All Party Parliamentary Group on Global Health

Submission from the Christian Medical Fellowship (CMF) in response to a call for evidence of the future development of nursing globally

A review by the All-Party Group on Global Health which will look specifically at how the UK can contribute to the development of nurses and nursing globally The agreement of the Sustainable Development Goals last year means that there will be an even greater demand for health workers globally. This will put particular pressure on nurses who carry the greatest burden of care and treatment throughout the world. In light of this, the All-Party Parliamentary Group on Global Health is undertaking a review of nursing globally with support from the Royal College of Nursing. It will look at how nursing needs to develop globally – addressing such issues as education, recruitment, retention, role definition and regulation – as well as considering, numbers of nurses, capacity and finances.

The Christian Medical Fellowship (CMF) was founded in 1949 and is an interdenominational organisation with over 4,500 British doctor members in all branches of medicine, and around 250 nurse and midwife members. We are the UK's largest faith-based group of health professionals. A registered charity, we are linked to about 40 similar national bodies for nurses in other countries through Nurses Christian Fellowship International (www.ncfi.org). In this submission, CMF offers comments on a number of the issues and perspectives that the APPGA has proposed for discussion based on conversations with our national and international nursing members, including several with significant experience of nurse education in a developing world context.

1: **How does nursing need to develop globally in order to contribute most effectively to improving health globally and delivering Universal Health Coverage**

There is no globally accepted definition of nursing, and when some major national nursing bodies withdraw from international networks like the ICN (e.g. the Royal College of Nursing) it undermines moves towards global standards in nurse education and training. So we need to fully engaged as a UK profession in the development of global standards of training. Working towards a global standard of nurse training is vital.

This will mean an increasingly mobile nursing workforce – and we should be prepared to look at how to use this to develop skills and training that can be brought back to local communities through paid clinical attachments out of country, salary top-ups and other mechanisms to encourage nurses to return to their home country and practice and train others.

We also need to accept training to the appropriate level. Graduate level nursing is vital, and the evidence that it benefits patient care and clinical outcomes is strong. However, there is also a need for those who can do basic, essential nursing care in both the secondary and primary settings who do not need to be graduate trained, but do need appropriate training, regulation and registration. We should look at what levels of training are necessary and sustainable in each community, formalising the training of informal carers (as has been done with traditional birth attendants) to improve the efficacy of the care they provide.

Likewise, there needs more multi-centre, international nursing research. We need more evidence of appropriate and effective practice in different settings, rather than assuming that the 'West is best'.

Furthermore, we need a way to collect and disseminate research and examples of appropriate practice - helping nurses manage in differently resourced situations by creating a repository (or repositories) of appropriate nursing knowledge. This can help nurses in similar resource poor settings to learn from the problem solving of other nurses working in similar settings.

Nursing has a vital role in public health, and developing public health skills as part of the core training of nurses will have a massive impact in preventative healthcare. From a faith communities' perspective, the emergence of Parish Nursing or Faith Community Nursing is a new, locally led initiative that brings public health nursing skills into the local community in a sustainable manner. Although this is currently most developed in Europe and North America, many CIS and developing countries are adopting this approach.[1]

Furthermore, because of their role close to the clinical needs of their patients and communities, nurses must have a strong voice in national and global health policy. This voice has been noticeably missing. Nurse training must include leadership development as part of its core curriculum, equipping nurses to engage with health policy, to write critically and engage in debate at academic and public policy levels. An example is the leadership development programme of Nurses Christian Fellowship International (see **http://iicn.ncfi.org/**), which seeks to equip nurses to lead in different ways, at the local/clinical, regional, national and global level, using different models of leadership to develop core competencies. This is an international, distance learning, modular programme, currently under development. But which in time will be a programme that can be adapted and expanded for different settings, and is applicable to students and qualified nurses at all career stages.

2: **What are the key issues that need to be addressed globally in order to enable nursing to develop in this way**

Nursing is still an overwhelmingly female profession (and even where it is not, the public perception is that is). Combined with the nature of nursing – dealing with intimate and personal health and hygiene issues, handling unclean bodies and body fluids, etc. the low status of women in many societies often means that nursing is a very low status profession. Addressing the social status of women and girls and their access to education beyond the primary level is key. Educated women mean healthier children, but it also means more women able to gain access to nursing as a career that enriches their families and benefits their communities.

An example is the Grameen Caledonian College of Nursing, Dhaka, Bangladesh, where a Scottish nursing school partnered with the Grameen Bank to build a nursing and midwifery school that educates girls from the rural communities of Bangladesh to a high and appropriate standard of nursing and midwifery practice, with a particular focus on rural public health. Their education is paid for by a low-interest social loan that is then repaid when the young women start working in rural community health. This creates a sustainable training model, equips the students with skills that have a real impact on the health of rural communities, and raises their social status and income, benefitting their family and community.[2]

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[1] Wordsworth H, Moore R & Woodhouse D, (2016) Parish nursing: a unique resource for community and district nurses British Journal of Community Nursing | Vol. 21 | No. 2 | pp 66–74 10.12968/bjcn.2016.21.2.66

[2] Parfitt B. & Nahar N.S. (2015) Nursing education in Bangladesh: a social business model. International Nursing Review 00, 00–00

Healthcare is still very hierarchical outside of Northern Europe, and even here, the vestiges of hierarchy still have a significant influence on clinical and professional working relationships. Nursing needs to be recognised globally and nationally as a profession in its own right – hence the need for internationalised nurse training curricula, a global body of research informing evidence based practice, and appropriate practice sharing across nations. Again, it is a bigger issue than nursing alone; there needs to be a cultural shift in the clinical setting towards multidisciplinary team working that is not based on status and hierarchy. This only develops by institutions committing to a culture and ethos of multidisciplinary working. Developing nurse leaders will be a vital component in bringing about such cultural changes.

3: What can the UK Government and UK organisations do to help develop nursing and nurses globally?

Nurses are a highly mobile workforce, and if British nurses can have more flexibility to take training experiences outside of the UK, to work as visiting scholars with the WHO, ICN and other global bodies, and allow similar exchanges for nurses from other nations to take experience in practice and nurse research and academia in the UK, it will add greatly to global sharing of knowledge, skills and cooperation in the development of the profession. The NMC in particular needs to develop greater flexibility in its requirements for clinical practice and revalidation – the new revalidation regime coming into effect this April will have a potentially dampening impact on nurses developing long term careers in overseas development and needs to be much more flexible.

As mentioned in response to question 1, a very practical step is for the RCN to re-join the ICN, which will strengthen the British profession's global standing and engagement with the profession internationally.

As a nation we should be encouraging international volunteering and careers in global health for our nurses. Funded short-term programmes, partnering with INGOs, national health systems, etc. could all be extended to give more nurses an opportunity to contribute to global health initiatives and develop skills to train and equip nurses in resource poor contexts.

Partnerships between British nursing schools and national governments and local institutions, such as the Glasgow Caledonia partnership with Grameen Bank (see the response to question 2), can be a creative way to share skills and learning in nurse education and practice – not just from the UK to developing countries, but also in reverse.

British nursing enjoys a strong global reputation, not just because of the high quality of training and clinical practice, but also because of the values of care, compassion and commitment to excellence in patient centred, whole person care that are central to our training, practice and professional codes. It is often a challenge to find that many of those values are not universal in nursing. For example, I know several highly skilled and qualified nurses from other parts of Western Europe who were appalled to find they were expected to care for the hygiene and nutritional needs of their patients when they came to work in the UK. Again, in many countries the high status roles in nursing are often the technical ones, with low status, low paid carers dealing with personal care. British nurses can model something very different – an integrated, whole person approach to care that combines the highest levels of technical competence with attention to detail in personal care and an openness to address the spiritual and psychosocial needs of patients.

Values based training is something we can do a lot to export. In medical education, the UK charity PRIME has been pioneering values based, whole person medical training in Eastern Europe, Africa and

South Asia for over a decade. It is increasingly working with nurse educators to bring this training into nursing schools and post-graduate nurse education in the same areas (see **www.prime-international.org**). The government can look at releasing funds to encourage such training partnerships between institutions, NGOs and others working in values based training.

In the UK we have a very strong ethic that access to good quality, appropriate healthcare is a fundamental human right, not a privilege for those who can afford to access it. Healthcare is delivered free at the point of need. This ethos is fundamental to achieving Universal Health Coverage, and again it is about sharing values and transforming culture rather than just developing infrastructure and funding mechanisms. Many nations are adopting models of primary care and health service funding influenced by the National Health Service. This also creates open doorways to develop these values in nurse education – again with a strong focus on public health and universal access. The government at all levels (DFID, DTI, DoH, etc.) should be encouraging UK institutions to build partnerships with hospitals, professional bodies and training institutions in these countries

4. **Any other thoughts or comments**

Coming from within the faith based, not for profit sector, the majority of the examples and illustrations we have used have come from faith based organisations. There is a lot of innovative work happening globally and nationally by Christian organisations working in healthcare and nurse education, and we are keen to work with national and international bodies to build the capacity of the profession to have an impact on the health and well-being of nations. If Universal Health Coverage is to be achieved, it will need to include not just INGOs, governments, national and global institutions, but also civil society, including churches, other faith communities and faith based organisations.[3]

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[3] See the CMF submission to the High Level Panel consultation on the Post-2015 Goals; Faith Matters - the contribution of faith to health and healthcare in the post 2015 agenda, 10 January 2013, accessed at http://www.cmf.org.uk/publicpolicy/submissions/?id=153