AFRICAN HEALTH PROFESSIONS
Regulatory Collaborative for Nurses and Midwives
Summative Congress
Johannesburg South Africa June 2012
FIRST REPORT YEAR 2
AFRICAN HEALTH PROFESSIONS REGULATORY COLLABORATIVE

PARTNERSHIP FOR EXCELLENCE IN AFRICA’S HEALTH WORKFORCE
Johannesburg South Africa 20-22 June 2012

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ACKNOWLEDGEMENTS

This report was written by Jill Iliffe, Executive Secretary, Commonwealth Nurses Federation, on behalf of the ARC faculty. jill@commonwealthnurses.org
# LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AJM</td>
<td>African Journal of Midwifery and Women’s Health</td>
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<td>ARC</td>
<td>African Health Professions Regulatory Collaborative</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>CDC</td>
<td>US Centers for Disease Control and Prevention, Atlanta, Georgia</td>
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<td>CNF</td>
<td>Commonwealth Nurses Federation</td>
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<td>CNO</td>
<td>Chief Nursing Officer</td>
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<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>ECSA</td>
<td>East, Central and Southern Africa region</td>
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<td>ECSACON</td>
<td>East, Central and Southern Africa College of Nursing</td>
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<tr>
<td>ECSA-HC</td>
<td>East, Central and Southern Africa Health Community</td>
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<tr>
<td>GAGNM</td>
<td>Global Advisory Group on Nursing and Midwifery</td>
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<td>GNCBP</td>
<td>Global Nurse Capacity Building Programme</td>
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<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICAP</td>
<td>International Centre for AIDS Care and Treatment Programmes</td>
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<td>ICM</td>
<td>International Confederation of Midwives</td>
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<td>ICN</td>
<td>International Council of Nurses</td>
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<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
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<td>I-TECH</td>
<td>International Training and Education Centre for Health</td>
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<td>NCD</td>
<td>Non-communicable disease</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<tr>
<td>NEPI</td>
<td>Nursing Education Partnership Initiative (PEPFAR funded)</td>
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<td>NIMART</td>
<td>Nurse Initiated and Managed Antiretroviral Therapy</td>
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<td>NNA</td>
<td>National Nursing Association</td>
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<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PMTCT</td>
<td>Preventing mother to child transmission (of HIV)</td>
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<td>PRF</td>
<td>Professional Regulatory Framework</td>
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<td>RPRF</td>
<td>Regional Professional Regulatory Framework</td>
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<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>VMMC</td>
<td>Voluntary medical male circumcision</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1. EXECUTIVE SUMMARY

The United States Centers for Disease Control and Prevention (CDC) under the US President’s Emergency Plan for AIDS Relief (PEPFAR); Emory University’s Lillian Carter Center for Global Health and Social Responsibility; the East, Central and Southern Africa Health Community (ECSA-HC), the Commonwealth Secretariat, and the Commonwealth Nurses Federation have established a collaboration titled: The African Health Professions Regulatory Collaborative (ARC), which creates an innovative south-to-south partnership to engage and build on the capacity of Africa’s health professional regulatory leadership for nursing and midwifery. The aim of this Collaborative is to improve health professional standards and practice in the region using local solutions and peer-based learning.

A number of challenges for the nursing and midwifery workforce were identified when Emory University, the Commonwealth Secretariat, the CDC and the ECSA-HC met at a regional meeting for East, Central and Southern Africa (ECSA) in March 2005. These challenges included that:

- only 42 per cent of births are attended by trained personnel;
- there was an acute shortage of nursing and midwifery personnel;
- there was a lack of capacity for scaling up the education of nurses and midwives; and
- there was inadequate data to inform policies and workforce planning.

The ARC initiative aims to improve health care and health outcomes by investing in nursing and midwifery education and nursing and midwifery regulation. The rationale for the ARC initiative is that: there is a proven correlation between the number of providers and health outcomes; there is a disproportionate correlation between the high burden of disease in sub-Saharan Africa and the available workforce (25% of global disease burden and 1% of global health workforce); global initiatives have invested in patient services without comparable investments in workforce issues; and the largest workforce in Africa’s health delivery system are nurses and midwives.

The ARC conceptual framework is adapted from the Institute for Healthcare Improvement (IHI) model for breakthrough organisational change. The Institute for Healthcare Improvement Breakthrough Series© model is a short-term (6 to 15 month) learning system in which organisations learn from each other, as well as from recognized experts, about an area needing improvement. The structure of the IHI model is a series of alternating Learning Sessions and Action Periods (see figure 1).

Figure 1: IHI Breakthrough Improvement Model (adapted for ARC)
Preliminary discussions on a regional approach to strengthening nursing and midwifery took place in April, 2010 when PEPFAR and World Health Organisation (WHO) launched the ‘Educating Nurses for the Future’ initiative. This provided an opportunity to develop the ARC proposal. The concept, to enable countries to expand high quality nursing and midwifery services through strengthening and harmonising midwifery regulation and practice in the ECSA region, was finalised at a meeting in Georgia, Atlanta in June 2010.

The objectives of the four-year Collaborative are to:

1. Ensure that quality standards of nursing and midwifery practice that align with global standards are harmonised in the ECSA region.
2. Ensure that national regulatory frameworks for nursing and midwifery are updated to reflect nationally approved reforms to practice and education.
3. Strengthen the capacity of professional regulatory bodies to conduct key regulatory functions in nursing and midwifery within the ECSA region.
4. Establish a sustained consortium of African health leadership in nursing and midwifery practice and regulation.

To achieve these objectives, the Collaborative initially brought together representatives from 14 countries in the ECSA region including Chief Nursing Officers, Registrars of Nursing and Midwifery Councils, the Presidents of national Nursing and Midwifery Associations, and a representative of nursing educational institutions.

The first meeting of the African Health Professions Regulatory Collaborative was held in Nairobi, Kenya from 28 February to 2 March 2011 in collaboration with the Kenya Ministry of Health. Fourteen countries in the ECSA region were represented: Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe, as well as representatives from the CDC, Emory University, the Commonwealth Secretariat, the World Health Organisation, the Commonwealth Nurses Federation, the International Council of Nurses, the International Confederation of Midwives, and the East, Central and Southern Africa Health Community, and invited guests and speakers.

The specific objectives of the first ARC meeting were to:

- Foster regional dialogue on shared challenges and promising solutions in nursing and midwifery regulation, practice and standards.
- Facilitate country teams’ identification of regulatory issues that can be advanced through a south-to-south collaborative.
- Foster collaboration between African nursing and midwifery stakeholders in the ECSA region.
- Assess the role of nursing and midwifery regulatory bodies with the ECSA region.
- Advance nursing and midwifery leadership and problem-solving skills through the implementation of mini grants that target nursing and midwifery regulatory advancement.

Following the meeting, the 14 countries were invited to submit proposals for four available funding grants of US$10,000 to address a key regulatory issue in their country achievable within the grant period of 12 months. Ten countries subsequently submitted proposals and after a rigorous evaluation, five country proposals were accepted for funding: Lesotho, Malawi, Mauritius, Seychelles and Swaziland. The objectives of each proposal are outlined below.

- **Lesotho**: The Lesotho proposal was to develop a national continuing professional development (CPD) programme for nurses and midwives in Lesotho.
- **Malawi**: The Malawi proposal was to evaluate their existing CPD programme; revisit the implementation strategy to ensure that all nurses and midwives understand the value of CPD; and intensify monitoring and evaluation of CPD across the country in collaboration with all stakeholders.
- **Mauritius**: The objective of the proposal from Mauritius was to insert into legislation and regulation standardised qualifications for nurse and midwife educators covering both the public and private sector.
Seychelles: The Seychelles proposal is to review the Seychelles Nurses and Midwives Act 1985 to establish a full-time registrar for nursing and midwifery.

Swaziland: The purpose of the Swaziland project was to establish and sustain a national CPD model based on a needs assessment of practising nurses in Swaziland and other relevant stakeholders.

The second meeting of ARC, which took the form of a learning session, was held in Durban, South Africa from 24 to 26 June 2011. Representatives from the five countries which were successful in their funding applications for ARC grants attended the meeting. The learning session aimed to provide an opportunity for successful countries to be supported in refining their funding proposals following input from the ARC team, from invited technical experts, and from the other countries attending the meeting, and to develop action plans that were measurable and achievable.

The third meeting of the African Health Professions Regulatory Collaborative which also took the form of a learning session was held in Arusha, Tanzania from 5 to 7 October 2011. The countries attending the meeting were those that had been successful in receiving ARC Year 1 grants: Lesotho, Malawi, Mauritius, Seychelles and Swaziland. The meeting aimed to provide the countries with an opportunity to report on their progress of the project; to submit their progress for peer review; and to arrange any further technical assistance that might be required for their projects to be successfully completed.

2. INTRODUCTION TO ARC SUMMATIVE CONGRESS

In February 2012, a call for proposals for Year 2 ARC funding was announced (see Attachment 5: Grant Application Guidelines ARC Year 2). Ten countries submitted proposals: Botswana, Kenya, Lesotho, Mauritius, Mozambique, Rwanda, Swaziland, Tanzania, Uganda and Zimbabwe. These proposals were subject to a rigorous evaluation process in order to select the countries to receive ARC funding in Year 2 of the initiative.

The ARC Year 2 Summative Congress was held in Johannesburg South Africa 20-22 June 2012. Seventeen countries from the East, Central and Southern Africa region attended the Congress: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Partners in the ARC initiative were represented by: Ms Patricia Riley, Ms Alexandra Zuber, Dr Carey McCarthy and Mr André Verani from the Centers for Disease Control and Prevention; Dr Maureen Kelley and Ms Jessica Gross from Emory University; Dr Magna Aidoo and Ms Peggy Vidot from the Commonwealth Secretariat; Mr Alphonse Kalula from the East, Central and Southern Africa Health Community, and Ms Jill Iliffe from the Commonwealth Nurses Federation. Invited technical experts included: Ms Mary Fanning from CDC South Africa; Ms Genevieve Howse (legal practitioner and legislation adviser from Howse Fleming Consulting); Ms Jean Barry from the International Council of Nurses; Ms Sheena Jacob, Dr Dorothy Namate and Ms Rose Wasili from I-TECH (International Training and Education Centre for Health); and Ms Eleanor Msidi representing both NEPI (Nursing Education Partnership Initiative) and ICAP (International Centre for AIDS Care and Treatment Programmes).

The purpose of the Summative Congress was to showcase the regulatory improvements made by the ARC Year 1 grant recipients; facilitate dialogue on key issues facing nursing and midwifery in the region; and announce the successful ARC Year 2 grant recipients. The specific objectives of the Congress were to:

- facilitate regional dialogue on shared challenges and promising solutions in nursing and midwifery legislation, regulation and standards,
- foster collaboration between African nursing and midwifery stakeholders in each country, and advance their collaborative leadership skills,
- celebrate regulatory achievements and progress made during ARC Year 1 and identify regulatory streams for ARC Year 2, and
- announce a second round of ARC grant funding to support national regulatory improvement projects for nursing and midwifery.
A writer’s workshop was held the day preceding the Congress (19 June) facilitated by Ms Sophie Gardner and Dr Christina Mudokwenyu-Rawdon from the African Journal of Midwifery and Women’s Health (AJM), supported by Dr Grace Omoni. The purpose of the writer’s workshop was to give guidance and support to countries who received ARC Year 1 grants in order for them to prepare a case study of their project for publication in a future edition of the AJM. The countries who attended the writer’s workshop were Lesotho, Malawi, Seychelles and Swaziland. A full report of the writer’s workshop is included in Attachment 6.

3. OFFICIAL WELCOME AND GREETINGS

Dr Maureen Kelley, ARC Principal Investigator, Emory University introduced the official guests: Dr Anban Pillay, Deputy Director General Department of Health; Mr Alphonce Kalula, Senior Programme Officer, ECSA-HC; Ms Mary Fanning, PEPFAR Liaison Officer South Africa; and Dr Magna Aidoo, Health of Health, Commonwealth Secretariat, who welcomed participants and extended greetings from their different organisations.

(from left to right) Dr Anban Pillay; Mr Alphonce Kalula; Ms Mary Fanning; Dr Magna Aidoo

Dr Pillay gave a brief outline of health issues for South Africa. He shared with participants that South Africa had a high burden of communicable disease such as HIV, AIDS and TB and with little improvement in the mortality and morbidity rates for maternal and child health. The increasing rates of NCDs constituted a double burden for the health system which was already burdened with high rates of trauma, particularly related to road accidents. Dr Pillay explained that, similar to many other health systems, there was a disproportionate focus on acute care. South Africa was introducing school health programmes to provide screening and facilitate early intervention. They were also introducing public health initiatives and a community health worker programme. One of the emerging issues for South Africa was the difference between the well off and the not so well-off and the development of a parallel private health sector which was attracting resources from the public sector. Dr Pillay gave, as an example, that the private sector provides care to 16% of the population but attracts 40% of the nursing staff. This negatively affects the public sector where people who were less well-off seek care. Another concern which Dr Pillay raised was that there had been only a 3% growth in the nursing workforce despite active recruitment campaigns. He informed participants that the South African Government was considering lowering the entry level to nursing, especially to attract people from rural areas, and having several entry points so that people could start at a lower level and move upward to tertiary level education. Dr Pillay emphasised that the South African Government saw nursing as a catalyst to change in the health system.

Mr Alphonce Kalula brought greetings from the Director General of ECSA-HC, Dr Josephine Kibaru-Mbæ and welcomed participants to the meeting. Mr Kalula gave an overview of the objectives of ECSA-HC, the countries which were part of the region and the burden of disease across the region. One of the major issues for the region is the inadequate resources to address the disease burden. Mr Kalula emphasised the commitment of ECSA-HC to the ARC initiative and concluded by inviting participants to attend the 10th ECSACON Scientific Conference to be held 2-8 September 2012 in Mauritius.

Ms Mary Fanning welcomed participants to South Africa on behalf of CDC South Africa and acknowledged that nurses and midwives are in the front line of health care. She emphasised the difficulties of recruiting health workers to rural areas and the lack of engagement and opportunities for professional development. Ms Fanning emphasised the importance of the ARC initiative in strengthening nursing and midwifery standards and regulation and considered it a wonderful opportunity for the countries involved in the initiative to share and grow together.
Dr Magna Aidoo, Health of Health, Commonwealth Secretariat brought greetings from the Commonwealth Secretary General, His Excellency Mr Kamalesh Sharma, and said that the Commonwealth Secretariat is pleased to be a partner in the ARC initiative. Dr Aidoo expressed gratitude to the Government of South Africa through the Department of Health for hosting the ARC meeting and recognised the countries present at the Congress. Dr Aidoo said that, although this was her first attendance at an ARC event, she had heard a lot about the work that is being done and the outcomes that have been achieved so far. Dr Aidoo explained that the mandate for the work of the Health Section of the Commonwealth Secretariat comes from the Commonwealth Health Ministers and Heads of Government. The Commonwealth includes one third of the world’s population; 54% of the global burden of disease; 60% of the burden of HIV and AIDS; and 60% of maternal and infant mortality; but only 15% of doctors and 18% of nurses.

Dr Aidoo said that no health system can deliver health care efficiently and of a high quality without nurses. She expressed her appreciation to participants for their attendance and said she was encouraged by the achievements of the countries who had received ARC Year 1 grants. Dr Aidoo concluded by emphasising the benefits of working collaboratively to strengthen nursing regulatory leadership in the region.

Ms Alexandra Zuber then invited participants to introduce themselves to each other and welcomed special guests: Ms Carolyn Hall from PEPFAR; Ms Letitia Robinson from CDC South Africa; Mr Malik Jack from USAID South Africa; and Ms Bernadette Robyn Calder from the ELMA Foundation. Ms Zuber encouraged participants to take the opportunity to network with the special guests during refreshment breaks.

4. KEYNOTE ADDRESS: Death of a disease in the 21st Century: engaging the critical link
Ms Patricia Riley Division of Global HIV and AIDS Center for Disease Control and Prevention

Ms Riley’s explained to participants that the title of her keynote address: ‘Death of a Disease in the 21st Century: Engaging the Critical Link’, was partially borrowed from Dr DA Henderson’s personal story of how he led the World Health Organisation’s campaign to eradicate smallpox – the only disease in history to have been deliberately eliminated. Ms Riley said that the global health efforts that coalesced in eradicating smallpox provide relevant parallels to global HIV and AIDS targets. Ms Riley told participants that nurses and midwives provide the ‘critical link’ in realizing this century’s global health challenge – achieving an ‘AIDS-free generation’.

Ms Riley said that the smallpox eradication efforts demonstrate what can be accomplished when governments, organisations, and thousands of health care workers focus on a single objective. Similarly, resources from global initiatives like PEPFAR and the Global Fund can make comparable advancements in achieving an AIDS-free generation, which was very relevant to ARC and its goal of developing nursing and midwifery leadership in the east, central and southern Africa region.

Ms Riley went on to say that thirty years ago, due to the nature of smallpox manifestation and disease containment, the focus was on surveillance, epidemiology, and use of the public health workforce to forestall spread of a dread disease in the community. In contrast, with today’s AIDS-free generation goals, the emphasis has reverted to health services and the successful delivery of key interventions: ART, PMTCT, and VMMC for which nurses and midwives are seen as playing a pivotal role.

Ms Riley explained that while advances had been made during the first five years of the PEPFAR initiative, the role of workforce – especially that of nurses and midwives - was overlooked along with many missed opportunities for strategic involvement. In 2008, with the second USA Congressional reauthorization of the PEPFAR initiative, the role of nurses, midwives, and physicians was emphasized and today PEPFAR provides a platform for initiatives that support professional leadership and regulatory reform - like ARC. The call for an AIDS-free generation provides an opportunity for the nursing and midwifery professions to assume an influential role at the table and help shape solutions to service delivery challenges that have confronted the profession for years.
The title of Ms Riley’s address: ‘Death of a Disease in the 21st Century: Engaging the Critical Link’, she explained was designed to emphasise the role and opportunity for nursing and midwifery involvement in addressing this century’s most vexing global health challenge. In order to realize the goals of an AIDS-free generation, Ms Riley said we must do our best to ensure quality at all levels – quality in how we train our professionals; quality in maintaining our knowledge and skills throughout our career; and quality in providing service - regardless of where we work in the health delivery system.

Ms Riley concluded by reminding participants that there are global health heroes and heroines for every generation. In this century, she said, there is yet another opportunity for a new cadre and new leaders to make a difference, to discover advances, improve approaches and techniques for stemming an epidemic that has held a grip on this sub-continent for way too long. This niche needs to be filled with African’s nurses and midwives – now more than ever for a healthy world.

In closing, Ms Riley shared a recent quote from Dr Marla Salmon, who was named the 2012-2013 Institute of Medicine Nurse Scholar in Residence: These are times in which there is great opportunity - times of significant professional and scientific breakthrough. And yet, there are also major challenges that face nurses and midwives as they work to enhance the health of the people they serve. Ms Riley said she thinks nurses and midwives are ready to step centre-stage and together define their contribution for the 21st century global health community, and most of all, for the people they serve. (A full transcript of Ms Riley’s address can be found in Appendix 1.)

5.  **SESSION 1**

**Country team project progress**

Swaziland, Malawi, Lesotho, Seychelles, Mauritius

Ms Jessica Gross introduced the session by providing participants with a brief overview of the ARC initiative. Ms Gross emphasised that the unique strength of ARC was in supporting country led initiatives that resulted in strengthened collaboration in-country between nursing leaders. The regulatory improvement grants allowed countries to focus on short-term achievable regulatory improvements and to gain skills and experience in project management. The design of ARC with an annual Congress, learning sessions and action periods, combined with targeted technical assistance and south-to-south collaboration contributed to the successful completion of country projects.

**SWAZILAND**

The Swaziland country team consists of: Ms Gladys Thembisile Khumalo (Chief Nursing Officer); Dr Ruth Nkosazana Mkhonta (Head of Department, General Nursing, University of Swaziland); Ms Glory Msibi (Registrar, Swaziland Nursing Council); and Mr Bheki Mamba (President, Swaziland Nursing Association). The purpose of the Swaziland project was to establish and sustain a national CPD model based on a needs assessment of practising nurses in Swaziland and other relevant stakeholders. The Swaziland report was presented by Dr Ruth Mkhonta.
The Swaziland team was pleased to report they had met all their project objectives. They had conducted a needs assessment to identify the actual and potential continuing professional development (CPD) needs of nurses; they had developed a national continuing professional development framework which included a monitoring and evaluation plan; they had developed CPD modules based on needs identified from the needs assessment; and, working with partner organisations such as the university, training of nurses had commenced.

Additionally they had developed and distributed information, education and communication material to market the national CPD programme and had designed and developed a CPD logbook. The biggest challenge for the Swaziland team had been the short time frame for the project. The lessons they had learned were the need for commitment and dedication; the need to make use of available resources; the need to involve stakeholders in every phase of the project so they had ownership of the CPD programme; the need to have political support from the beginning of the project; and the need to stay united as a team.

The next steps for the Swaziland team are to print the CPD logbook for all nurses; formalise and launch the CPD programme; focus on publishing the regulations covering the new CPD requirements in the Government gazette; update the Swaziland Nursing Council database; and mobilise resources to ensure the ongoing sustainability of the programme over time. The Swaziland team expressed their thanks and appreciation to the ARC faculty for their continuous support in the development of the CPD programme and to their ‘south’ colleagues who critiqued their work and gave constructive input and encouragement.

MALAWI

The Malawi country team consists of: Mrs Martha Mondiwa (Registrar, Nurses and Midwives Council of Malawi); Mr Jonathan Abraham Gama (President, National Organisation of Nurses in Malawi); Mrs Chrissie Chilomo (Country coordinator and Nursing Officer, Nurses and Midwives Council); and Mrs Sheilla Bandazi (Director of Nursing Services, Ministry of Health). The purpose of the Malawi proposal was to evaluate their existing CPD programme; revisit the implementation strategy to ensure that all nurses and midwives understood the value of CPD; and intensify monitoring and evaluation of CPD across the country in collaboration with all stakeholders. The Malawi report was presented by Mrs Chrissie Chilomo.

The Malawi team reported that their national CPD programme was launched in 2010. CPD facilitators had been appointed and trained and nurses and midwives started to undertake CPD activities from July 2010. After almost a year, a monitoring and evaluation exercise demonstrated that nurses and midwives did not fully understand the concept of CPD; there was a knowledge gap for some CPD facilitators; there was inadequate support from nurse managers and other nurse leaders; and a lack of collaboration from stakeholders.

The specific objectives of the Malawi project were to increase the number of CPD facilitators; intensify CPD sensitisation among nurses and midwives; strengthen the monitoring and evaluation of CPD activities; and strengthen the collaboration on CPD implementation among the Malawi team.
In meeting their objectives, the Malawi team had reviewed their CPD guidelines; held orientation meetings and training for CPD facilitators; held advocacy meetings with nurse leaders; identified institutions to offer CPD activities; and conducted monitoring and evaluation. The monitoring and evaluation findings demonstrated that 95% of health facilities had trained CPD facilitators and established a CPD committee; 99% of facilities visited received management support; 75% of nurses had achieved the required number of CPD points; and facilities had noted a positive impact of CPD including improved care, improved patient care documentation, and improved attention to duties. A number of challenges were also identified. There were inadequate resources both financial and human; political decisions had led to economic challenges; there was lack of standardisation of training modules; accreditation of CPD training sites had not been accomplished; and the proposed CPD inventory had not been disseminated. Additionally, the development and dissemination of information, education and communication material was costly; newly trained CPD facilitators still exhibited a knowledge gap in relation to the implementation of CPD; and some nurses still had a negative attitude toward CPD.

The most important lesson learned by the Malawi team was the value of leveraging resources from other funding sources. They also acknowledged that, as a result of the ARC project, there was strengthened collaboration between nursing leaders in Malawi. In the future the team planned to continue the process of reviewing their CPD guidelines; continue conducting training for CPD facilitators; develop CPD training manuals; and continue supportive supervision of CPD activities and implementation.

**LESOTHO**

The Lesotho country team consists of: Mrs Flavia Moetsana-Poka (Registrar, Lesotho Nursing Council); Mrs Tjoetso Veronica Lehana (representing Lesotho nurse training institutions); Mrs Nthabiseng 'Makholu Lebaka (Chief Nursing Officer); and Mr Maraka Monaphathi (President, Lesotho Nurses Association). The Lesotho proposal was to develop a national continuing professional development (CPD) programme for nurses and midwives in Lesotho.

The Lesotho report was presented by Ms Flavia Moetsana-Poka. The objectives for the Lesotho team were to introduce the concept of CPD to relevant stakeholders; develop and implement the CPD programme; and monitor and evaluate the programme. The Lesotho team held sensitisation forums for nurses, midwives, nursing assistants and other relevant stakeholders; developed, printed and distributed the CPD framework and logbook; conducted training sessions for nurses in charge of all health facilities in the usage of the CPD logbook; conducted a pilot study to assess logbook usage; and reviewed the implementation of the CPD programme. The national CPD programme was launched on 21 May 2012. The Lesotho team experienced a number of challenges. CPD was a new concept to many nurses. Information did not reach all the targeted users. There was a limited time frame to complete the project and there were competing agendas within the country beyond the control of the Lesotho team. Ensuring that nursing assistants were included in the national CPD programme was an additional challenge as was a change in members of the Lesotho team. The Lesotho team felt that their achievements had exceeded their expectations. They appreciated networking with other countries working on developing a national CPD programme and thought that the tools, support and guidance from the ARC faculty was critical to the success of their project.
The Lesotho team found there was an overall improvement in the re-licensure process; general buy-in from all stakeholders; and felt that the model developed by the nurses would be able to be replicated by other health professions in Lesotho. Of particular importance was that the ARC project had strengthened collaboration between the nursing leadership within Lesotho. The next steps for the Lesotho team are to provide orientation for charge nurses on CPD monitoring and evaluation; conduct supervisory visits; and pre-test, refine, administer and analyse a monitoring and evaluation tool.

SEYCHELLES

The Seychelles country team consists of: Ms Winifred Agricole (Registrar, Seychelles Nursing and Midwifery Council); Ms Elsia Sinon (President, Seychelles Nursing Association); Ms Jeanne D’Arc Suzette (representative of a nursing educational institution); and Ms Marie-Antoinette Hoarau (Chief Nursing Officer). The Seychelles proposal was to review the Seychelles Nurses and Midwives Act 1985 to establish a full-time registrar for nursing and midwifery. The Seychelles report was presented by Ms Winifred Agricole.

The objectives for the Seychelles team was to gain support from stakeholders for a review of the legislation; review the existing Nurses and Midwives Act 1985; define the roles and responsibilities of the Registrar; propose necessary amendments to the Act; obtain additional funding for the project; obtain the necessary technical assistance with the review of the Act and drafting of the amendments; submit the new Bill to the National Assembly for approval; and ultimately produce a new Nurses and Midwives Act. The Seychelles team were successful in developing close collaboration with relevant stakeholders and with obtaining support and financial assistance from the Ministry of Finance to supplement the ARC grant. The technical assistance provided by WHO enabled them to produce the necessary amendments to the Nurses and Midwives Act. In addition to consolidating the collaboration between the nursing leadership in Seychelles, the project increased the visibility of the Seychelles Nursing Council among nurses and midwives and other stakeholders.

MAURITIUS

The Mauritius team which attended the ARC Summative Congress were: Mr Hurryram Shewraj (Chief Nursing Officer); Mrs Bilgis Dinally (Vice President of the Mauritius Nurses Union); Mrs Saraswatee Krishnama (Chairperson of the Education Committee of the Nursing Council of Mauritius); and Mrs Manorama Bhutto (Senior Nurse Educator). The purpose of the proposal from Mauritius was to insert into legislation and regulation standardised qualifications for nurse and midwife educators covering both the public and private sector. The Mauritius report was presented by Mr Hurryram Shewraj.
Mrs Saraswatee Kristnama; Mr Hurryram Shewraj; Mrs Bilgis Dinally; Mrs Manorama Bhuttoo

The Mauritius team considered that upgrading and standardising the qualifications of nurse educators in both the public and private sector so they met global standards would not only attract more nurses toward a career in nursing education but would prepare the way for upgrading the existing certificate programme for nurses to a Diploma in Nursing.

The Mauritius team noted that engagement with all stakeholders was critical to the success of their project although it was not always easy to bring all stakeholders together and required careful lobbying and planning. The proposed change to the legislation has been agreed and is now waiting for the necessary Government process for enactment. The project revealed further changes that needed to be made to the Nursing Council Act to bring it in line with global standards and contemporary practice. Challenges faced by the Mauritius team included the short time frame for the project and limitations for the Nursing Council in autonomous decision making. Changes of personnel at political, bureaucratic, and professional levels also impacted on the progress of the project.

In the immediate future, the Mauritius team is looking forward to enactment of the legislative change and planning for a complete review of the Nursing Council Act so that it is more reflective of current practice.

6. **SESSION 2**

**ARC evaluation framework**

Dr Carey McCarthy

Dr McCarthy’s presentation focused on evaluating the impact of ARC and the development of the *Regulatory Function Framework*. Dr McCarthy explained that it was important to evaluate the ARC initiative in order to raise awareness of the importance of support for regulatory improvements and to generate evidence around the benefits of investing in regulation to justify continuing support. Dr McCarthy had identified five incremental stages in regulatory improvement: planning, developing, defining, managing, and optimising.

Dr McCarthy had also identified seven key regulatory functions: registration, licensure, continuing professional development, accreditation, scopes of practice, professional conduct and discipline, and revising legislation. She emphasised that regulatory improvement is incremental and likened progress to that of an infant who learns to sit, stand, crawl and walk before being able to learn higher level skills. Dr McCarthy provided country teams with a copy of the *Regulatory Function Framework* and asked country teams to determine for each regulatory function their stage of development. Clarifying the current stage of regulatory development would enable countries to demonstrate current progress and plan for the future.
7. **SESSION 3**  
*CPD resources panel*  
Ms Jill Iliffe, Ms Rose Wasili, Mr Evasen Naidoo

Ms Jill Iliffe shared with participants the development of the ARC CPD Toolkit which is a step by step guide on how to develop a national CPD framework. The toolkit chapter headings include: definitions, rationale, principles, requirement, scope, documentation, accreditation, monitoring compliance and evaluation. Each chapter begins with introductory discussion about the topic before giving specific examples from other national CPD frameworks. The toolkit also includes discussion about credit hours or credit points and gives examples of how other countries have weighted CPD. There is also a section on needs assessment and a section on implementation. The toolkit is still in draft form which provides countries which have recently developed national CPD programmes or countries who are planning to do so, with the opportunity of having input into the final document to ensure that it meets their needs. It is anticipated that the final document will be published online by the end of 2012.

Ms Rose Wasili from I-TECH Malawi and Mr Evasen Naidoo from I-TECH South Africa shared with participants an online information technology programme for tracking CPD and other nursing regulatory functions. The I-TECH tracking programme is called ‘TrainSMART’ which is an open source, web-based training data collection system accessible to anyone with internet connectivity. ‘TrainSMART’ can be used to track key regulatory activities, eg: registration, licensure, accreditation, credentialing and is being used currently to track inservice and CPD training in multiple settings. ‘TrainSMART’ is currently available in English, French, Ukrainian and Russian.

The programme provides real-time data access to interested parties, eg: Ministries of Health, Nursing Councils, training institutions, etc. The programme will assist country teams to report data to various funders and partners. ‘TrainSMART’ is an ideal programme to track CPD activity, identify nurses who do or who do not meet CPD requirements, and collect data on regulatory body certified facilitators, institutions and programmes.

The only costs associated with the implementation of ‘TrainSMART’ are I-TECH customization of the client website to meet their specific data needs and an annual cost to I-TECH for hosting the website. The open source software is free. Tracking regulatory functions is an important activity for nursing regulatory bodies which is why TrainSMART was developed.

Enquiries about TrainSMART should be directed to the I-TECH head office in America to Mr Robert McLaughlin email: robmcl@uw.edu or Ms Sheena Jacob email: jacob2@uw.edu.

8. **SESSION 4**  
*Professional affiliations: break-out session*  

Participants separated into four groups: Chief Nursing Officers or their representative; Nursing Council Registrars or their representative; Presidents of National Nursing Associations or their representative; and representatives from the nursing education sector from each country. The groups were asked to work together to answer the following questions:
1. What are the current challenges?
2. What are the specific challenges in relation to regulation?
3. What obstacles are likely to be faced to address the challenges?
4. What task-shifting has taken place? What have been the successes and what have been the challenges?
5. What are the priority areas of action to address the challenges for nursing and midwifery?

The report from the Chief Nursing Officer group was given by Ms Janet Michael from South Sudan who reported as follows:

**The most pressing challenges facing nursing and midwifery across the countries were:**
- Inadequate financial resources to education nurses in the nursing process,
- The chronic shortage of nurses and midwives exacerbated by the attitudes of nurses and midwives; the uneven distribution of nurses and midwives across each country and being able to deploy nurses in hard to reach areas; internal migration of nurses and midwives from the public sector to the private sector; and the sometimes poor quality of nursing education.
- Poor quality of care due to the shortage of trainers, lecturers and tutors; the professional qualifications of nurse educators and nurses in leadership roles being less than what is desirable; and the poor documentation of patient care.
- Poor working conditions.

**The most pressing challenges in nursing and midwifery regulation across the countries were:**
- Inadequate regulatory provisions particularly relating to renewal of practising license and inadequate regulatory tools.
- Delay in enactment of regulations leading to nurses and midwives practising outside of their scope and political interference in regulatory processes.
- No CPD framework and difficulty implementing CPD requirements combined with a lack of professional self-regulation.

**The obstacles in addressing regulatory challenges across the countries were perceived as:**
- political interference; resource shortages (financial, human, material) with little resource support from management; the migration of nurses; lack of recognition of experience; and poor planning.

**In relation to task-shifting, the group identified successful task-shifting in relation to:** nurse initiated ARV and ART; male circumcision by nurses; and nurse empowerment. The group noted however that task-shifting is not universally accepted or embraced; it often results in a heavy increase in workloads for individuals; there is inadequate remuneration for nurses taking on additional tasks; and it is difficult to retain nurses when their tasks are increased without recognition or remuneration.

**The priority areas of action were:**
- Staffing and education norms and standards,
- Development of nursing strategy and planning,
- Provision of adequate resources,
- Improvement of working conditions,
- Revisiting professional and work ethics,
- Entrenchment of patient rights and responsibilities,
- Strengthening the role of regulatory bodies,
- Providing capacity development for leadership roles within regulatory bodies,
- Inspiring a passion for nursing practice,
- Revisiting the recruitment and selection of nursing students,
- Rebuilding and revitalising nursing education and training.
The most pressing challenges facing nursing and midwifery across the countries were:

- Human resource shortages combined with the quality of nursing education; nursing school intake issues; and remuneration generally across the profession.
- The political and economic environment which resulted in insufficient financial support.
- The nursing practice environment which was not conducive to quality or safety especially in relation to the physical infrastructure, supplies, isolated postings, and nurses practising outside their scope particularly in more isolated areas.
- Difficulty in providing supportive supervision throughout the country.

The most pressing challenges in nursing and midwifery regulation across the countries were:

- Professional misconduct and complicated and expensive disciplinary procedures,
- Licensure examinations and competing authorities,
- Lack of capacity for the regulatory body to adequately address public complaints about nurses,
- Poor professional image of nursing,
- Inadequate Government support at Ministry level,
- Amending legislation which is both lengthy and tedious,
- Implementation of CPD,
- Conflicting stakeholder views,
- Pressure of establishing umbrella regulatory bodies,

The obstacles in addressing regulatory challenges across the countries were perceived as:

- Political pressure and intervention; lack of appreciation of the contribution of the regulatory body so inadequate support; conflicting authorities (regulatory body, qualifications authority, education authority);
- Negative attitudes of nurses toward regulatory authority and consequently resistance to change; and lack of mechanisms for exposure to best practice.

In relation to task-shifting, the group identified successful task-shifting in relation to: male circumcision, mental health, anaesthesia, and rapid testing. The challenges were adequate remuneration to recognise the increasing scope of practice; impact on care; insufficient preparation of nurses assuming additional tasks; displacement of other nursing tasks; and resistance among employers to implementing a task-shifting framework. Zimbabwe noted that they use the term ‘task-sharing’ rather than ‘task-shifting’ which has helped to engender a more positive attitude.

The priority areas of action were:

- Developing and reviewing standards, guidelines and protocols,
- Maintaining professional integrity and identity,
- Self-regulation for nursing and midwifery in evolving regulatory structures,
- Sensitisation of stakeholders to support regulatory initiatives eg: CPD.
The most pressing challenges facing nursing and midwifery across the countries were:

- General challenges in nursing education: such as recruitment and retention of students and nurses; and recruitment of suitable students;
- Clinical placement challenges: number of students; providing guidance, mentorship and preceptorship; challenges in providing skills laboratories (equipment) and equipment for simulation;
- Human resource challenges: such as low morale; burnout; unsafe practices; poor conditions of service; nursing workforce shortages; poor nurse attitudes; inappropriate deployment; and poor role models.

The most pressing challenges in nursing and midwifery regulation across the countries were:

- Aligning nursing education programmes with National Qualifications Authority standards and Nursing Council acts and regulations.
- Lack of autonomy for Nursing Councils with deferment of disciplinary procedures and powerless regulatory authorities.
- Little support for the development of a CPD framework and implementation and poor attitudes of individual nurses toward CPD.

The obstacles in addressing regulatory challenges across the countries were perceived as: lack of assistance, mentorship and technical expertise; insufficient financial resources; poor collaboration and communication from Ministries of Health and regulatory bodies; basic education systems do not meet higher education requirements; political interference; and merging regulatory bodies (health professional bodies rather than an individual nursing and midwifery council).

In relation to task-shifting, the group identified successful task-shifting in relation to: ART and PMTCT however noted there is opposition to task-sharing from medical practitioners; that the education sector and medical council are still hesitant despite the need in the rural sector; nurses seldom have the appropriate authority to prescribe; additional tasks for nurses and midwives requires training which takes them away from the workplace; additional tasks increase the workloads of nurses and midwives and there is no clarity regarding legal issues and indemnity.

The priority areas of action were:

- Developing strategic plans to cover identified challenges,
- Standardising regulation relating to education,
- Improving clinical teaching and learning especially addressing facilities, human resource issues, supplies,
- Developing CPD frameworks and implementation strategies.

The report from the National Nursing Associations and Unions group was given by Ms Thembeka Gwagwa from South Africa who reported as follows:

The most pressing challenges facing nursing and midwifery across the countries were:

- Loss of control of the profession caused by lack of unity among the different stakeholders within the profession.
- Political interference in nursing issues with politicians deciding for the profession (eg: merging of regulatory bodies; and who to recruit for training as a nurse).
- Lack of capacity of nursing regulatory to monitor nurse training schools.
- Negative image of nurses.
- Separating nursing and midwifery as two separate professions (loss of unity and cohesion).
- Retention of nurses in the clinical setting.
- Workplace violence.
The most pressing challenges in nursing and midwifery regulation across the countries were:
* Emerging private nursing colleges and the privatisation of nursing education with challenges in monitoring the process and the end product.
* Lack of standardisation of nursing curricula and cross recognition of training across countries in the region.

The obstacles in addressing regulatory challenges across the countries were perceived as: lack of unity; lack of resources; and lack of capacity to reach out for assistance.

In relation to task-shifting, the group identified successful task-shifting in relation to: nurse prescribing which increases access to services for consumers however they also noted that task-shifting is done haphazardly and nurses are not given appropriate training, supervision or guidelines for the new tasks and when guidelines are provided, they are frequently not followed because of lack of resources. There are no regulations and therefore no protection, and there is inadequate remuneration for the added responsibilities.

The priority areas of action were:
* Improve remuneration and conditions of service to retain nurses in clinical settings.
* Deal with contributory causes of poor image of nurses eg: increase numbers, educate the public on the role of nurses.
* Strengthen unit among the nursing leadership. The ARC 'Quad' should not only exist when funding is available; regular meetings of the nursing leadership will bring the profession back into our hands.

9. **SESSION 5**

**Country regulatory improvement proposals and announcement of Year 2 grant recipients**

Ten countries submitted proposals for ARC Year 2 grant funding: Botswana, Kenya, Lesotho, Mauritius, Mozambique, Rwanda, Swaziland, Tanzania, Uganda and Zimbabwe. The proposals are outlined below.

**BOTSWANA**

The Botswana country team proposal was presented by the Nursing Registrar, Ms Khumo Modisaeman. The aim of the Botswana proposal was to develop a framework for continuing professional development (CPD) and a CPD implementation plan. A national CPD programme would empower nurses and midwives in Botswana to acquire knowledge that is current and evidence based, and promote the provision of quality health care to individuals, families and communities in Botswana. A national CPD programme would also promote the professional development of nurses and midwives and inform policy decisions taking into account changes in practice and service needs.
The Kenya country team proposal was presented by Mr Fredrick Ochieno Oduori, Deputy Registrar, Nursing Council of Kenya. The aim of the Kenya proposal was to devolve some of the services and activities of the Nursing Council of Kenya to specified zones in order to make regulatory services more accessible to nurses. The proposal is in line with the Nursing Council of Kenya Strategic Plan 2012-2016 which reflects the decentralisation approach of the Constitution of Kenya 2010. The proposal is to set up four zonal offices by 2013 and eight zonal offices by 2016. The proposal includes developing criteria for selection of the services to be devolved; developing selection criteria for zonal agents; designing an orientation and induction programme for zonal agents; identifying the infrastructure requirements for the zonal offices; implementing the devolved services; and monitoring and evaluating the implementation process and outcomes.

The Lesotho country team proposal was presented by the President of the National Nursing Association, Mr Maraka Monaphathi. The aim of the Lesotho proposal was to develop an implementation strategy for the CPD framework they had developed as a result of an ARC Year 1 grant.

An analysis of the uptake of CPD had demonstrated a lack of understanding of the CPD framework by nurses, educators, and managers. A need to further train and disseminate an understanding of CPD, the features of the national CPD framework, and the importance of participation to all areas of the country was identified.
MAURITIUS

The Mauritius country team proposal was presented by Mrs Manorama Bhutto, Senior Nurse Educator. The aim of the Mauritius proposal was to define and include in the Nursing Council Act 2003 the scope of practice for nurses and midwives to guide and enforce nursing practice within set parameters and to provide a basis for the development of practice standards and competencies. A scope of practice would also provide clarification of the role, functions, extent and limitations of nurses and midwives and serve as a reference to review and expand the parameters of practice as the need arose.

MOZAMBIQUE

The Mozambique country proposal was presented by Ms Maria Matavel from the National Association of Nurses in Mozambique. The aim of the proposal was to make sure that the standard of education of nurses in Mozambique is consistent with the standards of training for other Southern Africa Development Community (SADC) countries and to compare practice standards with those of neighbouring countries and with those proposed by the International Council of Nurses.

RWANDA

The Rwanda country proposal was to establish a reliable registration verification system in order to identify and register all qualified nurses and midwives in Rwanda and to issue registration numbers, certificates, and practising licenses to eligible registration applicants. Rwanda as a young country recovering from war and genocide has to establish the necessary infrastructure for professional practice. Currently in Rwanda the Council is striving to deal with more than 11,000 registration applications and to develop an effective professional register.
SWAZILAND

The Swaziland country proposal built on their Year 1 ARC grant by implementing the national CPD programme developed in ARC Year 1, providing log books to all nurses, sensitising all stakeholders to the importance of CPD, marketing the programme, updating their data base, keeping an inventory of accredited CPD providers, and monitoring and evaluating their CPD programme. The outcome was designed to assist the regulatory body to comply with regional and international requirements for CPD as one of the essential pillars of regulation resulting in nurses who are knowledgeable, competent and confident in providing quality evidence based nursing services, assuring the public of safe care.

TANZANIA

The Tanzania country proposal was presented by the Registrar of the Tanzania Nursing Council, Mr Gustav Moyo. The proposal was to conduct a needs assessment in relation to continuing professional development to determine the demand for CPD and the barriers to undertaking CPD; develop a national framework for nurses and midwives to meet the legislative requirements for CPD; and develop an implementation plan so that nurses and midwives met the CPD requirements for re-licensure.

UGANDA
The Uganda country proposal was presented by Ms Janet Obuni, President of the Uganda Nurses and Midwives Union. The aim of the Uganda proposal was to develop a ‘scope of practice’ for nurses and midwives in Uganda. Uganda does not currently have a formal scope of practice and consequently, nurses and midwives are currently practising beyond their level and educational preparation and competence which makes it difficult for the Uganda Nurses and Midwives Council to fulfil their regulatory responsibilities. The role of nurses and midwives has changed over time and continues to evolve with the complexity of health care and emerging new diseases and care practices. Without a ‘scope of practice’ nurses and midwives in Uganda cannot develop new roles and skills to meet the changing demands of health care. A ‘scope of practice’ is an essential tool in guiding the delivery of quality nursing and midwifery services. Without a ‘scope of practice’ the global trend the ‘task shift’ is a threat to nursing and midwifery practice in Uganda instead of an opportunity to develop new roles. The Uganda proposal is the first phase of a three year project to develop scopes of practice for all cadres of nurses and midwives in Uganda.

ZIMBABWE

The Zimbabwe country proposal was presented by Ms Muriel Mothobi, Registrar of the Zimbabwe Nursing Council. The aim of the proposal was to orient nurses, midwives, managers and other stakeholders across the country and in all districts of Zimbabwe through specific education and communication strategies to the Nursing Council requirement for CPD. The Zimbabwe Nursing Council planned to develop a CPD log book for distribution to all nurses and midwives and subsequently monitor and evaluate the compliance of nurses and midwives in meeting the CPD requirements for re-registration.

At the end of the country presentations, Dr Maureen Kelley announced the successful grant recipients for 2013: Botswana, Kenya, Swaziland, Tanzania, Uganda, and Zimbabwe.

10. SESSION 6

Project planning: break-out session

Participants separated into three groups. Group 1 was comprised of countries which had unsuccessfully submitted proposals for funding (Lesotho, Mauritius, Mozambique and Rwanda). Understandably, this group were experiencing significant disappointment and the facilitators, Ms Alexandra Zuber and Mr André Verani, spent time debriefing country teams and discussing with them other options to progress their proposals. Group 2 was facilitated by Ms Patricia Riley and Dr Carey McCarthy, and consisted of countries which had not submitted proposals (Ethiopia, Malawi, Namibia, Seychelles, South Africa, South Sudan, and Zambia). These countries discussed the regulatory proposals they wished to work on in the future and what the process might be. Group 3 was facilitated by Dr Maureen Kelley and Ms Jessica Gross and consisted of the countries which had been awarded grants (Botswana, Kenya, Swaziland, Tanzania, Uganda and Zimbabwe). The focus for these countries was on how to progress their projects within the required time frame; the reporting requirements of the grant; the technical assistance they might require from the ARC faculty; and the project management tools which might be able to assist them.
11. **SESSION 7**  
*Comparing and reviewing national legislation and regulation*  
Mr André Verani and Ms Genevieve Howse

Mr André Verani commenced his presentation by explaining to participants the advantages of comparing legislation and regulation. Comparing legislation and regulation and exploring similarities and differences provided points of reference to inform legal and regulatory reform and facilitate regional harmonisation and south-to-south sharing. Mr Verani shared with participants the ARC Legal and Regulatory Matrix which he had developed which compared and contrasted legislation and regulation on specific issues, such as continuing professional development; the issuing of practising licenses; and scopes of practice, from eight countries which had provided relevant legislation. Mr Verani demonstrated to participants from the regulatory matrix some of the regional similarities and differences and how countries could learn from each other.

Following the presentation, participants broke into mixed country groups and used the matrix to list the similarities and differences in scope of practice provisions in the legislation and regulation of the eight countries represented in the matrix. They then shared with each other the similarities and differences they had identified. Participants were provided with a copy of the matrix which Mr Verani explained was a work in progress. Participants were encouraged to contribute their own legislation to the matrix.
Ms Genevieve Howse’s presentation focused on the process of review and reform of legislation. Ms Howse suggested that before deciding on review or reform of legislation, the following questions need to be asked:

1. What is the policy issue which needs to be solved?
2. Is it really necessary to change the legislation?

The first step, she suggested was to carefully examine the current legislation to see whether there is any flexibility to address the issue apart from legislative reform. Sometimes a policy, code or guideline can be developed instead. Sometimes an administrative action can solve the problem. Sometimes regulations can be promulgated. Non-legislative options should always be considered as changing legislation is resource intensive, difficult, unpredictable and always takes longer than you think it will.

Before embarking on legislative change, the international legal and policy environment on the issue should first be explored as well as the domestic legal and policy environment. Is anything in the country’s constitution relevant. What other legislation might have an impact and need to be considered (eg: poisons legislation, public health legislation, public service legislation). Is there a national health strategy? Is there any relevant research or reports? Does a needs assessment need to be undertaken? What is public and stakeholder opinion likely to be? How supportive will they be? How supportive will the Government be? What are the budgetary implications? Are funds available for implementation?

Understanding the broader legal and treaty obligations, domestic legal environment, present policy objectives, and any current country specific issues giving impetus to a review gives credibility to any legislative proposal and will provide the basis on which a proposal to review may be based and justified.

Suggested steps in the process are:
1. Conduct a legal and policy analysis,
2. Identify issues for consideration in a review, indicating how they fit with Ministry of Health policy and how the current legislation fails to address them,
3. Prepare a timeline and indicative budget including once only and recurrent costs,
4. Obtain Ministry of Health support,
5. Develop terms of reference for a review,
6. Draft a discussion paper, obtain Ministry of Health approval, and seek submissions,
7. Consult widely,
8. Prepare a report based on consultations and initial legal and policy analysis, making policy recommendations,
9. Policy about how to address the identified issues is finalised and submitted to Ministry of Health for approval and acceptance,
10. Policy is translated into ‘drafting instructions’,
11. Drafting instructions are translated into draft legislation or ‘bill’,
12. Approval from other portfolios such as Attorney General, Treasury, Public Service Commission etc is obtained,
13. Consequential amendments to other legislation is undertaken,
14. Any regulations required are organised,
15. Minister needs to champion the bill at cabinet level,
16. Cabinet needs to approve and then send to Parliament.

Ms Howse concluded by saying that if there is no funding – don’t give up. Put together a proposal which justifies the need for legislative change. Seek funding from alternative sources, such as donors, and be ready to act if donors are interested.

Following Ms Howse’s presentation, participants discussed some of the regulatory issues of concern to them. Key amongst those were:
(a) the trend for governments to push for umbrella regulatory bodies rather than separate regulatory bodies for each profession. Participants shared their experiences and their concerns.
(b) the issue of the 3rd level worker (however titled: nursing assistant, health care assistant) and whether that worker is a nurse, doing nursing work, and should be covered by a nursing regulatory body.
Ms Howse suggested that, during negotiations about umbrella regulatory bodies, each country’s nursing leadership, particularly the regulatory body and their Council, need to determine what are the elements of nursing regulation they need to maintain control over, such as: autonomy in decision making, establishing standards of education and practice, accrediting nursing programmes, determining who is and who is not to be registered, determining penalties, etc so these positions can be argued for. What fees are set and what share of the fees belongs to nursing is another important issue. The ultimate objective is for the regulatory function to be self-sufficient of government and for nurses to have control over nursing.

The issue of the 3rd level worker is one which each country needs to make decisions about. One important aspect is whether the worker is doing nursing work and if so, then nursing needs to be involved in their education and regulation to make delegation safe. Another important issue is substitution of a less qualified worker for a more highly qualified worker. Developing clear scopes of practice for all health workers makes substitution less likely.

Ms Howse suggested that the nursing leadership in each country needs to be proactive; to identify issues of concern or likely to be of concern in the future and determine their position and how they want the issue to be managed before governments or other stakeholders come up with their own solutions.

12. SESSION 8

Global standards and resources

Mr Alphonce Kalula, Ms Jean Barry, Dr Frances Day-Stirk

The topic of Mr Alphonce Kalula’s presentation was: Improving nursing and midwifery in the ECSA region through the ECSACON Professional Regulatory Framework (PRF).

Mr Kalula explained that, in 1997, nursing and midwifery leaders identified and discussed issues and challenges facing the nursing and midwifery professions. The discussion culminated in the production of the PRF document in 2001, outlining standards of education and practice for nursing and midwifery in the region. The purpose of the PRF is to ensure the adequate and effective regulation of nursing and midwifery in the ECSA region.

The PRF has four regulatory elements:
1. Scope of practice for nursing and midwifery,
2. Standards of practice for nursing and midwifery,
3. Nursing and midwifery education standards, and
4. Core competencies and content.

The scope of practice defines who is a nurse or midwife; defines the parameters of practice for the entry level nurse and midwife; describes the full range of nursing and midwifery practice within legal and self-regulated boundaries; and focuses on the health care needs and demands of individuals, families, groups and communities to which the nurse or midwife must respond.

The standards of practice for nursing and midwifery explain what is meant by a standard and provides clear descriptions of the major roles of the nurse and midwife that are reasonably expected to be obtainable in the region. The standards are based on three key roles of nurses and midwives: the provider and collaborator role; the professional role; and the advocacy role.

The nursing and midwifery education standards describe the minimum requirements for educational programmes to adequately prepare graduates to respond appropriately to the health care needs and demands of individuals, families, groups and communities and provide direction in designing educational programmes and curricula implementation. The standards include structure, process, and outcomes.
The core competencies serve as a guide in the development of educational content relevant to nursing and midwifery and describe the essential competencies for entry level practice. They are broad and flexible.

Ms Jean Barry from the International Council of Nurses (ICN) opened her presentation with a discussion about the benefits of having global nursing and midwifery standards. Collaboration globally, she said, facilitates the sharing of regulatory best practices and results in greater congruence in national, regional and international regulatory systems. Global standards allows nursing to define more consistently and clearly what it can offer and promotes a more uniform development of the profession and an international identification for nurses and nursing. The standardisation of competencies and regulatory frameworks can help the public better understand the expectations of the profession.

Ms Barry explained that there were challenges in adopting global standards at a country level: education and regulation must be relevant to the local context and the health care needs of the population; they have to be agreed to and used at the country level to have value; and a standardised approach, acceptable to all or most could result in standards so broad that they are not useful; or a dilution of standards for the purpose of incorporating the widest possible range of countries. One possibility is to circumscribe an area of minimal standards in nursing education and regulation that can be further adapted locally. This approach would provide some degree of international convergence and a minimum standard to address patient safety, while respecting the need to address capacity and relevance in the local context. Some of the possible standards might include: protection of title; establishing criteria for entry to the register such as education and competence, good character and fitness to practice; and establishing criteria for staying on the register such as recent practice and continuing competence.

In relation to regulation, Ms Barry referred to resources available through the ICN, some of which can be freely downloaded; others can be purchased through the ICN website (http://www.icn.ch):

- Global Database of Regulators (free) http://www.icn.ch/pillarsprogrammes/global-database/
- Role and Identity of the Regulator (free) http://www.icn.ch/pillarsprogrammes/the-role-and-identity-of-the-regulator/
- Model Nursing Act (available for purchase CHF 40.00) http://www.icn.ch/vmchk/English/Model-Nursing-Act-Toolkit.html
- Regulation 2020 (available for purchase CHF 25.00) http://www.icn.ch/vmchk/English/Regulation-2020.html

*General Agreement in Trade and Services

The Global Database of Regulators is able to be searched by country or location on map; includes contact information on regulator contact point (eg: registrar) and website if available; contains summary information on the regulatory authority and basic information on the health system in the county.

In relation to education, Ms Barry emphasised the importance of having standards in place to ensure the quality of pre-entry nursing education and to support improving and maintaining standards of all nursing programmes. Quality nursing education results in graduates equipped with the knowledge and skill required for safe competent and appropriate practice for their country and communicates to nurses, policy makers, employers and the public that the profession has established standards for education and regularly reviews and enforces these standards to ensure that graduates have met certain specified and agreed criteria. Resources in relation to education standards which are available from the ICN include:

Standards for practice are also important, Ms Barry said. Standards identify the profession, employers and the public’s expectations for the performance of nurses. They define who is a nurse, specify scope and accountability, include or are supplemented by codes of conduct and ethics; and establish criteria for nursing regulatory bodies to assess safe (or unsafe) practice. ICN resources in relation to standards for nursing practice include:

* Scope of Nursing Practice Toolkit (available for purchase CHF 25.00)
  http://www.icn.ch/es/English/Scope-of-Nursing-Practice-Toolkit.html
* Nursing Care Continuum: Framework and competencies (available for purchase CHF 30.00)
* Toolkit on Complaints Management (available for purchase CHF 25.00)
  http://www.icn.ch/es/English/Toolkit-on-Complaints-Management.html
* ICN Code of Ethics for Nurses (free)
  http://www.icn.ch/about-icn/code-of-ethics-for-nurses/
* Describing the Nursing Profession: Dynamic language for advocacy (free)
* Advanced Practice Nurse Scope of Practice Standards and Competencies (available for purchase CHF 25.00)
  http://www.icn.ch/English/APN-Scope-of-Practice-Standards-and-Competencies.html
* Disaster Nursing Competencies (free)
* Framework of Competencies for the Nurse Specialist (available for purchase CHF 25.00)
  http://www.icn.ch/English/ICN-Framework-of-Competencies-for-the-Nurse-Specialist.html
* Implementing Nurse Prescribing (available for purchase CHF 20.00)
  http://www.icn.ch/vmchk/English/Implementing-Nurse-Prescribing.html
* International Nursing Continuing Education Credits (free)

In closing, Ms Barry mentioned other regulatory supports from the ICN such as online discussion forums and position statements (eg: Protection of Title, Continuing Competence, Scope of Nursing Practice) which are available on the ICN website: http://www.icn.ch. Ms Barry emphasised that the public’s health is most assured when strong nursing regulatory bodies and NNAs work as partners with educational institutions, practice settings, governments, and the public to ensure quality education and regulation. Nurses must be leaders and collaborators to influence positive change, to promote quality care, and to improve health for all.

Difficulties with connecting to the internet prevented Dr Frances Day-Stirk, President of the International Confederation of Midwives (ICM), from using Skype to deliver her presentation to delegates. Delegates were however provided with a copy of Dr Day-Stirk’s presentation which addressed midwifery global standards and resources. Dr Day-Stirk explained that the purpose of global midwifery standards is to set quality indicators based on global norms and provide a framework for the design, implementation, and evaluation of ongoing quality of midwifery programmes.

The requirements for high quality midwifery care are a combination of midwifery competencies, midwifery regulation, and midwifery education. The ICM Global Standards for Midwifery Education are one of the essential pillars of ICM’s efforts to strengthen midwifery worldwide by preparing fully qualified midwives. The standards represent the minimum expected for a quality midwifery programme with an emphasis on competency based education rather than academic degrees.
ICM’s founding principles for midwifery education are:

- Minimum entry level of students is completion of secondary education.
- Minimum length of a direct entry midwifery education programme is three years.
- Minimum length of a post nursing or other health care provider programme is eighteen months.

In relation to regulation, Dr Day-Stirk said the ICM regulation standards provide a benchmark for global standardisation of midwifery regulation; provide a basis for a review of existing regulatory frameworks; and provide guidance and direction to countries seeking to establish regulatory frameworks for midwifery where none currently exist. Dr Day-Stirk added that the ICM regulation standards are deliberately generic and take a principles approach to midwifery regulation. Dr Day-Stirk described a framework for effective midwifery regulation and said that the framework should include such elements as: a definition of a midwife; the scope of practice; midwifery education standards; and midwifery competencies for registration. Regulation should also include consideration of public safety, membership of a midwifery association, and autonomy for midwives.

**Figure 2: A framework for effective midwifery regulation**

Competencies for midwives, Dr Day-Stirk explained, describe what the midwife is expected to know; define the core content of any midwifery education programme and scope of practice; ensure standardisation in basic midwifery education and practice; and provide guidance for educators, clinicians and policy makers. The ICM competencies have seven domains:

1. Social, epidemiologic and cultural context of maternal-newborn care;
2. Pre-pregnancy care and family planning;
3. Care during pregnancy;
4. Care during labour and birth;
5. Care for women during postpartum period;
6. Postnatal care of the newborn; and
7. Facilitation of abortion-related care.

Dr Day-Stirk concluded by reminding participants that there are three pillars for a strong profession: education, regulation, and association. Education provides a highly qualified workforce with basic competencies to practice. Regulation provides practice standards, defines and protects the scope of practice, provides quality assurance, and protects the public. Membership of an association provides professional support, contributes to policy development, maintains relationships with other health care professionals, and advocates on behalf of the profession. All ICM resources can be accessed at: [http://www.internationalmidwives.org/core-documents](http://www.internationalmidwives.org/core-documents).
Dr Eleanor Msidi explained that two programmes were coordinated within the Global Nurse Capacity Building Coordinating Centre at Columbia University: the Global Nurse Capacity Building Programme (GNCBP) and the Nursing Education Partnership Initiative (NEPI). The goal of the GNCBP is to increase nurse capacity to provide HIV and primary care services. The goal of NEPI is to strengthen the quality and capacity of nursing and midwifery education institutions, increase the number of highly skilled nurses and midwives, and support innovative nursing and midwifery retention strategies in selected African countries. NEPI is a five year project currently being implemented in five African countries: Lesotho, Malawi, Zambia, Democratic Republic of the Congo, and Ethiopia.

The key principles on which NEPI is based are that it is:
- evidence based,
- innovative and transformative education interventions,
- cost effective scale-up interventions,
- involves collaboration and country ownership, and
- produces transferable and generalizable models for scaling up.

The key steps for NEPI are:
- building partnerships,
- establishing a collaborative agreement with the Ministry of Health or Memorandum of Understanding,
- establishing a core advisory group,
- building basic operational infrastructure,
- building consensus on country priorities, goals, and intervention sites,
- achieving agreement on interventions, work plans and budgets,
- providing technical and methodological assistance and training, and
- developing a monitoring and evaluation dissemination plan.

Dr Namate shared with participants the development by the Global Advisory Group on Nursing and Midwifery (GAGNM) of a Regional Professional Regulatory Framework (RPRF). The Global Advisory Group on Nursing and Midwifery is a multidisciplinary group of professionals who provide the Director General of the World Health Organisation (WHO) policy advice on strengthening nursing and midwifery within the context of WHO programmes and priorities. The GAGNM was established by WHO by a resolution of the World Health Assembly (WHA) in 1992 (Resolution WHA 45.5). A further WHA Resolution of 2011 (64.7) called on member states to work ‘within their regions and with the nursing and midwifery professions in the strengthening of national or sub-national legislation and regulatory processes that govern professions’.

The RPRF was developed recognising that:
- quality assurance in nursing and midwifery is of paramount importance,
- accreditation and licensing are key regulatory mechanisms that offer protection to the public,
- regional disparities exist on regulatory mechanisms,
- harmonisation of professional regulation at national, sub-regional, and regional levels offers huge benefits.
Dr Namate explained that there are 46 countries in the WHO AFRO Region: 21 Anglophone, 20 Francophone, and 5 Lusophone. Nursing regulatory bodies only exist in 41% of those countries. Seven per cent are in the process of developing nursing regulatory bodies, however in 52% of countries, there is no nursing regulatory bodies and hence, no nursing regulation.

The draft RPRF was developed over the period 2009-2012 in collaboration with international, regional, and national experts and other stakeholders. The purpose of the RPRF is:

* Promote the creation of a common approach to the educational preparation and practice of nurses and midwives in the Africa region;
* Address variations that exist in nursing and midwifery across the region;
* Position nursing and midwifery to respond effectively to challenges in the regulatory environment; and
* Provide a tool to strengthen country regulatory systems.

The RPRF includes:

* key definitions of regulatory terminology,
* clear definitions of the titles of ‘nurse’ and ‘midwife’,
* standards for basic nursing and midwifery education and practice,
* essential competencies for the nurse and midwife’s entry into practice,
* codes of ethics for nurses and midwives,
* educational and career pathways for nurses and midwives, and
* monitoring and evaluation frameworks.

The steps to introduce the RPRF at a country level include:
1. collecting and analysing available data,
2. generating and mobilising commitment,
3. determining objectives and regulatory elements
4. designing an implementation strategy,
5. conducting broad consultations,
6. orienting and training key groups,
7. mobilising resources,
8. designing an operational plan,
9. integrating the RPRF into the management of nursing and midwifery at the country level.

Dr Namate concluded by stressing to participants that the RPRF is not prescriptive; countries are able to contextualise to suit their own environment. The RPRF is a key to aiding a common approach to the regulation, educational preparation and practice of nurses and midwives and a key to aiding harmonisation of professional regulation in the entire Africa region. Dr Namata acknowledged the difficulties of those countries which do not already have nursing regulatory bodies in implementing the RPRF.

14. **SESSION 10**

**Treatment as prevention**

Ms Alexandra Zuber

Ms Zuber informed participants of a new approach to preventing HIV and AIDS: *Treatment as prevention*. The approach involves the early administration of anti-HIV drugs, known as *Highly Active Antiretroviral Therapy (HAART)* to HIV positive individuals. Because HAART reduces the amount of the virus in the body, the chances of spreading HIV to other people, including from pregnant women who are HIV positive to their infant diminishes dramatically. Studies have shown as much as a 96% reduction in the transmission of HIV with the viral load in the body decreasing to almost undetectable amounts. Ms Zuber explained that to stop the spread of HIV we need to encourage as many people as we can to get tested and learn their HIV status. If someone is HIV positive but does not know their status, they may be unknowingly spreading the virus. The sooner they are diagnosed, the sooner they can access treatment, and significantly decrease their likelihood of infecting others with HIV.
Treatment as Prevention has four fundamental principles:

- HIV testing is the foundation for both prevention and care efforts.
- Early identification of infection empowers individuals to take action that benefits both their own health and public health.
- Early treatment of infected persons substantially reduces their risk of transmitting HIV to others.
- The prevention benefit of treatment can only be realised with effective treatment, which requires linkage to and retention in care, and adherence to antiretroviral therapy.

Ms Zuber informed participants of the outcome of the HIV Prevention Trials Network (HPTN) 052 randomised clinical trial which enrolled 1,763 sero-discordant couples (one HIV-positive and one HIV-negative) to determine whether initiating treatment early in the HIV-positive partner could help reduce the risk of sexual transmission of HIV to the HIV-negative partner. The results showed that early administration of ART to the HIV-positive partner reduced the risk of transmitting HIV to their HIV-negative partner by 96%. Based on the evidence, the trial was halted and immediate treatment was offered to all HIV-positive partners.¹

Ms Zuber went on to talk about the importance of Nurse Initiated and Managed Antiretroviral Therapy (NIMART) reminding participants that nurses and midwives have an essential role in Treatment as Prevention both from an education perspective and a clinical perspective. NIMART has the potential to help prevent the spread of HIV and save lives. Nurses are the primary providers of health care and in an ideal position because of their training and education to initiate and manage the administration of ART. Ms Zuber emphasised the responsibility of nurse leaders to ensure that NIMART was available in their countries and if not, to lobby the government so that nurses and midwives are able to initiate and manage the administration of ART. It is also important that nurses involved in NIMART have the necessary education to administer ART safely, the necessary organisational and regulatory framework to support them, and that it is included in their scope of practice.

Countries shared their experiences with NIMART questioning whether NIMART was an activity of advanced nursing practice or whether all registered nurses should be educated in NIMART. Comments were made about the constant expansion of nursing scopes of practice. New tasks are added to nursing without existing tasks being delegated by the organisation to other categories of health worker. Comments were also made about the lack of available education in NIMART and the potential for education on NIMART to be provided through the national continuing professional development programmes that countries are developing through ARC grants. Concerns were also raised that new nursing tasks were being introduced without the necessary regulatory framework in place to support nurses performing the task.

15. SESSION 11

Update on PMTCT approaches
Dr Margarett Davis

Dr Margarett Davis is the Chief of the Maternal and Child health Branch, Division of Global HIV and AIDS, Centers for Disease Control and Prevention, Atlanta, Georgia, USA. Dr Davis’ presentation provided an update of the prevention of mother to child transmission (PMTCT) of HIV and AIDS. Dr Davis explained that there are four pillars of PMTCT:

- Prevention of HIV in women,
- Prevention of unwanted pregnancies,
- Prevention of transmission of HIV from an HIV infected woman to her infant, and
- Care and treatment for HIV infected women and their families.

Dr Davis shared with participants the overall goals of the Global plan toward the elimination of new HIV infections among children by 2015 and keeping their mothers alive 2011-2015 (HIV-free infant/child survival and AIDS-free maternal survival) and new initiatives which have been developed to attain those goals (see: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf).

Dr Davis referred to recent developments that suggest that both clinical and programme advantages can be attained by adopting a single, universal regimen both to treat HIV-infected pregnant women and prevent mother-to-child transmission of HIV. While one of the WHO currently recommended PMTCT ARV programme options, Option B, takes this unified approach, now a new, third option, Option B+ recommends not only providing the same triple ARV drugs to all HIV-infected pregnant women beginning in the antenatal clinic setting but also continuing this therapy for all of these women for life regardless of CD4 count. Important advantages of Option B+ include:

1. Further simplification of PMTCT programme requirements - no need for CD4 testing to determine ART eligibility (as required in Option A) or whether ART should be stopped or continued after the risk of mother-to-child transmission has ceased (as in Option B) (although CD4 counts or viral load assays are still desirable for determining baseline immunological status and monitoring response to treatment);
2. Extended protection from mother-to-child transmission in future pregnancies from conception;
3. A strong and continuing prevention benefit against sexual transmission in sero-discordant couples and partners;
4. Likely benefit to the woman’s health of earlier treatment and avoiding the risks of stopping and starting triple ARVs, especially in settings with high fertility; and
5. A simple message to communities that, once ART is started, it is taken for life (see: http://www.who.int/hiv/PMTCT_update.pdf).

**Figure 3: Three options for PMTCT**

<table>
<thead>
<tr>
<th>Treatment (for CD4 count &lt; 350 cells/mm3)</th>
<th>Prophylaxis (for CD4 count &gt; 350 cells/mm3)</th>
<th>Infant receives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option A</strong></td>
<td>Antepartum: AZT starting as early as 14 weeks gestation</td>
<td>Daily NVP from birth until 1 week after cessation of all breastfeeding; or, if not breastfeeding or if mother is on treatment, through age 4–6 weeks</td>
</tr>
<tr>
<td>Triple ARVs starting as soon as diagnosed, continued for life</td>
<td>Intrapartum: at onset of labour, single-dose NVP and first dose of AZT/3TC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Postpartum: daily AZT/3TC through 7 days postpartum</td>
<td></td>
</tr>
<tr>
<td><strong>Option B</strong></td>
<td>Triple ARVs starting as early as 14 weeks gestation and continued intrapartum and through childbirth if not breastfeeding or until 1 week after cessation of all breastfeeding</td>
<td>Daily NVP or AZT from birth through age 4–6 weeks regardless of infant feeding method</td>
</tr>
<tr>
<td>Triple ARVs starting as soon as diagnosed, continued for life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: UNICEF 2012. Option B and B+: Key considerations for countries to implement an equity focused approach available from: http://www.unicef.org/aids/files/hiv_Key_considerations_options_B.pdf p.3
Dr Davis emphasised that for Option B+ to have the greatest success, ART needs to be initiated and managed by nurses and midwives (NIMART) in all maternal and child health settings. National policies and guidelines should be revised to enable nurses to initiate ART and include the indications for referral to a doctor or a higher level facility. Inservice and pre-service training curricula must be updated for nurses, midwives and other health workers to reflect any new responsibilities related to ART. As well, there needs to be adequate numbers of nurses and midwives employed in maternal and child health settings so they can provide ARC without detracting from their existing client responsibilities. Further information from WHO can be found at: http://www.who.int/hiv/pub/mtct/programmatic_update2012/en/index.html and from the UNICEF publication about Option B+ (see: http://www.unicef.org/aids/files/hiv_Key_considerations_options_B.pdf).

Dr Davis shared with participants the global impact of PEPFAR initiated treatment in 2011:

- More than 800,000 deaths of HIV patients had been averted,
- Nearly 1.6 million children were prevented from being orphaned,
- Nearly 220,000 sexual infections with HIV were prevented,
- More than 93,000 mother-to-child HIV infections were prevented, and
- More than 7.7 million life years were saved.


16. SESSION 12
Closing remarks
Ms Peggy Vidot

Ms Vidot expressed her pleasure at having the opportunity to make a short address at the end of the ARC summative meeting. She referred to the three full days of learning, sharing and networking, and much discussion about the importance of a strong regulatory framework for nurses and midwives. The discussions she said have moved from raising awareness to the need for strategic actions. Ms Vidot went on to say that we all understand that to address these issues greater collaboration is needed at both national and regional level. The countries who were grant recipients last year all echoed the importance of collaboration as one of the many lessons learnt in implementing their project. They have demonstrated that much can be done over a year even with limited resources. They shared with us that determination for success was not deterred by some of the challenges they faced.

When ARC was launched in February 2011 we had a number of nursing and midwifery luminaries who joined us and shared their knowledge and experiences with us on leadership. One of these inspirational nurses is the well-respected nurse leader Marla Salmon and in her wonderful presentation on leadership legacy, she said that as leaders we need to be inspirational and a source of support for others; we should nurture and launch the next generation of leaders; and be mindful that leadership is passed on, not "owned". I would like this to be a take home message that we all reflect on and practice every day.

You have demonstrated great vision for nursing regulation in the projects presented. We need to use this vision as a source of unity and hope. The strength of unity or the power of togetherness came out strongly as one of the lessons learnt from the teams who presented on the implementation of their projects. It has come up often over the last three days. We are all in this together. As leaders we should be able to tolerate differences of opinion while maintaining a clear focus on the goal and creating positive spaces for every party we are engaging with. As we work, be it as quads at country level or as countries in the region, let unity be a guiding principle.
We are in leadership positions so we can make a difference to nursing and midwifery as well as to the communities we serve. We can make that difference and ARC offers an opportunity for us to do that. Let us make the most of this opportunity.

I would like to thank all of you who have participated, those who have submitted grant proposals, and the presenters who have travelled to be here with us this week and who shared their knowledge with us. I would like to thank all the partners for their continued support and I congratulate those countries who have been awarded an ARC grant for 2012.

I will be leaving the Commonwealth Secretariat in two weeks’ time and heading back to my home country Seychelles. In my capacity as Health Adviser, I have enjoyed being part of the ARC faculty. I am grateful that I have had the opportunity to have worked with so many wonderful people and be a part of this tremendous initiative which will strengthen nursing and midwifery regulation in this region. I would like to wish you all well and hope to be able to continue contributing to the faculty.

In concluding let me thank you for, first your friendship, I have met some amazing people in my nursing journey and have learnt much from you. Thank you for your commitment to ARC. It has been such a pleasure working with you all and above all thank you for your dedication to nursing. It is making the world a better place.

At the conclusion of her closing remarks, Ms Vidot received a standing ovation from participants and was presented with a bouquet of flowers as a token of the esteem in which she is held within the ARC faculty and the region and appreciation for her wonderful achievements on behalf of nurses and midwives over many years working with the Commonwealth Secretariat.
Good morning. The title of my speech *Death of a Disease in the 21st Century: Engaging the Critical Link* is partially borrowed from Dr DA Henderson’s personal story of how he led the World Health Organisation’s campaign to eradicate smallpox – the only disease in history to have been deliberately eliminated. While seemingly unrelated to the theme of this week’s ARC Summative Congress, the global health efforts that coalesced in eradicating this disease provide relevant parallels to global HIV and AIDS targets recently set by President Obama. Over the next several minutes I’ll explain the logic behind this association, its relevance to ARC, and highlight the ‘critical link’ nurses and midwives provide in realizing this century’s global health challenge – achieving an ‘AIDS-free generation’.

As many of you know, the story of smallpox’s devastation is long and deadly. Smallpox has been described as the worst infectious disease in history. During the last 100 years of its existence, smallpox is thought to have killed at least half a billion people. By comparison, since the beginning of the AIDS epidemic, 30 million people have died of AIDS-related illnesses. As reported by UNAIDS in 2010, the overall growth of the epidemic has stabilized with the annual number of new HIV infections steadily declining. Due to the significant increase in people receiving antiretroviral therapy (or ART) AIDS-related deaths has also declined.

**History of smallpox**

- Described as worst infectious disease in history
- Attributed to have killed at least half a billion people
- Believed to have emerged in human population around 10,000 BC
- Easily recognized by pustular rash

The smallpox virus is unique in that it only infects humans. It has survived for thousands of years by infecting one person after another in an unbroken chain of disease. Transmission occurs usually after face-to-face contact. The disease takes its human host by surprise, who (as described by Dr. William Foege) “...are unaware the virus has entered their body and has established a beachhead” and multiplied in the hundreds. It is only after 2 weeks of viral multiplication - just when the body’s immune system is organizing a defense - that the virus’s host realizes something is wrong. The presenting symptoms start out as a headache, backache, vomiting, and fever, followed soon after with lesions on the mucous membranes and bodily pustules that leave indelible scarring among the survivors. There is no cure for smallpox. For the smallpox virus to survive, it needs a population large enough to enable one susceptible person after another to be infected. The severity of this scourge underscores the significance of its eradication 32 years ago.

Smallpox has played a pivotal role in every era of human history. Its introduction into new, unexposed populations has always had a catastrophic impact. The earliest documentation of smallpox ravages date back to the Egypt and southern Asia, some 3,500 years ago. Mummified bodies of prominent Egyptian kings provide evidence of parchment-like skin studded with the telltale pustules. (Pharaoh Ramses V of Egypt who reigned for four years from 1145-1141 BC died from smallpox 1141 BC.) Since that time, there has been an unbroken chain of human transmission until its eradication in 1980. As the world’s population grew, the disease became associated with denser populations in Europe and Asia. The impact of smallpox on new, unprotected territories was particularly devastating to the indigenous populations of the Americans and Africa. It supplanted plague, typhus, leprosy, and syphilis as the foremost pestilence.
According to London’s Bills of Mortality dating back to the mid-1600s, smallpox accounted for 10% of all deaths – many within the royal families. Although sub-Saharan Africa was more sparsely populated at the time that Europe or Asia, as a result of traders from these areas, smallpox was prevalent in tribal groups across the African continent. Similar devastation of up to 90% mortality occurred among indigenous populations in the Americas as a result of European colonization.

By the mid-18th century, the practice of variolation - whereby an individual was deliberately infected with the smallpox virus by rubbing pulverized smallpox scabs into superficial scratches in the skin - was accepted as an early form of smallpox inoculation. While hardly perfect – as many as 2% of variolated people died – the risk of death from this practice was lower than the 30% death rate to smallpox by non-exposed humans. During the American Revolutionary War in the Battle of Quebec in 1775, although the American colonists outnumbered the British, they were unable to sustain their attack because so many were weakened by smallpox. England prevailed in that skirmish and as a result Canada became part of England as opposed to the future United States. Out of concern over the impact of a smallpox outbreak among the American troops, George Washington subsequently gave the order to variolate all American troops. It has been said that variolating the troops may have been Washington’s most important tactical decision in the pursuit for independence.

Nearly a century later, smallpox played another role in American history with the US’s 16th President, Abraham Lincoln. In 1863, during the midst of the American Civil War, President Lincoln delivered the Gettysburg Address, in Gettysburg, Pennsylvania - site of a major Union victory over the Southern Confederacy. This address, which is regarded as one of the most important speeches in American history, conveyed the fundamental principles of human equality and freedom for all citizens – including slaves. Reporters at the time described Lincoln as being sad, tired, and haggard. Upon returning to Washington that evening, Lincoln became ill with a severe headache, fever and was eventually diagnosed as having a mild form of smallpox. How Lincoln acquired the disease is unclear. Some speculate that it could have occurred while he was visiting soldiers in Union hospitals. However, had Lincoln’s incubation period been one day shorter, the Gettysburg Address might never have been delivered. Had he not survived smallpox, American history would not be what it is today.

The story of smallpox eradication would be incomplete without mention of Dr. Edward Jenner’s efforts in developing a smallpox vaccine in 1796. Dr. Jenner was a physician working in Berkeley, England, whose keen observation that milkmaids rarely acquired smallpox or smallpox scars led him to believe their protection was related to the cowpox sores on their hands they acquired by milking cows with sores on their udders. (Cowpox, unlike smallpox, was self-limiting and with little clinical significance.) After observing this phenomenon for a dozen years, Jenner decided to inoculate an 8 year-old child, James Phipps, with the cowpox virus. (This was years before the development of medical ethics codes for human experimentation.) Jenner then waited several weeks before using the method of variolation to inject the child with material from lesions of a smallpox patient. The child remained healthy and confirmed what Jenner suspected – cowpox somehow provided protection against subsequent exposure to smallpox. While Jenner’s work in vaccine discovery is still considered a significant breakthrough in public health, the fear of acquiring smallpox and the inability to widely distribute the vaccine made little in-roads in smallpox elimination until mid-twentieth century.

The first smallpox vaccine

Dr Edward Jenner’s 1796 discovery

- Observations of milkmaids in England
- Experiment with cowpox inoculation of James Philip followed by variolation of smallpox material
- No ill effects resulted in smallpox immunity
- Jenner’s work on vaccine discovery now seen as one of the greatest public health advances in modern history
- Limited impact on halting smallpox spread due to fear and vaccine transport challenges

WHO’s realisation of a smallpox free world took 185 years after Jenner’s discovery
Although the World Health Assembly passed a resolution in 1958 to eradicate smallpox globally, it took an additional 8 years for the WHA to pass a plan and a budget supporting a global smallpox eradication programme.

Two of the most significant players in the smallpox eradication effort were Dr DA Henderson who led WHO’s Smallpox Eradication Unit from its inception in 1967 through 1977 - when the last naturally occurring human case of smallpox occurred and Dr William (Bill) Foege, who was an American medical missionary at the time, and who worked as a consultant for WHO’s Smallpox Eradication Unit in eastern Nigeria and then Asia. Both physicians began their public health careers at CDC, with Dr. Foege later becoming Agency Director from 1977-1983. Dr Foege currently serves as an advisor to The Bill and Melinda Gates Foundation. Dr Henderson later went on to serve as Dean of the Johns Hopkins School of Hygiene and Public Health for 14 years before accepting an appointment as Chair of the Council on Public Health Preparedness. Both men received the Presidential Medal of Freedom, the US’s highest civilian honor - Dr Henderson in 2001 and Dr Foege in April of this year. Both men have recounted their experiences working on the Eradication (as the Smallpox Eradication Programme was eventually referred to); however, the contributions of each are creatively different and singularly significant in advancing this triumph of modern medicine.

In *Smallpox: The Death of a Disease*, Dr Henderson’s describes the challenges both scientific (many were skeptical about the feasibility and practicality of eradicating an infectious disease) and bureaucratic. Upon being assigned to WHO (from CDC) to head up the Eradication effort, Dr Henderson learned to navigate WHO’s bureaucracy and its regional structures – while simultaneously responding to global smallpox cases. Dr Henderson’s genius was his organisational creativity which enabled him to design a flat 9-person management structure in Geneva that oversaw 150,000 employees and staff who worked in the field. On the cover of his book there is an illustration of the bifurcated needle – a piece of sharpened steel wire that has a double point holding a droplet of the smallpox vaccine between points. The invention of this needle was a major technical advancement in the Eradication efforts since it required very little vaccine to get the job done. The needle enabled 100 vaccines dosages per vial of vaccine compared to prior techniques, which yielded only 25.

Whereas, Dr Henderson’s recount is a top-down story by a programme director, Dr Foege’s book, *House on Fire: the Fight to Eradicate Smallpox*, is told from the bottom up and focuses on the challenges he experienced in the field, first in Nigeria and later in India. Foege’s contribution to the Eradication effort was the advancement of surveillance and containment approach – a technique born out of necessity due to shortages of the smallpox vaccine. Surveillance and containment, also known as ring vaccination, refers to an approach that identifies and vaccinates everyone who has (or may have been) exposed to a smallpox as opposed to mass vaccination of an entire area. At the time, the concept of surveillance and containment was also met with scientific scepticism since it deviated from accepted mass vaccination, made possible as a result of new vaccine technologies. It was during his tour in India, that Foege was able to prove the benefits of a more targeted approach. His book title, *House on Fire*, refers to the analogy provided by an Indian health officer who pointed out to the Indian Minister of Health at the time, that when a house is on fire, you pour water on the targeted house – as opposed to the surrounding houses in case the fire spreads.
On May 8, 1980, the World Health Organisation (WHO) declared smallpox eradicated. No cases of smallpox had occurred since. Thanks to the eradication efforts led by two public health giants, Drs DA Henderson and William F Foege, and their respective teams of scientists and public health workers, the smallpox virus has been eliminated from the human species.

While epidemics are objectively different – even viral epidemics - to the patients and communities they afflict, all epidemics are emotionally alike. Each is met with its share of fear, awe, repulsion, stigma, rage, and blame. The stigma of smallpox can be as awful as the stigma of AIDS. The smallpox was as repellent in the last century, as HIV and AIDS is today. Its victims similarly share a sense of paralysing fatalism. Both diseases are lethal for which there is no cure; and both diseases create/created a disproportionate burden on low-income countries. While the smallpox global investment has since been dwarfed by today’s global community’s commitment to fight HIV and AIDS, thirty years ago the resources dedicated to eradicate one disease were among the largest amassed for any given global health campaign. The Smallpox Eradication effort was to the 20th century what the AIDS Free Generation is to the 21st.

<table>
<thead>
<tr>
<th align="left">Similarities:</th>
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<tr>
<td align="left">1. Stigma</td>
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<td align="left">2. A lethal disease for which there is no cure</td>
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<td align="left">3. Disproportionate burden on low income countries</td>
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<td align="left">4. Global efforts and resources</td>
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<td align="left">5. 20th century global health target was smallpox eradication</td>
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<tr>
<td align="left">6. 20th century global health target is an AIDS free generation</td>
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World AIDS Day, which is observed the first day of December every year, is designed to raise awareness of the global AIDS pandemic caused by the spread of HIV. Last December, President Obama, joined by former Presidents Bill Clinton and George Bush – reaffirmed the importance of continuing global investments to the President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. In reinforcing the theme for the 2011 World AIDS Day: ‘Getting to Zero’ - Zero New HIV Infections, Zero Discrimination, and Zero AIDS Related Deaths, President Obama stated his commitment to investing in “what works” in eliminating AIDS. Delineation of President Obama’s goal includes providing anti-retroviral therapy to more than 1.5 million HIV+ pregnant women over the next two years, and providing antiretroviral treatment to 6 million people by 2013 - two million more clients than PEPFAR’s previous goal of reaching 4 million. The President’s focus on increased AIDS-related care and treatment require expanded services of evidenced-based interventions such as, Preventing-Mother-to-Child-Transmission of HIV (PMTCT), Voluntary Medical Male Circumcision (VMMC) – a low cost procedure that reduces the risk of female-to-male transmission by more than 60%, and promoting the concept of ‘Treatment as Prevention’ – based on findings from clinical trials earlier in 2011 that documented effective treatment of a person living with HIV, reduced the risk of viral transmission to their partners by 96% - on par with vaccine outcomes.

President Obama’s proclamation reinforced a major foreign policy speech delivered by US Secretary of State, Hillary Rodham Clinton the previous month. On November 8, 2011, Secretary Clinton introduced the concept of ushering in an AIDS-free generation in which – first, virtually no children are born with the HIV virus, second, as these children become teenagers and adults they will be at a far lower risk of becoming infected thanks to a wide range of prevention tools, and third, if these young adults do acquire HIV, they will have access to treatment that helps prevent them from developing AIDS and passing the virus on to others. In her address, Secretary Clinton noted that until now, envisioning an AIDS-free generation has never been a policy priority for the US Government, largely because a few years ago a goal this lofty was unthinkable. Identifying an AIDS-free generation by 2015 is the 21st century’s global policy benchmark - similar in reach and ambition to the WHA’s commitment to eradicate smallpox in 1966. Additional points Secretary Clinton identified in her global policy address included the importance of allowing science to guide global policy and US investments; increased emphasis on country ownership of HIV/AIDS programmes; supporting ministries of health and local organisations in acquiring the skills to strengthen their own health systems; and underscoring the importance of global donor nations supporting and strengthening the Global Fund.
President Obama’s emphasis on expanding HIV services in AIDS-impacted countries has immediate ramifications with regard to the global health workforce and health systems – topics near and dear to those of us attending this meeting. Expanding HIV services not only requires adequate numbers of competent health care providers, but also functional, well designed health systems capable of forecasting service delivery needs and ensuring appropriate deployment strategies and services for meeting these needs. The connecting thread between current US global AIDS policy and health workforce efforts – is that without global agreement as to how to reliably provide programme services, strategically engage with health professionals, like yourselves, and use this information for strengthening health services, even the most revolutionary clinical advance will falter in reaching its goal. The smallpox eradication efforts demonstrate what can be accomplished when governments, organisations, and thousands of health care workers focus on a single objective. Similarly, resources from global initiatives like PEPFAR and the Global Fund can make comparable advancements in achieving an AIDS-free generation: which brings us back to ARC and its goal of developing nursing and midwifery leadership in the east, central and southern Africa region.

Thirty years ago, due to the nature of smallpox manifestation and disease containment, the focus was on surveillance, epidemiology, and use of the public health workforce to forestall spread of a dread disease in the community. In contrast, with today’s AIDS-Free generation goals, the emphasis has reverted to health services and the successful delivery of key interventions: ART, PMTCT, and VMMC for which nurses and midwives are seen as playing a pivotal role.

Unquestionably, PEPFAR made advances during the first five years of its roll-out, however, the role of workforce – especially that of nurses and midwives - was overlooked along with many missed opportunities for strategic involvement. In 2008, with the second USA Congressional reauthorization of the PEPFAR initiative, the role of nurses, midwives, and physicians was emphasized and today PEPFAR provides a platform for initiatives that support professional leadership and regulatory reform - like ARC. The call for an AIDS-Free Generation provides an opportunity for the nursing and midwifery professions to assume an influential role at the table and help shape solutions to service delivery challenges that have confronted the profession for years.

On Friday, the ARC agenda features two presentations emphasizing the role of nurse and midwives in reaching the AIDS-Free Generation goals. The first will discuss Nurse Initiated and Managed Antiretroviral Therapy (NIMART). Recent studies and clinical trials have shown that in certain settings, NIMART can produce health outcomes comparable to physician-initiated and prescribed ART. In Africa, nurses have a considerably greater population density than physicians and are the primary care providers in rural and lower level facilities. They represent a significant human resource for expanding HIV treatment to the additional 2 million patients being advanced by President Obama. As nursing and midwifery leaders in your country, your input and support of appropriate service delivery approaches will be invaluable in shaping the direction of how HIV/AIDS investments are spent.

The second presentation will provide the latest direction of the PMTCT intervention - which will significantly change the way in which ART is offered to pregnant and breastfeeding mothers. With the implementation of Option B+, that is, ART for all pregnant women for life, it is critical that key questions are asked and answered by you so that you not only inform decision-makers as to the best way to offer and provide these services but become decision-makers yourselves. Your input with regard to the shape and design of this intervention is both timely and critical.

The title of this talk, 'Death of a Disease in the 21st Century: Engaging the Critical Link’, was designed to emphasize the role and opportunity for nursing and midwifery involvement in addressing this century’s most vexing global health challenge. In order to realize the goals of an AIDS free generation, we must do our best to ensure quality at all levels – quality in how we train our professionals; quality in maintaining our knowledge and skills throughout our career; and quality in providing service - regardless of where we work in the health delivery system. There are global health heroes and heroines for every generation. I previously identified two from the past century who were inspirational to me. In this century, there is yet another opportunity for a new cadre and new leaders to make a difference, to discover advances, improve approaches and techniques for stemming an epidemic that has held a grip on this sub-
continent for way too long. This niche needs to be filled with African’s nurses and midwives – now more than ever for a healthy world.

In closing, I would like share a recent quote from Dr Marla Salmon, who was just named the 2012-2013 Institute of Medicine Nurse Scholar in Residence: These are times in which there is great opportunity - times of significant professional and scientific breakthrough. And yet, there are also major challenges that face nurses and midwives as they work to enhance the health of the people they serve. I think we are ready to step centre-stage and together as nurses and midwives define our contribution for the 21st century global health community – most of all – for the people we serve.
## APPENDIX 2: List of Participants

<table>
<thead>
<tr>
<th>Country or organisation</th>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Botswana</td>
<td>Mrs Khumo Dominica Modisaeman</td>
<td>Nursing Registrar</td>
</tr>
<tr>
<td>Botswana</td>
<td>Mr Lebogang Tshokolo Phillip</td>
<td>President Nurses Association of Botswana</td>
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<tr>
<td>Botswana</td>
<td>Ms Galeagelwe Baikeni</td>
<td>Chief Health Officer, Department of Health</td>
</tr>
<tr>
<td>Botswana</td>
<td>Dr Mabel Kefilwe Moeng Magowe</td>
<td>Educator, University of Botswana</td>
</tr>
<tr>
<td>Kenya</td>
<td>Mr Francis Otwayne Nyongesa</td>
<td>Deputy Chief Nursing Officer</td>
</tr>
<tr>
<td>Kenya</td>
<td>Mr Fredrick Ochieno Oduori</td>
<td>Nursing Registrar</td>
</tr>
<tr>
<td>Kenya</td>
<td>Mr Fredrick Omiah</td>
<td>Secretary General National Nurses Association of Kenya</td>
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<tr>
<td>Kenya</td>
<td>Dr Grace Omoni</td>
<td>Director School of Nursing Sciences University of Nairobi</td>
</tr>
<tr>
<td>Botswana</td>
<td>Mr Lepogang Tshokolo Phillip</td>
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<tr>
<td>Botswana</td>
<td>Mr Jonathan Abraham Gama</td>
<td>President National Organisation of Nurses</td>
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<tr>
<td>Botswana</td>
<td>Mrs Chrissie Chilomo</td>
<td>Malawi Nurses and Midwives Council</td>
</tr>
<tr>
<td>Mauritius</td>
<td>Mr Hurryram Shewraj</td>
<td>Chief Nursing Officer</td>
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<tr>
<td>Mauritius</td>
<td>Mrs Bilgis Dinally</td>
<td>Vice President Mauritus Nurses Union</td>
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<tr>
<td>Mauritius</td>
<td>Mrs Saraswatee Kristnama</td>
<td>Chairperson Education Committee Nursing Council</td>
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<tr>
<td>Mauritius</td>
<td>Mrs Manorama Bhuttoo</td>
<td>Senior Nurse Educator</td>
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<tr>
<td>Mozambique</td>
<td>Ms Herminia Azarias Cossa</td>
<td>Nurse Educator, Ministry of Health</td>
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<tr>
<td>Mozambique</td>
<td>Atalia Helena Nhacutone da Cruz</td>
<td>Chairperson National Midwives Association</td>
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<tr>
<td>Mozambique</td>
<td>Ms Maria Olga Matavel</td>
<td>Chairperson National Nursing Association</td>
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<tr>
<td>Mozambique</td>
<td>Dr Olga Novela</td>
<td>Head Department for Nursing, National Directorate</td>
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<tr>
<td>Namibia</td>
<td>Ms Josephine Elizabeth de Villiers</td>
<td>Nurse Educator</td>
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<tr>
<td>Namibia</td>
<td>Mr Isak Poppas</td>
<td>Acting Chief Nursing Officer</td>
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<tr>
<td>Rwanda</td>
<td>Ms Julie Kimonyo</td>
<td>Chief Nursing Officer</td>
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<tr>
<td>Seychelles</td>
<td>Ms Winifred Agricole</td>
<td>Nursing Registrar</td>
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<tr>
<td>Seychelles</td>
<td>Miss Marie-Antoinette Hoarau</td>
<td>Acting Chief Nursing Officer</td>
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<tr>
<td>Seychelles</td>
<td>Ms Elisa Simon</td>
<td>President NNA</td>
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<tr>
<td>Seychelles</td>
<td>Mrs Jeanine D’Arc Suzette</td>
<td>Representative Nursing Education</td>
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<tr>
<td>South Africa</td>
<td>Ms Khanyisa Newhutulu</td>
<td>Chief Nursing Office</td>
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<tr>
<td>South Africa</td>
<td>Professor Mashudu Maselesele</td>
<td>Educational Representative</td>
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<tr>
<td>South Africa</td>
<td>Ms Thembeke Gwagwa</td>
<td>General Secretary Nurses Organisation</td>
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<tr>
<td>South Africa</td>
<td>Mr Tendani Mabuda</td>
<td>Nursing Registrar</td>
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<tr>
<td>South Sudan</td>
<td>Mr Repent George</td>
<td>President Nurses Association</td>
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<tr>
<td>South Sudan</td>
<td>Ms Janet Michael</td>
<td>Director Nursing and Midwifery</td>
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<tr>
<td>South Sudan</td>
<td>Ms Abua Victoria Bessarione</td>
<td>Deputy Director Nursing Midwifery Training and Education</td>
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<tr>
<td>Swaziland</td>
<td>Ms Thembsile Gladys Khumalo</td>
<td>Chief Nursing Officer</td>
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<tr>
<td>Swaziland</td>
<td>Ms Glory Msibi</td>
<td>Registrar, Swaziland Nursing Council</td>
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<tr>
<td>Swaziland</td>
<td>Mr Bheki Mamba</td>
<td>President, Swaziland Nurses Association</td>
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<tr>
<td>Swaziland</td>
<td>Dr Ruth Nkosazana Mkhonta</td>
<td>Dean Faculty of Health Sciences</td>
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<tr>
<td>Tanzania</td>
<td>Mr Gustav Moyo</td>
<td>Registrar Nurses and Midwives Council</td>
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<tr>
<td>Tanzania</td>
<td>Ms Dorothy Malya</td>
<td>Acting Principal Nursing Officer</td>
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<td>Tanzania</td>
<td>Ms Eliaremsa Ayo</td>
<td>Nurse Training Representative</td>
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<tr>
<td>Tanzania</td>
<td>Mrs Romana Sanga</td>
<td>President Nurses Association</td>
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<td>Uganda</td>
<td>Mr John Kennedy</td>
<td>Nursing Registrar</td>
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<td>Uganda</td>
<td>Ms Janet Obuni</td>
<td>President, Nurses Association</td>
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<tr>
<td>Uganda</td>
<td>Ms Helen Mukakarisa</td>
<td>Nurses and Midwives Examination Board</td>
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<td>49</td>
<td>Zambia</td>
<td>Ms Emily Chipaya</td>
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<td>Zambia</td>
<td>Ms Perpetual Mwanawasa</td>
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<td>51</td>
<td>Zambia</td>
<td>Ms Beatrice Zulu</td>
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<td>52</td>
<td>Zambia</td>
<td>Ms Universe Himoonga</td>
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<td>53</td>
<td>Zimbabwe</td>
<td>Mrs Regina Smith</td>
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<td>Zimbabwe</td>
<td>S Cynthia Chasokela</td>
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<td>Ms Muriel Mothobi</td>
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<td>Mrs Fushiwe Chiyaka</td>
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<td>57</td>
<td>Com Secretariat</td>
<td>Ms Peggy Vidot</td>
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<td>58</td>
<td>CDC</td>
<td>Ms Patricia Riley</td>
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<td>59</td>
<td>CDC</td>
<td>Ms Alexandra Zuber</td>
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<td>60</td>
<td>Emory University</td>
<td>Dr Maureen Kelley</td>
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<td>Dr Carey McCarthy</td>
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<td>62</td>
<td>Emory University</td>
<td>Ms Jessica Gross</td>
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<td>63</td>
<td>CNF</td>
<td>Ms Jill Iliffe</td>
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<td>64</td>
<td>I-TECH</td>
<td>Ms Sheena Jacob</td>
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<td>65</td>
<td>ECSA-HC</td>
<td>Mr Alphonce Kalula</td>
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<td>66</td>
<td>Guest</td>
<td>Ms Genevieve Howse</td>
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<tr>
<td>67</td>
<td>Guest</td>
<td>Dr Eleanor Msidi</td>
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<tr>
<td>68</td>
<td>Writer’s workshop</td>
<td>Ms Sophie Gardner</td>
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<td>69</td>
<td>Writer’s workshop</td>
<td>Dr Christina Mudokwenyu-Rawdon</td>
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APPENDIX 3: Meeting Agenda

ARC Year 2 Summative Congress
Sustaining Regulatory Collaboration
Johannesburg South Africa 20-22 June 2012

Meeting Objectives

1. To facilitate regional dialogue on shared challenges and promising solutions in nursing and midwifery legislation, regulation and standards.
2. To foster collaboration between African nursing and midwifery stakeholders in each country and advance their collaborative leadership skills.
3. To celebrate regulatory achievements and progress made during ARC Year 1 and identify regulatory streams (eg: scope of practice) for ARC Year 2.
4. To announce a second round of ARC grant funding to support national regulatory improvement projects for nursing and midwifery.

Wednesday, 20 June 2012

0830-1000  Official Welcome and Greetings
Dr Maureen Kelley, ARC Principal Investigator, Emory University
- Dr Anban Pillay, Deputy Director General, Department of Health, South Africa
- Mr Alphonce Kalula, Senior Programme Officer, ECSACON / ECSA-HC
- Ms Mary Fanning, PAPFAR Liaison Officer, South Africa
- Dr Magna Aidoo, Head of Health, Commonwealth Secretariat

1000-1030  Keynote Address
Death of a Disease in the 21st Century: Engaging the critical link
Ms Patricia Riley, Team Lead, Health Systems Human Resources, Division of Global HIV and AIDS, CDC Atlanta

1030-1100  TEA BREAK

1100-1300  Country Reports
Facilitator: Ms Jessica Gross
Continuing Professional Development: Swaziland, Malawi, Lesotho
Revising Nursing and Midwifery Legislation: Seychelles, Mauritius

1300-1500  LUNCH

1400-1500  ARC Evaluation Framework
Dr Carey McCarthy, Research Fellow, Health System Human Resources, CDC Atlanta

1500-1600  CPD Resources Panel
CPD Toolkit: Ms Jill Iliffe, Executive Secretary, Commonwealth Nurses Federation
CPD Tracking: Ms Rose Wasili, Pre-service Nursing Manager, I-TECH Malawi and Mr Evasen Naidoo, Monitoring and Evaluation Specialist, I-TECH South Africa

1600-1630  TEA BREAK

1630-1700  Summary
Ms Peggy Vidot, Head of Health, Commonwealth Secretariat
Thursday, 21 June 2012

0830-0930  **Break out Session: Professional Affiliations**  
Moderator: Ms Alexandra Zuber, HRH Advisor, CDC Atlanta  
Registrars; Chief Nursing Officers; Presidents of NNAs; Academic representatives

0930-1030  **Report Outs: Professional Affiliations**  
Moderator: Ms Alexandra Zuber, HRH Advisory, CDC Atlanta

1030-1100  **TEA BREAK**

1100-1300  **Regulatory Improvement Proposals**  
Moderator: Ms Peggy Vidot
  - Ten country proposal presentations

1300-1400  **LUNCH**

1400-1415  **Announcement of grant recipients**  
Moderator: Dr Maureen Kelley, Principal Investigator, Emory University

1415-1630  **Break Out Session: Project Planning**  
Regulatory proposals: Ms Patricia Riley, Dr Carey McCarthy  
Targeted technical assistance: Ms Alexandra Zuber, Mr André Verani  
Grants management: Dr Maureen Kelley, Ms Jessica Gross

1630-1645  **Summary**  
Ms Patricia Riley, Team Lead, Health Systems Human Resources, CDC Atlanta

1645-1715  **TEA BREAK**

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Friday 22 June 2012

0830-0840  **Opening remarks**  
Ms Patricia Riley, Team lead, Health Systems Human Resources, CDC Atlanta

0840-1030  **Comparing and Reviewing National Legislation and Regulations**  
Mr André Verani, Public Health Lawyer, CDC Atlanta  
Ms Genevieve Howse, Principal, Howse Fleming Legal

1030-1100  **TEA BREAK**

1100-1200  **Global Standards and Resources**  
Moderator: Ms Jill Iliffe, Executive Secretary, Commonwealth Nurses Federation  
  - Mr Alphonse Kalula, Senior Programme Officer, ECSACON / ECSA-HC  
  - Ms Jean Barry, Consultant, Nursing and Health Policy, International Council of Nurses  
  - Dr Frances Kay-Stirk International Confederation of Midwives (presentation via Skype)

1200-1300  **Regional Regulatory Activities**  
  - Dr Eleanor Msidi, Nursing Education Partnership Initiative  
  - Dr Dorothy Namate, Global Fund Coordinator, Ministry of Health, Malawi

1300-1400  **LUNCH**
1400-1500  Treatment as Prevention
   *Nurse Initiated and Managed ART (NIMART): policy and practice in the ECSA region*
   - Ms Alexandra Zuber, HRH Advisor, CDC Atlanta

1500-1530  Update on PMTCT Approaches
   - Dr Margarett Davis, Chief, Maternal Child Health Branch, CDC Atlanta

1530-1600  Closing Remarks
   Ms Peggy Vidot, Health Advisor, Commonwealth Secretariat

1600-1630  Evaluation
   Ms Sheena Jacob, Nursing Director, I-TECH
APPENDIX 4: Meeting Evaluation Results

Fifty five participants returned completed evaluation forms. While there was even representation among the quad members at the meeting, most of the participants were from the public sector (73%). Overall, the scores for all sessions were very high with participants agreeing that sessions were somewhat to very useful!

When asked if participants understood the content presented in the session, found the session useful and would apply the lessons learned, participants gave the following sessions the highest marks:

- Grantee Reports (89%-91%)
- Professional Affiliation Breakouts (88%-89%)
- Professional Affiliation Reports (83%-87%)
- Proposal Development Session (85%)
- CPD Toolkit (83%)
- Grantee Proposals (81%-84%)
- Keynote Address (79%-85%)
- PMTCT Updates (80%)
- Legislative Review Process (73%-83%)

Of the grantee reports, one participant noted that it was: “very useful to learn how in one year there was a definite gain for the countries.” For the professional affiliations session, one participant remarked: “it showed that most of the African countries share the same challenges. It set a framework to network and harmonise some strategies to resolve challenges.” Overall, participants provided many comments, which can be found below each question.

In terms of meeting the conference objectives, 96% felt that the summative congress facilitated regional dialogue; 96% felt that it fostered in-country collaboration and advanced their leadership skills; and 91% felt that it celebrated regional regulatory advancements and identified priority areas for improvement. For the venue, 100% reported that it either met or exceeded their expectations.

The two most common complaints were the hotel security and shifting between the main meeting hall and the breakout room. Participants continued to value access to the Internet and asked that attention be paid to the room temperature. 91% were very satisfied with their airport pickup, 91% were very satisfied with the registration process, 90% were very satisfied with the meals and 84% were very satisfied with the tea breaks. Only 64% of people reported being very satisfied with the meeting room comfort, likely due to the shifting between rooms and the acoustics in the breakout room.

Only 63% of participants felt there was sufficient time for networking and only 48% agreed there was a good balance between didactic sessions and time for networking. A few participants recommended a site visit to the host country’s nursing council, as a time for learning, networking and socializing.

While 85% of participants reported receiving sufficient and timely information regarding their invitation to participate in the summative congress, there was overwhelming agreement that invitations should be sent earlier and be copied to the participants.

For future meetings, participants indicated interest in the following topics: unity and team building; proposal development; the roles of various nursing organisations and positions; and specific regulatory issues such as: scope of practice or umbrella health professions associations. Overall, participants felt that the summative congress was well organised and a great learning platform.

One participant noted: “It was a fruitful, productive workshop where learning through sharing occurred. It was an opportunity to replenish and be convinced that the profession can move forward.”
Q1: Please indicate your primary professional role

- Registrar or regulation: 22.0%
- Professional organisation/union: 24.0%
- Education: 27.0%
- CNO: 20.0%
- Other: 7.0%

Q2: Are you employed in the public (e.g. government) or private sector (e.g. NGO)?

- Public Sector: 73.0%
- Private Sector: 16.0%
- Other: 11.0% (67% of ‘other’ were at parastatals)

WEDNESDAY 20 JUNE 2012

KEY NOTE ADDRESS

Q3: As a result of this session I have new knowledge that will be useful in my role as a nursing and midwifery leader.

- Do not agree: 0%
- Somewhat agree: 21%
- Completely agree: 79%

Q4: As a result of this session I am able to identify the contributions of the nursing profession to improving health outcomes.

- Do not agree: 0%
- Somewhat agree: 15%
- Completely agree: 85%

Comments

An excellent parallel of the diseases, a big eye opener
Excellent comparison of smallpox and HIV/AIDS and how this challenges and gives hope to nursing and midwifery efforts towards an HIV free world!!
The presentation made me think and reflect deeply. Pat is very inspirational
The comparison of how smallpox was eradicated – it gave me hope that even HIV/AIDS can be eradicated if we are committed
It is possible, if we are provided with the tools, we will do more in improving the health situation of our communities

COUNTRY REPORTS

Q5: In general, how useful was it to hear about Year 1 ARC projects and progress made?

- Not helpful: 0%
- Somewhat helpful: 9%
- Very helpful: 91%
Q6: How useful was the session to assist you to apply lessons learned from Year 1 ARC projects to nursing regulatory work in your home country.
Not helpful: 0%
Somewhat helpful: 11%
Very helpful: 89%

Comments
Very useful to learn how in one year there was a definite gain for the countries
Need to use linking tools between theory and practice
It laid a platform for benchmarking for my country
Helped to see where countries are and are going
Something outstanding in the project is the importance of the quad
I agree with what I have learned, but I would like to say that the proposal of my country will focus on regulation standards
There is a lot to incorporate and improve our regulatory framework
I will apply where possible and be aware of the challenges in the process

ARC EVALUATION FRAMEWORK

Q7: As a result of this session, I understand the importance of measuring the impact of the ARC initiative.
Do not agree: 0%
Somewhat agree: 33%
Completely agree: 67%

Q8: The boxes on the RFF accurately describe the phases (past, present, or future) of regulations in my country.
Do not agree: 2%
Somewhat agree: 31%
Completely agree: 67%

Q9: The RFF will be useful to me for documenting my country’s progress or articulating goals for strengthening our regulations.
Do not agree: 0%
Somewhat agree: 24%
Completely agree: 76%

Comments
More needs to be done
This was enriching information which would assist in reviewing regulatory functions at home
Very good presentation Carey!!
I understood that [the] RFF is a process [that] can be improved according to the needs of the nation
This is to improve our regulatory framework
[The RFF] provided a strategy for evaluating progress

CPD RESOURCES PANEL

Q10: I will use resources from the CPD toolkit to help plan, implement or evaluate CPD activities in my country.
Do not agree: 0%
Somewhat agree: 17%
Completely agree: 83%

Q11: I intend to review the draft CPD toolkit and provide feedback for the purposes of strengthening this resource.
Do not agree: 0%
Somewhat agree: 23%
Completely agree: 77%
Q12: I understand how the TrainSMART database can be used to help track CPD and other regulatory functions.

Do not agree: 2%
Somewhat agree: 42%
Completely agree: 56%

Q13: A database such as TrainSMART would be helpful for tracking CPD or other regulatory functions in my country.

Do not agree: 2%
Somewhat agree: 23%
Completely agree: 75%

Comments
TrainSMART is very useful and can be used in many settings
TrainSMART concept was clarified
I would be very keen to access this network in order to track nurses who increased CPD
The presentation was educative and useful tool for developing CPD
Very useful and self-explanatory toolkit
[I] would like to know more about TrainSMART because of its importance
This was a very interesting and useful presentation; the TrainSMART programme is very good
I will need some support to be able to completely use the database

THURSDAY 21 JUNE 2012

PROFESSIONAL AFFILIATION BREAK OUT SESSION

Q14: Discussions with my professional affiliation group will be useful for my regulatory work.

Do not agree: 0%
Somewhat agree: 11%
Completely agree: 89%

Q15: I will contact ARC members with the same professional affiliation to provide consultation on programme development, identify solutions to challenging regulatory cases, and to provide support for each other in these roles.

Do not agree: 2%
Somewhat agree: 10%
Completely agree: 88%

Comments
Since my country is new, we will accept support from others
Professional affiliations are key
It showed that most of the African countries share the same challenges. It set a framework to network and harmonise some strategies to resolve challenges
Collaboration will be done
COLLABORATION, COLLABORATION, COLLABORATION
This was crucial – I learned that the enemy of the nursing profession can be controlled if we are unified
Need to learn from other and to strengthen the quad
Facilitators to be in groups to guide and control domination by some members
This session in regards to professional affiliations was a very good session in sharing knowledge and experience. (Time allocated too short)
Learned from the experienced groups
PROFESSIONAL AFFILIATION REPORT OUT

Q16: I have a better understanding of the challenges that my nursing regulatory colleagues face when it comes to improving nursing service delivery in the country.
Do not agree: 0%
Somewhat agree: 13%
Completely agree: 87%

Q17: Hearing reports from the regulatory team provided me with a better understanding of how to improve nursing practice in my country.
Do not agree: 0%
Somewhat agree: 17%
Completely agree: 83%

Comments
Information must be shared with others in the country
These reports were encouraging and assisted [me] in understanding the importance of working as a team in order to improve nursing and midwifery services
I learned that there are both successes and challenges all over the region and this gave me hope to sail on
Different approaches with the same objective
Learned that we are all nurses – whatever positions we are, but everybody has to play a role on strengthening nursing and midwifery
All face the same challenge which is comforting – that means we can find a solution together
The reports help build confidence in participants
It reinforced my appreciation of unity in a profession as a way forward

REGULATORY IMPROVEMENT PROPOSALS

Q18: This session helped me to learn more about the priority regulatory issues in other ARC countries.
Do not agree: 0%
Somewhat agree: 16%
Completely agree: 84%

Q19: After returning home, I will communicate with fellow ARC teams with similar priority regulatory issues in order to share lessons learned and obtain advice on programme development and implementation.
Do not agree: 0%
Somewhat agree: 19%
Completely agree: 81%

Comments
Peggy has been a very supportive and wonderful leader. We shall improve our proposals
We will keep it up
Need to share knowledge on how to prioritize issues
This is good knowledge. Maybe visit to each other’s country to share experience
There is power in networking
Networking with ARC teams in the region will be of great importance, as there is a lot of sharing that can be done online
There are differences and commonalities in all groups so there is always something to learn from one another

PROJECT PLANNING BREAK OUT SESSION

Q20: This regulatory proposal session helped me think about future proposal development.
Do not agree: 0%
Somewhat agree: 15%
Completely agree: 85%
Q21: The targeted assistance section helped me reframe how our country might use ARC grants to leverage further funding/ further improvement in regulatory functions.

Do not agree: 0%
Somewhat agree: 31%
Completely agree: 69%

Q22: The grants management session helped me understand the reporting and budgetary framework for ARC.

Do not agree: 2%
Somewhat agree: 25%
Completely agree: 73%

Comments

Reporting framework was highlighted, but more can still be done
In future, announcements of grants should not be done in the forum where we are all there as those who did not win; it’s kind of embarrassing to them; do it like the 1st year grants

Knowledge is power
The proposals were challenging but after having accepted for grants, I have realised that I gained knowledge: the explanation on how to use the grants was clear and had a simplified way to write
The management one was lesson learned
Proposal development is challenging and it is good to learn about it. The use of grant money as seed is wonderful, especially where it is difficult to get a budget
ARC faculty should emphasise the importance of the same member attending to enable continuity in work
The importance of pursuing write-ups for other grants was (an) idea that strongly came to consideration and realisation
Needs ample time to fully understand the concept: I’m sure with consultation it will be clearer
All the topics cover in project planning will be very useful when I go back home. As it has enhanced my capacity in proposal writing in the future and how to better report on the budget allocated to the project

FRIDAY 22 JUNE 2012

COMPARING AND REVIEWING NATIONAL LEGISLATION AND REGULATION

Q23: I understand how to use the ARC legal/ regulatory matrix for locating key regulatory documents from multiple ARC countries.

Do not agree: 2%
Somewhat agree: 44%
Completely agree: 54%

Q24: I will use the ARC legal/ regulatory matrix and its accompanying regulatory documents to help inform my work in my own country.

Do not agree: 2%
Somewhat agree: 29%
Completely agree: 69%

Comments

I will use the ARC legal/regulatory matrix if my country starts to implement!
Time was very little. It could have been a fruitful exercise to compare and contrast acts from various countries.
Need to know more
We failed to use the technology in our group where the flash failed to open
Legal people usually make their presentations complicated, but Andre’s was to the point
It strengthens the operations and regulations
A good idea to establish the system by putting in documents for use
Paper based back up should have been used or provided to achieve the objective
This will reduce the time to compare nursing regulation in the region
We need to try and study the matrix to be utilized fully. Some of the countries’ Acts are not in there matrix. Is there a possibility of including them?
I need to study the matrix further
I still need time for self-study of this presentation, and consultation
It is a useful tool – need to better acquaint one self and share with other colleagues: a very good initiative

NURSING AND MIDWIFERY IN AFRICA: PROCESS OF REVIEW AND REFORM

Q25: I understand the factors to consider in the process of legislative and regulatory review.
Do not agree: 0%
Somewhat agree: 27%
Completely agree: 73%

Q26: I plan to use content from this presentation to inform my work with legislative and regulatory review.
Do not agree: 0%
Somewhat agree: 17%
Completely agree: 83%

Comments
Factors differ from country to country...complex!
Definitely!!
This was helpful
The session was very inspiring
I enjoyed the presentation
As indicated, Genevieve drove the message home
Good presentation
Very relevant presentation
Very informative presentation!!!
I plan to use the content where applicable
Very informative presentation
A good resource and [good] information
It was an opportunity to analyse and compare the work done and gaps to improve
Presentation was clear
I still need to read through this
Very good information and will be useful for the future and sharing with others

GLOBAL STANDARDS AND RESOURCES

Q27: I have a better understanding of key nursing global standards.
Do not agree: 0%
Somewhat agree: 31%
Completely agree: 69%

Q28: I will use international global standards to help benchmark regulatory activities in my own country.
Do not agree: 0%
Somewhat agree: 26%
Completely agree: 74%

Comments
I will use global standards in my country
This session enriched my knowledge on these bodies/organisations
The triad will seek assistance from the organisations to work on the (b) above - the use of international standards to benchmark regulatory activities in my country
They came up with an appropriate topic at an opportune time when we are reviewing our regulatory framework
It gave me an opportunity and reminded [me] how we used ECSACON pathway to teach students on nursing regulations
Good lessons to apply and to critically look at local conditions and health needs
It is crucial to know where to get resources and information
Had already been using the framework to develop curriculum and nursing standards
i still need to look at the standards critically for me to be fine that I can use them. Otherwise, [the] presentation was clear. I will take time to read further

REGIONAL REGULATORY ACTIVITIES

Q29: I have a better understanding of regional resources for regulatory work.
- Do not agree: 0%
- Somewhat agree: 49%
- Completely agree: 51%

Q30: Hearing about regional regulatory activities was useful for my work.
- Do not agree: 0%
- Somewhat agree: 34%
- Completely agree: 66%

Comments
Yes, it indicates how complex the regulation of nursing is
More information can improve understanding
Eye opening and very updating
Thank you for reminding us [of] the resources we have regionally
Provided better insight
Good to learn of it - for us to use and become partners
Very useful information
Seems to have commonalities with other regulatory regional and professional bodies
Too many groupings will tend to confuse us. We already have ICN and ARC. Why can’t efforts be channelled towards strengthening ICN and ARC

TREATMENT AS PREVENTION

Q31: I have a better understanding of challenges and successes related to implementing NIMART across the region.
- Do not agree: 2%
- Somewhat agree: 31%
- Completely agree: 67%

Q32: This session provided a helpful forum for my ARC quad to have a productive discussion regarding NIMART.
- Do not agree: 0%
- Somewhat agree: 38%
- Completely agree: 62%

Comments
We don’t have a quad at the moment
Yes, more needs to be done to improve NIMART
This was incredible
Required adequate time
There is a lot needed to have success
Session provided opportunity to learn from others

UPDATE ON PMTCT APPROACHES

Q33: I have a better understanding of the latest PMTCT updates, including using Option B+.
- Do not agree: 2%
- Somewhat agree: 28%
- Completely agree: 70%
Q34: I would like more updates on this topic in the future.
Do not agree: 2%
Somewhat agree: 18%
Completely agree: 80%

Comments
Noted lots of new approaches different to current practices - OK for professionals, but will be very challenging for the general public/users
I will get her contacts to learn more on the topic
I learned a lot from this presentation
Very pertinent and relevant to take future action
Very important presentation
This will call Ministries’ of Health to pioneer it and provide the policy framework
Provide web address or newsletter
Not too clear presentation
Needs plenty of time
Session was too long and presenter was not sensitive to the stress listeners were going through

OVERALL WORKSHOP EXPERIENCE

Q35: Workshop Objectives: In your opinion, were the workshop objectives met?

1. To facilitate regional dialogue on shared challenges and promising solutions in nursing and midwifery legislation, regulation and standards.

   Objective not met  0%
   Objective mostly met  4%
   Objective fully met  96%

2. To foster collaboration between African nursing and midwifery stakeholders in each country, and advance their collaborative leadership skills.

   Objective not met  0%
   Objective mostly met  4%
   Objective fully met  96%

3. To celebrate regulatory achievements and progress made during ARC Year 1 and identify regulatory streams (e.g. scope of practice) for ARC Year 2.

   Objective not met  0%
   Objective mostly met  9%
   Objective fully met  91%
4. To announce a second round of ARC grant funding to support national regulatory improvement projects for nursing and midwifery.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Not met</td>
<td>0%</td>
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<tr>
<td>Mostly met</td>
<td>4%</td>
</tr>
<tr>
<td>Fully met</td>
<td>96%</td>
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</tbody>
</table>

**Comments**

- Needs to talk more about community-based health systems, HRH, etc
- Objectives well met, but we needed more time to dialog and share experiences from other countries
- But Rwanda deserved a grant: had a better proposal
- Very fitting to pursue ahead
- There has been a lot to hear and share with others
- Fruitful workshop!
- Successful outcome of workshop objectives

**MEETING VENUE**

Protea Balalaika, Johannesburg, South Africa

**Q36: The meeting venue met my requirements for optimal work and rest.**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Did not meet</td>
<td>0%</td>
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<tr>
<td>Met</td>
<td>38%</td>
</tr>
<tr>
<td>Exceeded</td>
<td>62%</td>
</tr>
</tbody>
</table>

**Comments**

- However, the idea of shifting venues was about tiring
- It was a nice meeting. Quad is a brilliant idea: keep it burning
- Fabulous
- Hotel security not good - colleagues lost their belongings
- Venue - friendly, hospitality good, but need to improved on security - others lost property
- I applaud the hotel for providing with Internet services because I managed to keep in touch with my office
- On June 21st, there were too many movements which were inconveniencing
- Excellent venue
- Just too much movement
- There was too much movement
- Security threat; put CCTV until pickpockets disappear
- Better temperature regulation. Lunches were cold and very repetitive
- The people were hospitable but there were too many losses of property
- For security reasons it should be more high-class for a 4-star hotel
- Too much movement; change of meeting venues
- Generally, the management was excellent. Keep up
- The movement up and down was not good
- Tea breaks were congested
- Well organized
- Challenge with Internet - on/off
- Shifting everyone [between] rooms was tiring
- Groups can be separated during discussion as much as possible
GENERAL COMMENTS

Q37: Were the following satisfactory to you?

1. Airport pick-up
   - Not satisfactory: 0%
   - Satisfactory: 9%
   - Very satisfactory: 91%

2. Registration process
   - Not satisfactory: 0%
   - Satisfactory: 9%
   - Very satisfactory: 91%

3. Conference room comfort and appropriateness for activities
   - Not satisfactory: 0%
   - Satisfactory: 36%
   - Very satisfactory: 64%

4. Tea breaks
   - Not satisfactory: 2%
   - Satisfactory: 14%
   - Very satisfactory: 84%

5. Hotel breakfast and lunch
   - Not satisfactory: 2%
   - Satisfactory: 8%
   - Very satisfactory: 90%

Q38: I had sufficient time to network with my nursing regulatory colleagues during the meeting.

- Do not agree: 0%
- Somewhat agree: 37%
- Completely agree: 63%

Q39: There was a good balance between didactic sessions and opportunities to network during the 3-day meeting.

- Do not agree: 0%
- Somewhat agree: 52%
- Completely agree: 48%

Comments
- There could be more time available for networking
- Not adequate [time to network] between sessions
- I am continuing to network from here on
- Tight timetable
- Need for field visits to be enriched in future
- Programme was too tight

Q40: Did you receive sufficient and timely information regarding your invitation to participate in this meeting?

- Yes: 85%
- No: 15%

Comments
- Heard late - hope to receive direct emails next time
- One day before departure
- It was well organized and timed
I heard from colleagues about the meeting
Network difficulties
Regular and timely; thanks
The invitation could have been sent and copied to quad participants
Delay was at the country - otherwise, letter was sent in good time. Ministry approval very bureaucratic!!
Jill was fast, swift with communication
In the future, communication should be copied to the nursing chief nurse and registrar because MOH leaders may not communicate to the concerned department in good time
Invitation letters come a bit late

Q41: What strategies could help facilitate your ability to get timely approval (from the PS at the MoH, your direct supervisors, etc.) for your attendance at future ARC meetings?

Comments
Direct emails to me
(PS/MOH) should get a copy of our invitation and funding details
Early communication
Two weeks notification
Direct email requests especially to CNOs/DNOs from the organising team
Communication to reach MOH one month before travel time
Invitation letters to be sent timely to the invitees
Send invitation (two months before meeting dates) by email and also call the leader in the MOH
Early invitations to countries with copy to the invited
The channel used for this invitation (my supervisor) was effective
Early communication - say a month earlier
If the invitations could also be sent directly to the association; the time the MOH informs us is very late
I do not need MOH approval and do not have a problem being released by my supervisor
Send invitation copy to quads
Could be copied to individual participants
Always send a copy of your communication to us so that they make follow up to the Ministry
I need at least three weeks to get clearance
Forward invitations to the PS and to the participants
Direct contact with the leader of the team
Provide a report to the PS on the performance of the country team. Regular contact via phone and mail
Send copies of letters to us so we may use them to follow up the PS, etc.
Inform the PS about the performance of the country team
One month before
Writing a report and sending it to the senior chair and executive
The invitation should be sent in time
To put invitation earlier
There was enough except invitation letters should come in as early as possible to enable processing of visa
Communicating with MOH directly helps to forward
Inviting the team member and requesting the PS to support the team by approving travel clearance and time off. If this is not done, there is a tendency to replace the member and this will impact the project negatively
When sending the invitation letter to the PS, copy the deputy director nursing and registrar for follow up
For Director of Nursing MOH - always putting her in copy of ARC correspondence would help
Explaining to them how important their approval would be for the betterment and enhancement of nursing and midwifery education and practice
Copy communication to registrars and chief nursing officers
Writing to the PS for approval is sufficient but copy the invitation letter to the CNO
Getting the invitations three weeks before
Write a letter to the PS and send personal invitation letter early
There was enough time
Sending the information to the PS and copy me at least a month before. Also, send a tentative programme for the meeting and travelling itinerary. I need to attach all these and write a cabinet paper before
Writing letters to PS and copies to me
Q42: What additional topics or speakers should be included in future ARC meetings?

Comments
Advocacy, unity
Strengthening community health systems through nursing regulation
More topics on nursing and midwifery education - than practice and regulation
Union of quad
Best practices sharing. Regulatory models
Any new trends
WHO representative in host country; Representative from another health profession authority
Contemporary nursing issues; Maternal and neonatal issues
Emphasise unity because CNOs and Registrars seem to be untouchables
Determining scope of practice
Leadership and teamwork in the quad
Segregation of duties and responsibilities
More speakers with legal background; Share ideas on umbrella regulatory bodies
Writing project proposals; what can be done to improve the ethical attitude and standard of nurses in the region
The role of the nurses association; the role of the CNO
Presentation of research done on regulatory issues
Nurse leaders in region and beyond; other associated agencies
Resource obligation - As noted, the funding for the project is to help countries jump start the process of implementing their project activities. There is need to sustain the project and so need for more resources
Leadership
Speakers on the functions of NNA and the union
Negotiation skills and team building
Maybe include a visit to the nursing council of the hosting country to see what they are doing
Proposal development; to enable everyone to compete effectively
Proposal writing, lobbying skills

Q43: Please share any additional comments or suggestions regarding the overall ARC meeting.

Comments
Keep it up!!
Could be an annual event!?
Well organized
The meeting went well, coordinated rapidly. Time not adequate some topics like the legal matrix rushed over
ARC is an eye opener. We shared ideas and constructive information
Well organized. Programme fully packed for the day. Could have been spread to another day
Well organized. Team spirit of the facilitators and caring
Well organized. Other speakers were given more time for questions and others not
More time should be given for ARC team countries to interact and share experiences on various issues
The organisers should consider increasing the amount of the award considering the current economic situation
My hope is that the emphasis on nursing and midwifery separately will not split among the nursing slots. There are other areas of nursing - preoperative, paediatric, psychiatry, renal, emergency and accident, etc. who might also come up demanding to be on their own and this will affect the nurses unity.
Good work done by ARC. I feel the non-availability of ICM was a blessing because most countries reject the separation of midwifery and nursing
SANNAM and STTI are important collaborators to involve
Excellent, however countries are bound to lie while the truth is that there is no unity or quad in their countries
They are very useful meetings
Generally the meeting was very successful
Great: productive meeting; great facilitators
These opportunities are very good and give an opportunity to learn and share
Should consider the weather in the next conference; thank you, very useful to us and this gives us a needed look into our mode of work
It was a good learning platform. The facilitators were very helpful and resourceful
Very good initiative; must be encouraged to move forward in a spirit of south to south collaboration
ARC is no doubt a wonderful, wonderful idea, especially for advancing nursing and midwifery issues through the quad. It should definitely be sustained and should not die please. Was good, well planned except for we worried of the thieves - carrying our bags everywhere we go. To continue to organize the meeting every year. Arrangement to be made for host country travel and field visit. It has been educative. Challenges are too huge for proper success. Overall, the meeting was a success. There was much to learn from all presenters and sharing with colleagues. It was more than I expected in such a meeting. It was a fruitful, productive workshop where learning through sharing occurred. It was an opportunity to replenish and be convinced that the profession can move forward. The meeting has been an excellent learning platform - bringing together the chief nurse, regulators of the council, the association, and the schools of nursing. This is a great way in achieving, strengthening nursing and midwifery, which needs to be supported. I look forward to the next meeting and it will be fabulous to share the next date early enough for purposes of planning. The nursing leaders (CNOs) are at various levels. Some are directors, deputy directors and Chief Nursing Officers. Please indicate so that it will embrace other levels. For example, in my country, there is a possibility of nominating a CNO (who is a subordinate) instead of the deputy director. I am concerned about programmes like NEPI which are reducing the length of training for midwives. Can it be standardized please, instead of having 3 ½ years and 4 years in some countries? Quick action will serve the profession. It was well organized. The faculty did a good job. It was a good meeting where a lot was learnt and shared. I like the retention of countries. We hope next time it will be in another country. It was a wonderful meeting with expected outcomes.

**THIS YEAR'S GRANT REVIEW PROCESS FOR COUNTRIES WHO SUBMITTED A PROPOSAL**

**Q44:** My team received adequate technical support from ARC during the grant-writing process.

- Do not agree: 19%
- Somewhat agree: 10%
- Completely agree: 71%

**Q45:** I have a better understanding of how to write and submit a grant after participating in this year’s grant process.

- Do not agree: 0%
- Somewhat agree: 24%
- Completely agree: 63%

**Q46:** I feel empowered to write future proposals based on my experiences with proposal writing for ARC Year 2.

- Do not agree: 0%
- Somewhat agree: 19%
- Completely agree: 81%

**Comments**

Thank you for all of the assistance. I/we may still need help in this area and hope if we request you will be of help. The organizers cared to look at our work. That gave us more confidence to move forward. Adequate support received during the grant writing process. Technical assistance will be appreciated in the implementation of the programme.

**Q47:** What worked well during the grant-writing process?

**Comments**

Enough technical support from ARC. Following the templates to the dot. Commitment by the quad. Teamwork – guidance from the registrar.
Analysis on objective and implementation plans
Comments (timely) from technical support team
We were very well guided after a detailed analytical discussion with Jill and Maureen. Bless you.
Sense of purpose to be able to participate in the ARC project so that we can document best practices that can be shared at the regional meeting as well as help us progressively achieve targeted activities
The guidelines helped a lot
Team work and support given by Jill and Maureen
The coordination among the quad members
The guide for proposal writing; excited about publication

Q48: What was your biggest challenge(s) during the grant-writing process?

Comments
Time constraints to meet deadlines for submission
Time constraints and getting letters of approval from those involved at an earlier date. Lots of follow up and time consuming
Time constraints
Time; especially that we were from different organisations; electronic communication was helpful
Getting ARC members to a meeting and work together
Choosing the topic for the proposal that met the approval of all stakeholders and having them all on board to give their views to write the proposal
Budget
Looking forward to succeed
Finding the priority areas and naming the topic
I was worried before Jill and Maureen intervened - not sure what we were to present. Anxiety was treated by Jill and confidence instilled
Initialization of the concept; identifying specific activities and time allocation
Meeting the deadline
Minimal support and participation from the Ministry of Health especially the Chief Nurse office
Time was not on our side. Juggling work with writing up [the proposal]
No information about ARC was provided to me by my predecessors
Having adequate time together as a team to write the proposal; but through commitment, it was possible to complete it
The process and the scope of the project
Getting everyone for a meeting at the same time because of different commitments

Q49: How can next year’s grant-writing process be improved?

Comments
Enough time, six weeks, to prepare and submit proposal
Use template. Include review process before finalisation to help countries
Areas to be addressed will be expanded
Maintain quad approach
Enough time for proposal writing
Having more feedback on areas that need to be approved
Have technical assistance well before coming
By taking all stakeholders on board
Continue guidance of the country team
Feeling support from the secretariat and guidance; regular meetings among the four pillars
Timelines and deadlines to be announced at the end of congress
I think this was OK except for the time limit
The team should be highly committed and create time specific for it
By giving early guidance to the quad
It was good that awardees were named before the end of the meeting
Q50: In your opinion, how satisfactory was the grant announcement process?
N=23
Not satisfactory 4%
Satisfactory 18%
Very satisfactory 78%

Comments
Well done
It was very considerate
Somebody wins, but those who lost are not any lesser! They are still winners
Very well done and credible
Timely and transparent
The secretariat deserve a big thank you for a job well done
Criteria used in selecting grantees should be announced as well to be a learning/teaching opportunity
This was a very exciting moment - having realized that more countries applied and only five were awarded. There should have been a public sharing of what made the recipients get the grant and why the ones that did not get and how they should improve for future. Transparency was observed and it should continue. Thank you.

ARC PROJECT MANAGEMENT INDICATORS (to be completed by one member of Year 1 team)

Q51: Number of times you met as an ARC quad in your country (input indicator).
N=9: three times (1); four times (2); five times (1); ten times (1); twelve times (2); twenty-five times (2)

Q52: Number of meetings held with stakeholders (process indicator).
N=10: No meetings (1); two meetings (4); three meetings (1); five meetings (1); seven meetings (1); eighteen meetings (2)

Q53: Number of regulations reviewed or revised because of ARC (outcome/impact indicator).
N=7: No regulations (3); one regulation (2); nine regulations (2)

Q54: Have you received an increase in funding support for nursing and midwifery related to your ARC activities (outcome/impact indicator).
N=9: Yes (5); No (4)
APPENDIX 5: Grant Application Guidelines ARC Year 2

Guidelines for Country Team Grant Applications

Purpose
The African Health Profession Regulatory Collaborative (ARC) for Nurses and Midwives seeks to:

- Improve the health of individuals, families and communities through the promotion of safe and effective nursing and midwifery standards of practice
- Facilitate country-level collaborative projects which will result in measurable and sustainable change in a key area of nursing or midwifery regulation or standard setting
- Apply a collaborative model to engage countries in sharing progress, results, and lessons learned
- Select and fund at least four proposals, during ARC Year 2, up to $10,000 per proposal in support of national regulatory improvement projects.

Scope
Examples of the type of country-level projects that ARC seeks to fund include, but are not limited to, the following:

- Review and revise the scope of practice for nurses and midwives to address task shifting through regulatory policy (e.g. nurse prescribed ART)
- Ensure the standards for nurses and midwives are updated to address national reforms to education and practice
- Evaluate the current national legislative framework for the practice of nursing and midwifery to ensure optimal regulation of professional practice
- Review national nursing and midwifery educational standards to align with regional and international standards and country needs
- Formalize continuing professional development requirements for licensure renewal and recertification
- Strengthen the credentialing and accreditation policies and procedures for nursing and midwifery training institutions.

In order to fit within the timeframe of the grant cycle (9 months), countries should focus their project proposal to achieve an important first step(s) in addressing one of these issues.

Eligibility
In order to apply for an ARC grant, representatives—including the registrar(s) of the country’s nursing and midwifery council(s), the chief nursing officer or delegated representative, the president of the national nursing and midwifery professional association(s) and a representative from an academic institution—must form a team and:

- Submit a project proposal by April 20th, 2012 and attend the ARC Summative Congress, June 2012
- Commit to sending the same four representatives to two additional learning sessions, tentatively scheduled for early October and early February, and the Summative Congress in June 2013
- Designate an authorized institution to receive ARC grant funding
- Designate a project coordinator to liaise between Emory and the country team.

Due to funding limitations, participation in ARC is based on nursing leadership positions. Therefore, country representation and involvement in ARC may change from year to year, as new individuals are posted to the positions of chief nursing officer, registrar, president of the national nurses association, or appointed as the academic representative. Representatives currently holding these positions should comprise the country team to submit a grant application for ARC Year 2.

Grant Categories
In ARC Year 2, there are three categories for grant application: 1) Alumni 2) General and 3) Sponsored. The alumni category includes countries that were awarded ARC funding in the previous year. The general category includes all other country teams. The sponsored category includes country teams where an outside partner has pledged to sponsor their full participation in the ARC initiative. If a country received an ARC grant the previous year, but has an outside sponsor, they can apply under the sponsored category. This year, ARC will award one alumni grant, three general grants, and an unlimited number of sponsored grants. Regardless of category, all country teams must submit a project proposal according to the ARC guidelines. Only one application should be submitted per country.

Proposal Instructions
The grant application proposal should be comprised of the country team’s face page and the following sections: 1) problem statement, 2) methods section, 3) activities timeline, 4) feasibility, 5) budget and justification, and 6) programme management. Countries that received an ARC grant in the previous year should include a seventh section on prior performance. The proposal should include signed letters of support from each country team member’s institution, as well as from other organisations or institutions that will support your project.
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<thead>
<tr>
<th>Section</th>
<th>Content</th>
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<tbody>
<tr>
<td>Face Page</td>
<td>List the name, title, institution, e-mail, phone number and address for each member of the country team.</td>
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<tr>
<td>1</td>
<td><strong>Problem Statement</strong></td>
<td>2 pages</td>
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<td></td>
<td>• Identify the regulatory, standard setting or legislative issue the country team’s project will address.</td>
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<td>• Provide background information relevant to that issue, explaining why it is a problem in your country.</td>
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<td>• Describe why this project is significant and how it will enhance national nursing and midwifery regulation and standards.</td>
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<td>2</td>
<td><strong>Methods</strong></td>
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<td>• List clearly the specific objectives of the proposed regulatory improvement project.</td>
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<td>• List the key activities under each major objective and identify the individual who will be responsible for carrying out each project activity.*</td>
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<td>* Consider using the Project Methods Framework to clearly state the project’s objectives, activities, responsible party, anticipated outputs, outcomes or indicators, as well as any risks and mitigation strategies, as 1 page in the methods section.</td>
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<td>• Describe the anticipated outputs and outcomes from the project activities.</td>
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<td>• Explain how the team will measure and monitor progress towards the project’s activities and objectives (i.e. indicators).</td>
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<td>• Describe how meeting the project objectives will address the problem identified in the issue statement.</td>
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<td><strong>Timeline</strong></td>
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<td>Using the ARC Framework, describe the project activities the country team will implement during each action period.</td>
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<td>• Action Period 1</td>
<td>July 1 – September 30, 2012</td>
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<td>o Outcomes presented at Learning Session 2</td>
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<td>• Action Period 2</td>
<td>October 1 – December 31, 2012</td>
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<td>o Outcomes presented at Learning Session 3</td>
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<td>• Action Period 3</td>
<td>January 1 – March 31, 2013</td>
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<td>o Outcomes presented at Summative Congress (Launch ARC Year 3: June 2013)</td>
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<td>4</td>
<td><strong>Feasibility</strong></td>
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<td>• Describe the strengths, resources and experience that each member brings to the country team’s project.</td>
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<td>• Describe plan for team collaboration and governance and any history of prior collaboration.</td>
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<td>• Describe the feasibility of the project, including possible challenges the team may face in achieving planned objectives and how these will be overcome.</td>
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<td>• Describe other country resources and initiatives that can be leveraged to help achieve your project objectives.</td>
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<td><strong>Budget and Justification</strong></td>
<td>2 pages</td>
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<td>Provide an itemized budget for the total amount of the proposed project and a budget narrative, explaining how the awarded funds will finance project activities and justifying projected expenditures.</td>
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<td>6</td>
<td><strong>Programme Management</strong></td>
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<td>• Identify the authorized <strong>institution</strong> to receive the awarded grant funds.</td>
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<td>• Appoint a representative to serve as the <strong>Team Coordinator</strong> to liaise between the country team and Emory University for the purposes of reporting, planning and technical assistance.</td>
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<td>• Propose a schedule for conference calls with the ARC faculty to discuss project implementation progress and challenges.</td>
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### Section 7: Prior Performance

- State the key outcomes and accomplishments of your country’s previous ARC project.
- Explain how your country team worked together to achieve the stated objectives.
- Explain why any stated objectives were not met.
- Describe challenges encountered implementing the grant, the steps taken to address them, whether you anticipate similar challenges with the proposed project, and why or why not.
- Describe the key benefits your country team experienced by receiving an ARC grant.

### Section 8: Letters of Support

- Provide a letter of support from the agency of each team member.
- Provide letters of support for this project from relevant persons or agencies that will contribute to the feasibility of your country project.

### Formatting

**Font:**
- Times New Roman 12-point and 1.0 line spacing

**Paper size and margins:**
- 8.5 X11” letter for duplication and scanning purposes
- 1 inch margins on all four sides
- Left-align text
- Section headings should be flush left in **bold** type

**Page limit:**
- The narrative document (includes sections 1-6 of the proposal) cannot exceed 10 pages. This does not include letters of support or the application face page.

**Page numbering:**
- Bottom right side of document

### Checklist

- [ ] Face Page: listing all members of the country team with required professional and contact information
- [ ] Narrative Proposal: comprised of sections 1-6 and not more than 10 pages (General/Sponsored)
  OR sections 1-7 and not more than 11 pages (Alumni)
- [ ] Programme Management: be sure that section 6 of the proposal has specified the institution to receive funding and identified the team coordinator
- [ ] Letters of Support: from each members’ institution and other supporting organisations

### Submission

Completed country proposals should be e-mailed as a PDF attachment to Maureen Kelley at makelle@emory.edu by April 20, 2012. Letters of support can be scanned and e-mailed as separate PDF attachments. In order to be considered, proposals must be complete and submitted on time.
## Review Criteria

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<th>Weight</th>
<th>Item</th>
<th>Section of Proposal</th>
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<tr>
<td>25%</td>
<td>Country Collaboration</td>
<td>• Feasibility</td>
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<td>• Letters of Support</td>
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<td>• Programme Management</td>
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<td>• Prior Performance</td>
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<td>What strengths will members of the country team uniquely contribute to the proposed project?</td>
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<td>What is the leadership approach, governance and organisational structure for the project?</td>
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<td>Do team members have a history of successful collaboration on a previous ARC grant or project?</td>
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| 20%    | Approach              | • Methods                             |
|        |                       | • Timeline                            |
|        | Are the project objectives clearly stated? |
|        | Do the project objectives clearly address the problem described in the issue statement? |
|        | Are the project objectives clearly linked to specific project activities? |
|        | Are the project objectives and activities specific, measurable, time-bound and achievable within the ARC timeline? |

| 25%    | Significance         | • Problem Statement                   |
|        |                       | • Methods                             |
|        | How does the project address an important problem or critical barrier in nursing or midwifery regulation, standard setting or practice? |
|        | If your project objectives are achieved, how will nursing and midwifery regulation, standard setting, or practice be improved in your country? |
|        | What will be the overall impact of your project, if successfully implemented? |

| 20%    | Feasibility          | • Feasibility                         |
|        |                       | • Methods                             |
|        |                       | • Letters of Support                  |
|        |                       | • Prior Performance                   |
|        | What factors in the country environment will contribute to project success? |
|        | Are the institutional support and team member expertise adequate to carry out the proposed project? |
|        | Will the project benefit from unique institutional or collaborative arrangements? |
|        | Was the team able to successfully implement an ARC grant or other project in the past? |

| 10%    | Writing              | • Entire Proposal                     |
|        |                       |                                      |
|        | Is the proposal organized and well written? |
|        | Is the proposal formatted according to the application guidelines? |

## Review Process

All applications received by April 20, 2012, that meet the eligibility criteria will be reviewed by the ARC Review Panel, which is comprised of representatives from the CDC, Emory University School of Nursing, the Commonwealth Secretariat and the East, Central and Southern Africa Heath Community (ECSA-HC). Each application will be assigned a primary and secondary reviewer and evaluated according to the review criteria. Each application will receive a technical review, providing a written critique of the proposal, which will be sent out by May 18, 2012.
Notice of Award Status

The announcement of winning grant proposals will be made during the Summative Congress, June 2012. For country teams awarded funding, award notification letters will also be sent to their Ministry of Health.

All country teams awarded funding may be required to respond in a satisfactory manner to questions or concerns raised in the technical review prior to the release of funding. All grants will require a contract with the Task Force for Global Health. A session for grantees will be held during the Summative Congress to begin processing the required paperwork for ARC grants.

In addition, grant awardees will be notified of the schedule for grant reporting, including both progress and budget reports, as well as the final grant report.

Country teams that submit a proposal by the April 20, 2012, deadline, but do not receive grant funding will be offered targeted technical assistance (TA) during ARC Year 2. A session on targeted TA will be held during the Summative Congress.

Letter of Interest

All country teams intending to submit an application should e-mail a letter of interest (LOI) to Maureen Kelley at makelle@emory.edu by March 23, 2012. The LOI should identify the country team members that will submit the ARC proposal. The LOI should also indicate that the Minister of Health is supportive of the country teams’ representative members, as well as their participation in the Summative Congress in June 2012 and two subsequent learning sessions, should the team be awarded funding.

Additionally, the ARC faculty is willing to provide technical consultation to country teams regarding the grant application process. If your country team would like a technical consultation call from a CDC-Emory representative, please request a call in the LOI. Consultation calls will be scheduled via e-mail. ARC faculty can accommodate one technical consultation call per country team. Additional questions concerning the application process can be e-mailed to Maureen Kelley. We look forward to your applications and your participation in ARC!
WRITER’S WORKSHOP
19 June 2012

Country Team Participants:
Ms Glory Msibi and Dr Ruth Mkhonta (Swaziland); Mrs Shelia Bandazi and Mrs Chrissie Chilomo (Malawi); Miss Elsia Sinon, Mrs Winifred Agricole, Miss Suzanne Marie-Antoinette Hoarau and Mrs Jeanine D’Arc Suzette (Seychelles); Mrs Makholu Lebaka and Mrs Flavia Moetsana-Poka (Lesotho)

ARC Faculty:
Dr Maureen Kelley, Ms Pat Riley, Dr Carey McCarthy, Ms Jill Illife, Ms Peggy Vidot, Ms Jessica Gross, Ms Sheena Jacob

The purpose of the Writer’s Workshop was to provide an opportunity for ARC Year 1 grant recipients to prepare an article about their project for publication in the African Journal of Midwifery and Women’s Health. The editorial team from the African Journal for Midwifery and Women’s Health facilitated the workshop. The team consisted of Ms Sophie Gardner, Editor; Dr Christina Mudokwenyu-Rawdon, Editor in Chief; assisted by Dr Grace Omoni, Consultant Editor from Kenya.

SESSION ONE
COUNTRY TEAM EXPERIENCES WITH YEAR 1 GRANTEES
Ms Pat Riley, Team Lead, Health Systems Human Resources, CDC Atlanta

The first session was facilitated by Ms Pat Riley and provided an opportunity for country teams to reflect on their experience with their Year 1 grant in preparation for considering how to turn their experience into a case study for publication in the African Journal of Midwifery and Women’s Health. The country teams represented were Seychelles, Malawi, Lesotho, and Swaziland.

Seychelles:
The team benefited from technical assistance provided by WHO. Prior to the visit, consultation was conducted with stakeholders and lawyers and draft legislative changes prepared. At the end of the visit of the Technical Advisor draft legislative changes were finalised. Since then, meetings have been held with the Attorney General and the new Minister for Health has been briefed. Some difficulties were experienced with political changes internally especially with the appointment of a new Minister for Health. This affected achieving outcomes in the timelines. The team will be requesting an extension of time from the ARC Team to complete the project however do not require any further funding. Another difficulty experienced was who should be the budget holder for the project and it was decided that the Council would be the budget holder and that has worked out well.

The Seychelles proposal was to review the Seychelles Nurses and Midwives Act 1985 to establish a full-time registrar for nursing and midwifery. Seychelles was represented by Miss Elsia Sinon, Mrs Winifred Agricole, Miss Suzanne Marie-Antoinette Hoarau and Mrs Jeanine D’Arc Suzette. The comments from the Seychelles team were as follows:

- Focused on importance of collaboration
- Stayed in contact with ARC all along
- Finished proposal on time and was successful with the proposal
- Noted resources have always been a problem: funding, human capacity, etc.
- One of the objectives was to get help from someone in the region, had help from WHO to pay for the consultants
- Worked closely with several stakeholders, including Ministry of Education
- When the consultant left, continued with the work, consulted attorney general’s office to keep updated; followed up with our additional objectives
- Noted challenges: political changes, economic downturns, etc., which resulted in changes in timelines; however, the team was able to continue with activities
- Budget: Once received disbursement from Emory, had already planned that the Council would manage the budget. The Council also handled meeting planning and other logistics related to implementation of the main activities; the team requested a no-cost extension to continue their project timeline; discovered had to write to the bank to have a separate account for ARC, so ended up having a separate ARC account under the Nursing Council account
- Q: Were the tools provided by ARC adequate for developing the timeline, budget, etc.?
  Overall felt had sufficient guidance from the ARC team; noted after attended the second ARC meeting, the team really benefited from the networking
- Pat emphasized that this team was able to take the seed money from the ARC Year 1 grant to leverage funds from additional donors

Malawi:

Geographic difficulties made it hard for the quad to meet face to face; unreliable internet and phones; and lack of fuel in country. There were also difficulties with political changes in the country and changes in Minister for Health. Working as a quad has been very positive. Tools such as fishbone have been useful not only for project but also in daily work. Some activities which were outsourced were not able to be accomplished because the department who were to undertake the activity wanted too much money to do so. The quad also found it hard at times to fit project work within busy work commitments.
The purpose of the Malawi proposal was to evaluate their existing CPD programme; revisit the implementation strategy to ensure that all nurses and midwives understood the value of CPD; and intensify monitoring and evaluation of CPD across the country in collaboration with all stakeholders. The Malawi team was represented by Mrs Sheila Bandazi and Mrs Chrissie Chilomo. Comments made by the Malawi team are recorded below:

- It was easy for quad members decide on CPD for the regulatory activity to focus on for the proposal since this had already been flagged as a priority activity for the country.
- It was helpful to have collaboration among the quad members; after working together Sheila noted that the NOMN was very supportive of CPD activities once they started working together (previously had not been supportive).
- After attending the second meeting, the proposal was modified to be more practical.
- Had challenges with implementation, e.g. internet, phone issues, fuel shortages, political turnover, etc., but managed to complete most activities.
- Noted there have been several changes in leadership: three changes in Ministers over the past year, the president passed away recently, etc.
- One of our activities they could not complete was the production of IEC materials; they were required to take this activity to the MoH, but the costs of the materials exceeded anticipated costs, so unable to complete this activity.
- Noted that the grant was for a small amount, but they considered this to be seed money; the Council wrote an additional proposal to solicit funds.
- Q: Were the tools provided by ARC adequate for developing the timeline, budget, etc.? Team noted that they had adequate direction to move forward with implementation.

**Lesotho:**

The quad concept has strengthened nursing relationships within the country. The funding was too small to complete all the project activities, however were able to access other funding. It was not easy for team to start however the technical support provided helped us to stand up and start walking. Need to include nursing assistants because they are part of us and they were very enthusiastic. Also had difficulty with shortness of time and competing demands from work. Did some piloting of the CPD framework in four districts and found that many nurses still did not know about it and were negative. Still a lot to do to make sure all nurses are informed. Team had to postpone the launch mainly due to national elections in the country so now the tentative date is 20 or 27 July 2012. Change in quad when CNO retired meant new member needs to be included which destabilises the quad for a while until the new member assimilated. Also political changes in that there is a new coalition government and team do not know how supportive they will be of CPD. There to be a new Minister for Health who has not yet been appointed and there may even be a new Director General of Health. Log book and framework have now been printed. The team benefited from a larger technical working group of nurses in country.
The Lesotho proposal was to develop a national continuing professional development (CPD) programme for nurses and midwives in Lesotho. The Lesotho team was represented by Mrs Makholu Lebaka and Mrs Flavia Moetsana-Poka. Comments by the Lesotho team are recorded below:

- Had support from the Spark project; they are assisting regulatory bodies and nursing associations; the ARC money plus the Spark funds have been extremely helpful
- It was very helpful to have support from both Jill and Carey
- Budgeting: had limited resources for this; the registrar was in charge of this and learned a lot as a result of the activity
- Re: implementation, they encountered challenges, eg: falling behind on their timeline, difficulty with coordinating meetings for stakeholders, challenges with coordination of schedules of quad members with competing activities
- Managed to overcome challenges with scheduling by developing a joint ARC team schedule; eventually managed to sensitize all stakeholders.
- Launch was supposed to be in May, however had to postpone due to national elections, other meetings, etc. Tentative launch is in late July, 2012
- Implementation: Piloted in 2 health centres, initially nurses were negative about CPD – this was new to them; the team realized that they will have challenges with rolling the programme out unless they took time to sensitize nurses in other districts about this
- We have 2 cadres of nurses and nursing assistants – during the ARC period we realized that we had sensitized nurses, but not the nursing assistants; they were as a result very resistant to these changes; but planned for a training and eventually had very positive feedback from them
- Former CNO decided to retire and also had a change in the president of the professional association; the former deputy president is now the president; notes that these changes really affect the dynamics/coordination of the quad
- Given recent election, the quad does not know who the new Minister of Health will be; wonders whether the new Minister will be as supportive of ARC activities; “we are still in limbo as far as ARC is concerned”; it’s possible that the current Principal Secretary will also change; we have taken time to gain her buy-in, but if she changes, what will happen. If she goes we need to start afresh with somebody, which will take more time. It’s always challenging to gain buy-in/support for nursing-specific issues
- Noted already finished drafting and finalizing changes in CPD framework; a technical working group was formed, but is difficult to coordinate the members, the TWG has helped gain buy-in for the activity; the nursing directorate promotes CPD during all supervisory visits in the regions
- Paraphrased quote: ARC has really helped us a lot; there has been a lot of capacity building for writing skills; we expect to learn more during tomorrow’s writers’ workshop
- Noted nurses are very excited by the launch

**Swaziland:**
The funding made it easier to apply for other funding. Very motivated led by the Registrar. Felt confident that they could achieve. Undertook a needs analysis as part of the project and since the Durban meeting, have been developing modules. Conducted train the trainers and developed a log book.
Truly appreciate what ARC has done. Technical assistance has been very beneficial. The team is now working more closely together because of the quad concept. The Council was the budget holder and there was a special budget line for the project. Winning the grant was very exciting; the first time the Council had received a grant. Even the Ministry was excited. Launching the program mid-July and also celebrating the achievements of the Council. Partners in the country now want to be associated with CPD. Time factor of project made it difficult to achieve all activities in short time frame but taught us the importance of collaboration and how to collaborate.

The purpose of the Swaziland project was to establish and sustain a national CPD model based on a needs assessment of practising nurses in Swaziland and other relevant stakeholders. The Swaziland team was represented by Ms Glory Msibi and Dr Ruth Mkhonta. Comments from the Swaziland team appear below:

- Team was very grateful to ARC for ongoing support noting that this is why they have come so far with their activities; the team noted that even though the money appears to be small, they noted that it was of great benefit
- Noted that winning the grant was a very positive experience – this was the first time that the Council had received an award like this
- “If someone stands behind you and says YES, you can do it, you can do it” we are able to achieve many things through ARC.
- “Don’t underestimate small things, they bring a lot to you”
- Was able to leverage additional support; PEPFAR is donating a vehicle to the quad for the purposes of CPD activities
- The team was also very appreciative of Jill’s technical assistance for CPD activities
- Noted strong collaboration among quad members – the Swaziland quad had already been working together closely even prior to the ARC initiative working with them
- After leaving Kenya, we had strong motivation to win an ARC grant award; they developed strong rationale and objectives for their CPD programme
- Once we went home, the Nursing Council established a CPD board; the members of the CPD board started the ball rolling; the MoH designated a CPD coordinator for CPD
- Was helpful to look at the evidence base for CPD activities; we wanted to identify the specific needs of the nurses; carried out a needs assessment; discovered that nurses don’t have support to enable them to assist women during pregnancy as they should; findings were disseminated; a CPD framework was developed through assistance from Jill; it took a week to develop the framework; the framework was developed to stakeholders; subsequently developed a CPD module; ToT workshop was held; also developed a logbook; will be launching the programme in mid-July, 2012
- Registrar noted that the ARC money was wired into the Council account where they monitored how funds were utilized; it was easy for the Council to monitor dollar expenditure.
- Challenges: time for the project was too short; needed longer period to carry out these activities
- Through the programme, the registrar was recognized by the nursing association and awarded a nursing leadership award because of the CPD programme
**Summary Observations – Ms Pat Riley**

Small amount of money however completion of a successful project allows you to apply for other funds. It is also money that you didn’t have before. Even in your own domestic environment you have to do what you can with a finite budget. The ARC funding as it goes direct to nurses it provides an opportunity for nurses to manage their own funding and gain that experience. If you have a lot of money you often don’t need to collaborate. And then what do you do when the money runs out because you haven’t developed the relationships on the ground.

- We are turning the assistance paradigm on its head. Here is money to empower you and to support you to go forward so that you are in the driver’s seat for these programmes.
- The experience helps you to feel confident with your own decision making, etc. Whether we manage a $10,000 or a $10 million programme, it’s through the experience that we are able to grow.
- When there are political changes in the country it is very helpful to have a cohesive voice when you have nursing leaders working together; when you speak collectively you can only advance the profession of nursing and midwifery.
- When we plan programmes for the first time, we want to do everything and we’re very ambitious. The experience of being able to prioritize what you can do when you have limited funds over a short period of time is helpful. We really tried to emphasize going for a “winnable goal” with ARC. Even just a little bit of money to get something launched is helpful.
- When programmes have a lot of money, they don’t have to collaborate. In a strange way this does not lend itself to sustainable coalitions. Sooner or later the big pot of money dries up and in the end, the on the ground relationship required to sustain change is not there. Sometimes we have a hidden advantage with working with small grants since it forces us to work together, etc.

**SESSION TWO**

**THE AFRICAN JOURNAL OF MIDWIFERY AND WOMEN’S HEALTH**

Dr Christina Mudokwenyu-Rawdon

In the second session, Dr Christina Mudokwenyu-Rawdon, Editor in Chief of the African Journal of Midwifery and Women’s Health, gave an overview of the journal. Dr Mudokwenyu-Rawdon said the journal is a voice for African nurses and midwives. The journal was launched in November 2007 by the East, Central and Southern Africa College of Nursing (ECSACON) in collaboration with the British Journal of Midwifery (BJM). The late Helen Lugina (ECSACON), and Tina Lavender and Yana Richens (BJM) were the change agents who initiated the project.

The journal provides a region specific focus on midwifery and women’s health, meeting midwives’ needs in contributing to midwifery and reproductive health issues and being informed about clinical, educational, and other related information.

The journal is a quarterly multidisciplinary and international journal which publishes original research, clinical papers, comprehensive review articles, short reports, and commentaries on reproductive health in Africa. The journal is a forum for authors working in reproductive health and women’s studies in Africa. The journal has three main sections: research and education; clinical studies; and international women’s health issues. It may also include a number of commissioned papers in the areas of policy and professionalism. The editorial board consists of highly qualified and experienced regional and international nurses and midwives. Participants were encouraged to visit the journal at: [http://www.africajournalofmidwifery.com](http://www.africajournalofmidwifery.com).
Ms Gardner suggested that the use of figures and images enhances an article and makes it more interesting for the reader. When using figures and images, Ms Gardner suggested that:

- Images should be relevant and useful
- Include tables and graphs if appropriate
- Some data is more accessible if presented in a table
- Make sure you have permission to reproduce images
- Figures and graphs can be redrawn by a medical illustrator
- Suggest generic image ideas to the editor

The study title is critically important to capture the reader’s interest. The title should be short and succinct. It should capture the essence of the study and key words from the study and must be clearly stated and not vague.

The abstract should be written last, when the article itself has been completed. The abstract should serve as a snapshot, briefly summarising the article and outlining its key points. The abstract should include the purpose and objective; the design and setting; key finding; key conclusion; and implications for practice. It is important that the writer aim for brevity and not exceed the number of words specified by the journal for abstracts.

The introduction is designed to capture the reader’s attention so it should be as interesting as possible. Do not list statistics and facts in the introduction. You are merely trying to whet the appetite of the reader so they continue reading the article. Make a case in the introduction for why the article is important for the reader to read. Give some background information about the problem being studied. Make sure what you write is clear and understandable. Is the importance of the problem sufficiently described? Do the findings have the potential to improve practice?

The literature review is the next section. Is the literature review for the article adequate? Is it contemporary (ie: not too old) and comprehensive? Is it well organised? Are the findings integrated as they relate to each other? Does it reflect relevant background information to the study? Does the literature review establish a base or rationale for the research or study being reported?

The research methodology should be clearly outlined. Is the methodology robust? Is it clearly stated? Is it ethically sound?

Data analysis should form the next section. The question writers should ask themselves is whether the sample size is adequate for the type of data and the number of variables examined. Both qualitative and quantitative data should be included if appropriate: qualitative data analyses words while quantitative data analyses numbers.
When reporting on findings, writers need to consider:

- Have the results of the study been interpreted appropriately?
- Have the limitations to the study been identified?
- Were the results of clinical significance? i.e.: findings that have meaning for the patients or clients in the absence or presence of statistical significance.
- Are the implications for practice discussed?

The discussion section should try to make sense of the findings for the reader with reference to evidence from previous studies drawn from the literature review.

The conclusion to the article should be succinct and contain strong sentences justifying and championing the article. Do the conclusions tie up loose ends, summarise findings, and draw inferences? Can the conclusions be seen to be drawn from the findings? Is there a need for further research? Do the recommendations, if any, flow logically from the present study and relate to the findings?

When completed, Ms Gardner suggested that writers should leave the article for a couple of days before going back and making any necessary changes. It is important also to check and double check all references and to ask a colleague to proof read for spelling, grammar and inconsistencies.

In summary, Ms Gardner recommended writers to think objectively about your article. Does the article represent a contribution to the scientific body of knowledge? Will the article advance practice in the subject area? If the article is a case study, is the subject matter innovative or unusual enough to merit publication? Have you, as the author, clearly demonstrated knowledge and expertise in the study area?

The editorial process generally consists of the following steps: submission, review, resubmission, re-review, and then a final decision regarding publication. The process can take anything from one month to several years, depending on the responsiveness of the author to recommendations made during the review process and the timeliness in resubmitting their article for re-review.

In conclusion, Ms Gardner suggested that writers should acquaint themselves with the journal in which they are seeking publication. They should have confidence in their ability. A strong introduction is one of the most important factors in having an article accepted for publication and being read. Triple check references and do not plagiarise - ever! Most of all; enjoy the process.

**SESSION FOUR**

**BEGINNING THE WRITING PROCESS**

Maureen Kelley

In the last session, the country teams worked together with a facilitator, to begin the process of writing a case study about their project for the African Journal of Midwifery and Women’s Health. Country teams were encouraged to first decide what approach they wanted to take; what were the key messages. They then spent some time developing a draft title and beginning work on the introduction to their article.

Country teams were encouraged to consider authorship of their article and decide who would be the lead author and the order in which authors would be cited. It was stressed to country teams that, as this issue has the potential to cause conflict, it is best to address it before in-depth work on the article is undertaken. Ms Riley suggested that one option is to give points for level of involvement. Ask the questions:

- Whose idea was it in the first place?
- Who was involved in implementing the project?
- Who was involved in collecting the data?
- Who was involved in analysing the data?
- Who was involved in manuscript writing?
Country teams then reflected on what had been learned during the day. Malawi considered it was a good learning experience and that they had spent most of the time crafting the introduction so it ‘captures’ the readers interest and makes them want to read further. Lesotho has been working on the introduction and background which has taken most of their time. Swaziland spent a lot of time thinking about a title which captured the essence of the article. They then worked on the introduction, problem statement and objectives. They started on the literature review but were finding it difficult to find relevant articles. The Seychelles worked on the introduction and background. They have been thinking about the abstract and how to capture the essence of the article in a few words. They also worked on the literature review and appreciated the guidance from the AJM resource people.

Country teams then considered who would be the team leader for writing the article and prepared a draft work plan. Lesotho, Swaziland and the Seychelles decided that the Registrar would be the team leader. Malawi has still to decide. A time-line was established for producing a first draft and an ARC faculty member was allocated to each team to assist with editing, proof reading, and encouragement.

Before the close of the workshop, country teams were invited to share the writing they had accomplished with their peers for review. All country teams said they found it difficult to start writing but felt committed to persevere so the experience they had as ARC grantees could be shared with a wider audience.

In summary, Dr Omoni said one of the best ways of learning how to write well is to critique all the papers you read, learn from other people’s writing, the best and the not so good. Dr Mudokwenyu-Rawdon said she had observed a great deal of commitment from the teams and they had obviously been working very hard on their projects. Dr Mudokwenyu-Rawdon suggested that a future workshop would help teams so they could present their articles to each other for their colleagues to critique.