

to draw from and build on, and we look forward to the Commission doing so in its next stage of work.

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Delivering on global health priorities: the WHO Task Force on Nursing and Midwifery

WHO is entering a new era in its recognition of the vital domains of nursing and midwifery. After the appointment of WHO's Chief Nursing Officer in 2017, the Director-General has endorsed the establishment of the WHO Task Force on Nursing and Midwifery. The taskforce is engaging the global nursing and midwifery community to accelerate collaboration and progress on the health-related Sustainable Development Goals (SDGs).¹

Comprising almost 50% of the global health-care workforce, nurses and midwives are at the forefront of providing care and services across the health spectrum.² They are often the principal interface between patients, families, and communities, and have a pivotal role in the coordination and continuity of care, all of which are central to improving outcomes.^{3,4} From emergencies and conflicts, to serving communities throughout the life course, nurses and midwives work at all levels of health systems, in diverse settings, and across wide geographical areas. When integrated into interdisciplinary teams and supported by enabling environments, nurses and

midwives deliver high-quality, patient-centred services that translate into positive health outcomes.^{5,6} As such, it is hard to imagine achieving primary health care (PHC) and universal health coverage (UHC) without a qualified and motivated nursing and midwifery workforce.^{7,8}

The WHO Task Force on Nursing and Midwifery is convened by the office of the WHO Chief Nursing Officer and provides an interdisciplinary platform to strengthen nursing leadership, advocate for political commitment, develop research and evidence, improve coordination, and embed nursing and midwifery perspectives in WHO's work and global health initiatives. The task force is working on improving access to WHO technical guidelines and resources relevant to mainstreaming the contributions of nurses and midwives. Establishment of formal mechanisms that bring together WHO nurses and midwives who work directly with technical programmes will ensure that their perspectives are made visible and explicitly addressed across strategy, policy, and programming at WHO. This is important as WHO moves into detailed

planning on implementation of its 13th Global Programme of Work 2019–2023—WHO's 5-year plan to make sure that 1 billion more people benefit from UHC, 1 billion more are protected from health emergencies, and 1 billion improve their overall health.⁹ Meeting these ambitious targets will require the active engagement of nurses and midwives in clinical practice, with managers and decision makers around the world tackling the most pressing issues facing them, such as violence and abuse, dangerously low staffing levels, and increasing workloads.¹⁰

Strengthening and expanding the role of nurses and midwives will require investments in quality education, competencies, regulation, and professional standards. New and innovative solutions are needed to not only increase the numbers and quality of nurses and midwives in underserved areas but also to advocate for their expanded role in countries where they can assume more advanced positions such as nurse prescriber.¹¹ The WHO Task Force on Nursing and Midwifery is strengthening collaboration and establishing mechanisms to partner with government Chief Nursing and Midwifery Officers, the 46 WHO Collaborating Centres for Nursing and Midwifery, UN organisations such as United Nations Population Fund and UNICEF, and professional groups such as the International Confederation of Midwives and the International Council of Nurses. Such partnerships are vital to the first State of the World's Nursing (SOWN) 2020 Report and the third State of the World's Midwifery (SOWMY) 2020 Report that are expected to launch in 2020. These two publications will inform and guide countries on how to capitalise on the potential of their existing and future workforce.

2020 will mark the 200th anniversary of the birth of Florence Nightingale, a nurse and a statistician whose work contributed to public health policies.¹² The launch of the SOWN 2020 and SOWMY 2020 reports will inform necessary country policy dialogue as we strive to make meaningful progress toward the triple billion goals, PHC, UHC, and the SDGs. It is timely ahead of International Day of the Midwife on May 5 and International Nurses Day on May 12 to reflect on what actions governments can take to increase recruitment, reduce attrition, improve safety in the work place, promote professional development, address gender equity, and tackle dangerous staffing



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shortages that undermine the delivery of quality health care and impact patient safety and community trust.

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Towards eradication of chronic obstructive pulmonary disease: a *Lancet* Commission

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“One must be impressed by the very long road medicine must travel before an understanding of disease is reached, even when its clinical symptomatology is relatively simple.”¹ Whether one accepts the Dutch hypothesis advanced by pulmonologists Dick Orie and Henk Sluiter, this idea in the introduction to their 1961 book, *Bronchitis*,¹ still resonates today. Despite many advances in medicine, our understanding of the pathobiological mechanisms that underlie chronic obstructive pulmonary disease (COPD) remains incomplete, the definition of the disease is debated, our diagnostic tests are imprecise, and treatment is inadequate, even as the global burden of the disease continues to increase.²

Progress has been hampered by the heterogeneity of disease mechanisms and phenotypic expression. Compelling data support not only the Dutch hypothesis but also plausible aetiological roles for hypersecretion caused by bronchial infections, known as the British hypothesis,³ protease-antiprotease imbalance,⁴ autoimmunity,⁵ and eosinophils in driving disease activity.⁶ What is certain is that COPD requires urgent attention as the global prevalence of the disease increased by 44% from 1990 to 2015, and in 2017 alone 3.2 million people died from the disease worldwide, an increase of 17.5% since 2007 and more than six times as many who died from asthma.^{2,7} Although these data are alarming, they probably underestimate the true size of the problem.^{8,9} Thus, *The Lancet* has launched a global Commission to identify where traditional thinking about COPD has held us back and where new approaches to prevention, risk prediction, definitions, diagnosis, and treatment could spur meaningful change.

The global pattern of COPD risk factors is evolving. Although smoking is the major contributor to the COPD burden in high-income countries, environmental exposures explain about 60% of the disease in countries with the lowest sociodemographic index.² The traditional approach to curbing COPD risk by focusing almost exclusively on tobacco control must be revisited because deaths from exposure to ambient air pollution have increased by 25% since 1990, tobacco control efforts have had minimal impact or are non-existent, particularly in countries such as China, India, and the USA, and the long-term health consequences of the growth in vaping in young people is largely unknown.^{10,11} It is also notable that a third of the disability-adjusted life-years (DALYs) related to COPD is not explained by smoking or environmental exposures,² confirming we have incomplete understanding of the natural course and underlying pathophysiology of the disease, including lung function trajectories, the importance of early life predictors—eg, low birthweight, prematurity, and in-utero exposures—and the effects of tuberculosis and physical inactivity.^{12,13} As a consequence, risk models and prediction tools are inadequate and a new broader view of lung health is needed.

Although as Orie and Sluiter noted, the cardinal symptoms of COPD—breathlessness and cough—are readily recognisable, the diagnosis of the disease remains a challenge. This is partly because of the underuse of spirometry. Even when spirometry is applied, however, debate continues about the optimal thresholds to define airflow obstruction and stage severity, which can lead to wide variation in estimates