ms Sue Greig Australia	Clinical Nurse Consultant, WHO CC Albion Street Centre, Sydney
Professor Won-Hee Lee Korea, Republic of	Dean & Director, WHO CC Nursing Development in PHC
Mr Phillip Melling Australia	Infection Control and Resource Director, WHO CC Albion Street Centre, Sydney
Dr Sarah Nagamatsu Japan	WHO CC for Nursing Development in PHC St Luke's College of Nursing
Professor Wing Hong Seto Hong Kong	President, Asia Pacific Society of Infection Control WHO HQ
Dr Charmaine Turton Australia	Director, WHOCC International Health Services, Albion Street Centre, Sydney
Professor Jill White Australia	Proposed WHOCC for Nursing, Midwifery & Health Development Faculty of Nursing, Midwifery and Health
Professor Thomas Wong Hong Kong	Director Proposed WHOCC, Faculty of Health and Social Science, Hong Kong Polytechnic University
Professor Il Young Yoo Korea, Republic of	Associate Director, WHO CC Nursing Development in PHC

Other delegates

Professor Jim Buchan United Kingdom	Queen Margaret University College, Edinburgh
Ms Monica Fong Fiji	Human Resources Development Policy Officer, Pacific Islands Forum Secretariat

Ms Julie Hamblin Australia	Ebworth & Ebworth Lawyers
Dr Piya Hanoravongchai Thailand	Co-ordinator, Asia Pacific Action Alliance on HRH
Professor Frances Hughes New Zealand	WHO PIMHnet Facilitator and Adjunct Professor UTS
Dr Noriko Katada Japan	Dean and Professor of Nursing University of Hyogo
Lady Jocelyn Keith New Zealand	former Head of department of Nursing Studies, Victoria University of Wellington, New Zealand, and of the Department of Public Health, Wellington School of Medicine, Otago University
Ms Sue Kelly Australia	Director, Pacific Health, Education & Environment Australian Aid and Development Bureau
Professor Aileen Plant Australia	Professor of International Health Australian Biosecurity Cooperative Research Centre for Emerging Infectious Disease, Curtin University
Dr Judith Shamian Canada	President and Chief Executive Officer Victorian Order of Nurses
Professor Kim Usher Australia	Chair, Council of Deans of Nursing & Midwifery (Australia & New Zealand)
Delegates from Australian nursing and midwifery organizations invited to attend Summit to become acquainted with issues of the region and to share experiences related to leadership and pandemic preparedness (Attended Days 2 & 3)	
Ms Amanda Adrian Australia	Professional Officer, Australian Nursing Federation
Professor Pat Brodie Australia	National President, Australian College of Midwives
Ms Karen Cook Australia	Chief Executive Officer Australian Nursing and Midwives Council

Dr Anne Gardner
Australia Representative, Royal College of Nursing

Ms Jill Iliffe
Australia Federal Secretary
Australian Nursing Federation

**Representing University of Technology, Sydney (Faculty of Nursing,
Midwifery & Health)**

Professor Jim Buchan Visiting Professor, Centre for Health Services
Management

Professor Mary Chiarella Professor of Clinical Practice, Development and
Policy Research, Centre for Health Services
Management

Ms Lisa Conlon Lecturer

Professor Denise Dignam Associate Dean

Professor Caroline Homer Director of Centre for Midwifery, Child and Family
Health

Mr Kevin Kellehear Lecturer

Professor Nicky Leap Midwifery Practice Development & Research

Assoc Professor Lin Lock Senior Lecturer

Professor Sharon McKinley Critical Care Nursing Department

Mr Blair McRae Commercial Director, UTS

Ms Michele Rumsey Executive Officer

Dr Stephen Van Vorst Senior Lecturer & Acting Director of
Undergraduate Studies

Professor Jill White Dean

Observers

Professor Mavis Kirkham Visiting Professor of Midwifery, University of
United Kingdom Sheffield

Ms Cha-aim Pachanee AAAH Secretariat Asia-Pacific
Thailand