AFRICAN HEALTH PROFESSIONS

Regulatory Collaborative for Nurses and Midwives

Second Report

Durban South Africa June 2011

Lesotho  Malawi  Mauritius  Seychelles  Swaziland

[Flags of countries]

[Image of group of people]

[Logos of CDC, Emory, Commonwealth Secretariat]
AFRICAN HEALTH PROFESSIONS REGULATORY COLLABORATIVE
PARTNERSHIP FOR EXCELLENCE IN AFRICA’S HEALTH WORKFORCE
Durban South Africa Friday 24 June to Sunday 26 June 2011

CONTENTS

1 Executive Summary 9
2 Introduction to second meeting 11
3 Official welcome and greetings 12
   Ms Chalone Savant; Ms Frances Day-Stirk; Ms Joyce Kamdonyo; Ms Peggy Vidot;
   Ms Patricia Riley; Ms Carey McCarthy
4 Session 1 14
   Country team project progress
   Lesotho; Malawi; Mauritius; Seychelles; Swaziland
5 Session 2 20
   Introduction to quality improvement
   Ms Donna Jacobs: University Research Corporation, South Africa
6 Session 3 23
   Country team break-outs
7 Session 4 24
   Revising nursing and midwifery legislation
   Mr Peter Shayo; Mr André Verani; Ms Genevieve Howse
8 Session 5 28
   Continuing professional development
   Ms Jill Iliffe; Ms Veena Pillay
9 Session 6 32
   Applying quality improvement tools to nursing and midwifery regulation
   Ms Donna Jacobs: University Research Corporation, South Africa
10 Session 7 35
    Country team action planning
11 Session 8 37
    Country team revised action plan presentations
12 Session 9 42
    Validation of regulatory function framework
    Ms Carey McCarthy
13 Session 10 43
    ARC grants administration and management
    Dr Maureen Kelley
14 Session 11 44
    Closing remarks
    Ms Peggy Vidot and Ms Patricia Riley
AFRICAN HEALTH PROFESSIONS REGULATORY COLLABORATIVE PARTNERSHIP FOR EXCELLENCE IN AFRICA’S HEALTH WORKFORCE

ATTACHMENTS

1  Programme for second ARC meeting, 24-26 June 2011 Durban, South Africa
2  Address by Ms Chalone Savant (PEPFAR Provincial Liaison Officer, Durban)
3  ARC work plan reporting template
4  ARC budget reporting template

APPENDICES

1  Presentations
2  Country proposals

ACKNOWLEDGEMENTS

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

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>Quality from whose perspective?</td>
<td>20</td>
</tr>
<tr>
<td>F2</td>
<td>Designing and defining quality</td>
<td>21</td>
</tr>
<tr>
<td>F3</td>
<td>Institutionalisation of quality assurance</td>
<td>21</td>
</tr>
<tr>
<td>F4</td>
<td>Process of quality assurance institutionalisation</td>
<td>22</td>
</tr>
<tr>
<td>F5</td>
<td>Quality assurance and quality improvement</td>
<td>22</td>
</tr>
<tr>
<td>F6</td>
<td>PDSA model</td>
<td>23</td>
</tr>
<tr>
<td>F7</td>
<td>Law to health and health to law</td>
<td>25</td>
</tr>
<tr>
<td>F8</td>
<td>The ARC framework</td>
<td>25</td>
</tr>
<tr>
<td>F9</td>
<td>Malawi CPD programme</td>
<td>25</td>
</tr>
<tr>
<td>F10</td>
<td>The reality check</td>
<td>26</td>
</tr>
<tr>
<td>F11</td>
<td>Histogram</td>
<td>32</td>
</tr>
<tr>
<td>F12</td>
<td>Process mapping key</td>
<td>32</td>
</tr>
<tr>
<td>F13</td>
<td>Process map or flow chart</td>
<td>33</td>
</tr>
<tr>
<td>F14</td>
<td>Fishbone diagram</td>
<td>34</td>
</tr>
<tr>
<td>F15</td>
<td>Gantt chart</td>
<td>34</td>
</tr>
<tr>
<td>F16</td>
<td>CPD as a staged process</td>
<td>42</td>
</tr>
<tr>
<td>F17</td>
<td>Legislation review as a staged process</td>
<td>43</td>
</tr>
</tbody>
</table>
AFRICAN HEALTH PROFESSIONS REGULATORY COLLABORATIVE PARTNERSHIP FOR EXCELLENCE IN AFRICA’S HEALTH WORKFORCE

LIST OF ABBREVIATIONS

AIDS     Acquired Immune Deficiency Syndrome
ARC     African Health Professions Regulatory Collaborative
ART     Anti-retroviral therapy
CDC     US Centers for Disease Control and Prevention, Atlanta, Georgia
CEO     Chief Executive Officer
CNF     Commonwealth Nurses Federation
CNO     Chief Nursing Officer
CPD     Continuing Professional Development
ECSA    East, Central and Southern Africa region
ECSA-HC East, Central and Southern Africa Health Community
FPD     Foundation for Professional Development
HIV     Human Immunodeficiency Virus
ICM     International Confederation of Midwives
ICN     International Council of Nurses
LNC     Lesotho Nursing Council
NGO     Non-governmental organisation
NCM     Nursing Council of Mauritius
NMCM    Nursing and Midwifery Council of Malawi
PEPFAR  United States President’s Emergency Plan for AIDS Relief
QA      Quality assurance
SNMC    Seychelles Nursing and Midwifery Council
TQM     Total quality management
TB      Tuberculosis
URC     University Research Corporation
WHO     World Health Organization
AFRICAN HEALTH PROFESSIONS REGULATORY COLLABORATIVE
PARTNERSHIP FOR EXCELLENCE IN AFRICA’S HEALTH WORKFORCE
Strengthening nursing and midwifery regulation and practice in Africa
Durban South Africa 24-26 June 2011

1. EXECUTIVE SUMMARY

The Commonwealth Secretariat; 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; and the East, Central and Southern Africa Health Community (ECSA-HC), 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 aims to improve care 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.

Preliminary discussions on a regional approach to strengthening nursing and midwifery took place in April 2010 when PEPFAR and World Health Organization (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 are harmonised in the ECSA region that align with global standards.
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 councils 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 brought together Chief Nursing Officers, Registrars of Nursing and Midwifery Councils, the Presidents of National Nursing and Midwifery Associations, and a representative of training institutions from 14 countries in the ECSA region.
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. Thirteen Commonwealth countries in the ECSA region were represented: Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Uganda, United Republic of Tanzania, and Zambia as well as Zimbabwe, and representatives from the CDC, Emory University, the Commonwealth Secretariat, the World Health Organization, the Commonwealth Nurses Federation, the International Council of Nursing, the International Confederation of Midwives, and the East, Central and Southern Africa Health Community, plus invited guests and speakers.

The specific objectives of the first quarterly 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, 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 the African Health Professions Regulatory Collaborative was held in Durban, South Africa from 24 to 26 June 2011. Representatives from countries which were successful in their funding applications for ARC grants were invited to the meeting. The countries attending were: Lesotho, Malawi, Mauritius, Seychelles and Swaziland. The learning objectives of the meeting were:

1. To equip ARC country teams with improvement principles and tools to revise and strengthen their action plans.
2. To engage global and regional experts in the provision of technical assistance to strengthen ARC country team action plans.
3. To facilitate interactive sessions to foster peer learning in nursing and midwifery regulation.
The second meeting 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.

Technical expertise at the meeting was provided from the ARC CDC and Emory University team consisting of: Ms Patricia Riley, Dr Maureen Kelley, Ms Kitty McFarlane, Ms Alexandra Zuber, Ms Jessica Gross, Ms Carey McCarthy and Mr André Verani. Ms Peggy Vidot from the Commonwealth Secretariat and Ms Joyce Kamdonyo from ECSA-HC represented the other partners in the ARC initiative. Invited technical experts included: Ms Chalone Savant (PEPFAR Provincial Liaison Officer Durban); Ms Donna Jacobs (University Research Corporation, South Africa); Mr Peter Shayo (Consulting advocate and legal adviser for the ECSA-HC); Ms Genevieve Howse (Legal practitioner and legislation adviser from Howse Fleming Consulting); Mr Gustav Mayo (Tanzania Nurses and Midwives Council); Ms Veena Pillay (Foundation for Professional Development); and Ms Jill Iliffe (Commonwealth Nurses Federation).

As three of the successful proposals related to continuing professional development and two to regulation, presentations to the country teams were organised from technical experts in these areas. Additionally, countries were provided with a comprehensive presentation on quality, quality assurance, quality improvement, and using quality improvement tools to review and refine their proposals. Countries were provided with examples of quality improvement tools and given an opportunity to apply these tools to their proposals. Revised proposals were submitted to the meeting for peer review with a final draft to be forwarded to the ARC team for comment and approval following the meeting. Necessary technical assistance was also organised for each team following the meeting to assist them to meet their proposal objectives.

A third meeting was scheduled for Arusha, Tanzania, in October 2011, to provide an opportunity for successful countries to report on their progress; 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 SECOND MEETING

The second meeting of the African Health Professions Regulatory Collaborative was held in Durban, South Africa, on 24 to 26 June 2011. Representatives from countries which were successful in their funding applications for ARC grants were invited to the meeting. The countries attending were: Lesotho, Malawi, Mauritius, Seychelles and Swaziland. The learning objectives of the meeting were:

1. To equip ARC country teams with improvement principles and tools to revise and strengthen their action plans.
2. To engage global and regional experts in the provision of technical assistance to strengthen ARC country team action plans.
3. To facilitate interactive sessions to foster peer learning in nursing and midwifery regulation.

The US Centers for Disease Control and Prevention and the Emory University Team consisted of: Ms Patricia Riley, Dr Maureen Kelley, Ms Kitty McFarlane, Ms Alexandra Zuber, Ms Jessica Gross, Ms Carey McCarthy, and Mr André Verani. Ms Peggy Vidot from the Commonwealth Secretariat and Ms Joyce Kamdonyo from the East, Central and Southern Africa Health Community represented the other partners in the ARC initiative.

Invited technical experts included: Ms Chalone Savant (PEPFAR Provincial Liaison Officer Durban); Ms Donna Jacobs (University Research Corporation, South Africa); Mr Peter Shayo (Consulting advocate and legal adviser for the East, Central and Southern Africa Health Community); Ms Genevieve Howse (Legal practitioner and legislation adviser from Howse Fleming Consulting); Mr Gustav Mayo (Tanzania Nurses and Midwives Council); Ms Veena Pillay (Foundation for Professional Development); and Ms Jill Iliffe (Commonwealth Nurses Federation).

The purpose of the meeting was to provide an opportunity for successful countries to be supported in refining their funding proposal following input from the ARC team, from invited technical experts and from other countries and develop action plans that were measurable and achievable.
3. **OFFICIAL WELCOME AND GREETINGS**

   Facilitator: Ms Peggy Vidot, Commonwealth Secretariat

Welcome and greetings to delegates were given by Ms Chalone Savant, PEPFAR Provincial Liaison Officer based in Durban; Ms Frances Day-Stirk, President of the International Confederation of Midwives; Ms Joyce Kamdonyo, from the East, Central and Southern Africa Health Community; Ms Peggy Vidot, from the Commonwealth Secretariat; and Patricia Riley and Carey McCarthy from the United States Centers for Disease Control and Prevention.

Ms Chalone Savant, PEPFAR Provincial Liaison Officer provided an inspiring opening address. Ms Savant commented that:

‘To be a nurse today in Africa is about the most difficult job I can think of, and it’s understandable why so many nurses take their valuable sought-after skills to other parts of the world where the pay and working conditions are much better. I wish to encourage and remind you of your power; your potential; and that you can and must change the world you live in.

‘Think about this - YOU are the ones who are there every day doing the work - you have the power to change everything - to turn this whole situation around, and no one else can do it – only you. This era is your era to rise up and take control of the health care situation that is in your hands. Yours are the hands that care, that have compassion, that can heal, that understand. Yours are the hands that will deliver the life-saving drugs to men, to women, to children, to babies. Yours are the hands that will welcome young people into clinics to hear about how to keep themselves safe in very unsafe times. Yours are the hands that will help to circumcise millions in an effort to keep our future husbands and fathers alive to raise their children for another tomorrow. Yours are the hands that will safely deliver those children that will lead us, hopefully, into a future without HIV and AIDS. Now THAT is POWER.'
‘There can be no doubt that the burden on you now and in the coming years is tremendous. There can be no doubt that it is more than should be expected of you and that it is more than can ever be properly compensated. There can be no doubt that you will be asked to take on more and more responsibility in order to bridge the gap between a reactive and emergency health care system to one that promotes good health for prevention of disease and extension of life for all. The onus is on you to get us there. You are the leaders and the warriors of this battle - please don’t give up in the middle of the war even though it is difficult and unfair and too much work and not enough pay. Please don’t give up now. We will never win without you. You are the most important people in this fight - and this is the fight of the century for this continent.

‘As you deliberate and work together over the next few days, remember your burden, remember your potential, and remember your power. Open your minds and grab hold of creative ideas that can change the future of health care and nursing. You know more than anyone else, what it will take to change your communities, in terms of task shifting, task sharing, empowering, employing, training, capacitating, trusting, and deploying. You know more than anyone else, how you will turn HIV and AIDS and TB in Africa around. Don’t leave it to others - they are counting on you to take the responsibility and to show the way. I’m looking at a room full of people who have the POWER - please use it!’ (Ms Savant’s full address can be found at Attachment 2).

Ms Frances Day-Stirk, Director of Learning Research and Practice Development at the Royal College of Midwives in London, United Kingdom and newly elected President of the International Confederation of Midwives (ICM) brought greetings to participants from the ICM and mentioned some of the highlights from the 29th Triennial ICM Congress held in Durban on 19 to 23 June 2011. A new report, The State of the World’s Midwifery: delivering health, saving lives, was launched at the Congress.

The report, supported by 30 partner organisations, provides the first comprehensive analysis of midwifery services and provides new information and data gathered from 58 countries in all regions of the world. The report confirms that the world lacks some 350,000 skilled midwives: 112,000 in the neediest 38 countries surveyed – to fully meet the needs of women around the world available. The report is available from: http://www.unfpa.org/sowmy/report/home.html.

Ms Joyce Kamdonyo from the East, Central and Southern Africa Health Community (ECSA-HC) emphasised the importance of the ARC initiative to the ECSA region. She congratulated the successful countries and stressed their responsibility to bring their projects to a successful conclusion and share the outcomes with other countries in the region. Ms Kamdonyo pledged the support of ECSA-HC to provide, within their capacity, technical assistance and advice to the successful countries.

Ms Peggy Vidot welcomed participants on behalf of the Commonwealth Secretariat and congratulated the countries which were successful in their funding applications to the ARC initiative. Ms Vidot said she was looking forward to the presentation of the proposals from the successful countries and was confident of a positive outcome from their activities. Ms Vidot confirmed the commitment of the Commonwealth Secretariat to supporting countries in the ECSA region to strengthen nursing and midwifery regulation, standards and practice.
Ms Patricia Riley from the United States Centers for Disease Control and Prevention (CDC) also congratulated successful countries. She advised participants that there was a very competitive field of ten proposals. Originally only four proposals were to be funded, however funding was made available to fund five proposals: three focused on developing and implementing national continuing professional development programmes (Lesotho, Malawi and Swaziland) and two focused on changes to nursing and midwifery regulation as contained in their nursing and midwifery Acts (Mauritius and Seychelles). Ms Riley said that the CDC was committed to working with countries so that the proposals had a successful outcome within the required time frame and budget.

Ms Carey McCarthy is a PhD candidate working with the CDC as a Research Fellow to develop an evaluation framework to measure the impact of the ARC initiative. At the initial ARC meeting in Nairobi, Kenya in March 2011, a baseline survey was conducted and the preliminary results reported on in the first ARC report.

Ms McCarthy explained that the purpose of the evaluation framework was to develop indicators of progress toward country project objectives as well as the overall impact of the project; assess ARC activities and progress toward overall ARC objectives at the end of each year and at the end of the four-year cycle; and to create a framework outlining the key stages in nursing and midwifery regulatory functions as well as validate regionally relevant tools to document and plan progress in key nursing and midwifery regulatory functions.

Ms McCarthy envisaged four stages in the process (see below). She advised that during the current meeting, each country would be provided with the opportunity to meet individually with subject matter experts to decide on key regulatory functions; establish the specific stages of each function; and develop indicators to objectively distinguish between stages and measure progress.

Ms McCarthy stressed that countries should view their proposals as a staged process and gave examples of what a staged process might look like for developing a national CPD programme or undertaking regulatory reform. When reviewing and refining their proposals, Ms McCarthy suggested that countries consider their proposals in the four stages of: planning, developing, advancing, and optimising and develop objectives and actions for each stage so that one stage builds on the success of the preceding stage.

4. **SESSION 1**

*Country team project progress*

Lesotho, Malawi, Swaziland, Mauritius, Seychelles
LESOTHO

The Lesotho country team consists of: Mrs Nthabiseng 'Makholu Lebaka (President, Lesotho Nurses Association); Mrs Tjoetso Veronica Lehana (representing Lesotho nurse training institutions); Mrs Mantsebo Moji (Chief Nursing Officer); and Mrs Flavia Moetsana-Poka (Registrar, Lesotho Nursing Council).

The Lesotho proposal was to develop a national continuing professional development (CPD) programme for nurses and midwives in Lesotho. As background information, the Lesotho team explained that the Lesotho Ministry of Health and Social Welfare has developed a continuing education strategy for all health care workers in Lesotho (Continuing Education Strategy March 2010 - Ministry of Health and Social Welfare Human Resources Technical Working Group) and that the professional regulatory bodies are required to ensure the compliance of the members they regulate with the implementation of the strategy.

Nurses and midwives in Lesotho have expressed concerns about the lack of opportunities for continuous professional development within the Lesotho health service. This negative perception impacts on the morale and motivation of health workers and contributes to poor service delivery and some professionals leaving their jobs. If CPD is regulated well, the following benefits could be achieved:

* Giving people of all ages the opportunity to grow personally, professionally and academically.
* Enabling professionals to stay up to date with professional and organisational changes.
* Assisting professionals who are contemplating a change in position, job, or career.
* Acquiring new knowledge and skills and upgrading competencies.
* Helping employers and employees to increase productivity and effectiveness and improving the quality of services.

Since the CPD concept is new in the country, the Lesotho Nursing Council (LNC) lacks the capacity to handle it and there is therefore a need to capacitate the Credentials Committee of the LNC in this field. The broad objective of the Lesotho proposal is to build capacity for the Lesotho Nursing Council to enable them to develop, implement and monitor the CPD programme. Specific objectives are to:

* Introduce the CPD concept to LNC members.
* Capacitate the LNC to develop CPD guidelines for nurses and midwives in Lesotho.
* Capacitate the Credentials Committee of the LNC to implement and monitor the CPD programme.

The Lesotho team anticipate that the outcomes of the proposal will be that the LNC will be able to:

* develop CPD guidelines for nurses and midwives in Lesotho;
* implement the CPD programme for nurses and midwives in Lesotho; and
* monitor the implementation of the CPD programme.
MALAWI

The Malawi country team consists of: Mrs Sheilla Bandazi (Director of Nursing Services, Ministry of Health); Mrs Martha Mondiwa (Registrar, Nurses and Midwives Council of Malawi); Mrs Rose Wasili (representing Malawi educational institutions); and Mr Jonathan Abraham Gama (President, National Organisation of Nurses in Malawi).

Mrs Sheilla Bandazi; Mrs Martha Mondiwa; and Mrs Rose Wasili

The Malawi Nurses’ Act requires nurses and midwives to undergo “in-service education or a refresher course within a specified time period before renewal of registration” and gives the Nursing and Midwifery Council of Malawi (NMCM) a specific mandate to enforce the Act. In meeting this mandate, the NMCM have developed a national CPD programme for nurses and midwives. The initial phase of the CPD programme in Malawi focused on creating a data base at the secretariat; building human resource capacity (trainers) to implement the CPD programme; developing guidelines and logbooks; and orienting nurses and midwives to the need for CPD activities and its implication to their practice.

Almost one year after starting the CPD programme in Malawi, it is facing a number of challenges such as: the capacity to implement the programme at both secretariat and national level; an inadequate number of trainers to reach out to all health facilities; the inability of nurses and midwives to attend CPD sessions because of their workloads; the difficulty for nurses and midwives in understanding the CPD guidelines, completing the CPD logbook, and accumulating the necessary number of CPD points. The CPD facilitators, who were initially trained by the NMCM, are also facing challenges in understanding the CPD process and there has been a lack of collaboration among stakeholders to ensure that the CPD programme objectives are met. The NMCM proposal is to evaluate the 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.

The overall goal of the Malawi proposal is therefore to have a well-established and coordinated CPD programme for all nurses and midwives in Malawi through mainstreaming CPD activities. The specific objectives are to:

- have more trained facilitators who can understand and guide the CPD process,
- strengthen the monitoring and evaluation of CPD activities at the national level,
- increase the sensitisation campaign on the importance of well-coordinated CPD activities for nurses and midwives in Malawi, and
- strengthen the collaboration between all stakeholders on the implementation of the CPD programme in the country.
The Mauritius country team consists of: Mr Krist Dhurmah (Secretary, Nursing Association of Mauritius); Mr Anil Kumar Suggun (Chairperson, Nursing Council of Mauritius); Mr Sylvio Pierre (Chief Nursing Officer); and Mr Harilall Mungroo (representing nursing academic institutions).

Before 1980 there were two types of personnel teaching nurses in Mauritius: the nurse-tutor lecturing in the school of nursing, and the clinical instructor who was responsible for the practical teaching of student nurses at the placement level. During the post-independence era, the country started to experience a shortage of nurse tutors as there was expansion of the Central School of Nursing and only a few nurses were interested in going for further training in the field of nursing education.

A major problem that is affecting the whole health system in Mauritius is the lack of nursing and midwifery educators to prepare adequate professionals to meet immediate and long term needs in terms of the health workforce. The qualifications of both nurse-tutor and clinical instructor with only a few years of teaching experience in various nursing specialties, was accepted by the Public Service Commission as adequate qualification for the position, however today, nurse-educators in other countries have upgraded their qualification to degree level to keep pace with global trends.

As from 2005, a private college of nursing was established in Mauritius. This major development triggered the nursing regulatory body, the Nursing Council of Mauritius (NCM), established under the act of 2003, to look toward standardising and legalising the teaching qualification for nursing and midwifery educators in both public and private training institutions. With the opening of the first private school of nursing offering the Diploma in Nursing programme and concurrently following the recommendation of the Ministry of Health and Quality of Life to introduce the Diploma in Nursing programme for nurses educated in the public sector, it has become a matter of urgency for the NCM to standardise and legalise the qualifications for nursing and midwifery educators both in public and private nurse training institutions.

The objective of the proposal is to insert into legislation and regulation standardised qualifications for nursing and midwifery educators covering both the public and private sector. The specific objectives are to:

* Raise the profile of nursing and midwifery educators so they meet the global standard. This will also enable locally trained nursing and midwifery educators to teach and gain experience in other countries.
* Harmonise the qualifications of nursing and midwifery educators teaching in both the public and private sectors.
* Attract more nurses and midwives to teach nursing and midwifery by raising the standard of nursing and midwifery education. This will address the current shortage of nursing and midwifery educators.
* Assert the role of the NCM as being the body responsible for the regulation of nursing and midwifery, including educational standards and required qualifications of nursing and midwifery educators in Mauritius.
SEYCHELLES

The Seychelles country team consists of: Ms Winifred Agricole (Registrar, Seychelles Nurses and Midwives Council); Ms Bella Henderson (Chief Nursing Officer); Ms Marie-Antoinette Hoarau (President, Seychelles Nursing Association); and Ms Beryl Camille (representative of a nursing educational institution).

The Seychelles proposal is to review the Seychelles Nurses and Midwives Act 1985 to establish a full-time registrar for nursing and midwifery. The 1985 Act governs the functions of the Seychelles Nurses and Midwives Council (SNMC).

Standards for post-secondary education, including nursing education, are set by the Seychelles Qualification Authority. While this has been a positive move for nursing and midwifery, the SNMC is not visible and does not have much authority in nursing educational institutions. This lack of capacity has had major impact on the development of nursing and midwifery regulation in Seychelles. The current Act does not specify the appointment and position of the Registrar as being a nurse or midwife. Nurses and midwives however, account for the bulk of the health workforce and continue to deliver high quality care. The success of their work is evidenced through the country’s health indicators. An efficient regulatory system to regulate and enhance the quality of their contribution is however lacking.

Revising the Act aims to provide legislation which guarantees protection for the public but also allows for the growth of nursing and midwifery. The primary objective is to review the Seychelles Nurses and Midwives Act 1985 to establish a full-time registrar for nursing and midwifery. Specific objectives are to:

* Gain support for the review from stakeholders and sensitise them to the need for the review.
* Review existing regional and international Nurses and Midwives Acts for guidance.
* Define the roles and responsibilities of a dedicated Registrar of the Council.
* Obtain technical assistance with the drafting of the changes to the Act.
* Propose specific changes to the Act and produce a revised Act.
* Gain legislative approval for the changes to the Act.
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).

Currently in Swaziland none of the regulatory bodies have specific CPD requirements for re-licensure, however the National Health Policy and proposed legislation will require nurses to show evidence of CPD as a requirement for licence renewal in the future. The majority of nurses in Swaziland are stationed in rural areas with limited access to further education and training. Professional isolation as a result of working in remote areas without the benefits of CPD to update practitioners about new developments in the health field has the potential to erode the quality of services provided to communities. The currently ad hoc CPD offerings do not necessarily address nurses’ learning needs styles and preferences; apply advances in educational research to ensure instructional best practices; or engage in and support the process of nurses’ self-directed learning.

Although CPD activities take place almost continually throughout the year, it is doubted if the activities are effective, adequate, well planned or even relevant to the needs of the participants or society. The current approach to CPD is most often characterised by didactic learning methods and teacher-driven content that may or may not be relevant to clinical setting of the learner. It is essential that Swaziland begins the process of developing a system for CPD in line with the proposed future government requirements.

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

* Identify the actual and potential CPD needs of nurses, midwives and other relevant stakeholders.
* Review the CPD inventory and map the CPD involvement of nurses and midwives practising in Swaziland.
* Develop a CPD model for nurses in Swaziland based on the identified needs.
* Develop a marketing system for a national CPD programme.
* Develop a list of relevant teaching and learning materials, equipment and supplies needed to provide CPD.
* Mobilise resources for ensuring continued sustainability of a national CPD programme.
* Develop a monitoring and evaluation framework for a national CPD programme.
Ms Donna Jacobs is based in South Africa and is the Country Director for the Health Care Improvement Project of the University Research Corporation (URC) which is based in Maryland, USA. The URC has been providing innovative, evidence-based solutions to health and social challenges worldwide for over 45 years and is currently working in 30 countries. 

In this session, Ms Jacobs introduced the concepts of quality, quality assurance and quality improvement. A subsequent session will explore quality improvement tools for total quality management. The dimensions of quality include: access to services; effectiveness; interpersonal relations; efficiency of service delivery; continuity of services; safety; and physical infrastructure and comfort. Ms Jacobs explained that it was important to look at quality from a number of perspectives: clients; providers; health care managers; and the community.

Figure 1: Quality from whose perspective?

From a systems point of view, quality can be divided into: inputs (resources such as people, equipment, supplies, infrastructure and information technology); processes (activities such as what is done and how it is done); and outcomes (results such as health services delivered, changes in health behaviour, change in health status, client satisfaction).

Ms Jacobs explained that there is a cost to quality. Quality control costs such as prevention costs and appraisal costs are necessary for achieving high quality; quality failure costs (internal and external) are the consequences of poor quality. The costs of poor quality are: death, prolonged illness, misdiagnosed patients, incorrect treatment, and incorrect use of drugs such as antibiotics, however these are only the tip of the iceberg. There are less obvious costs such as: wasted materials, wasted time, dissatisfied patients, suspicious community, unnecessary services, frustrated workers, dissatisfied managers, lost productivity, prolonged infectiousness, and legal actions.

Ms Jacobs defined quality assurance as: a set of activities that are carried out to set standards in order to monitor and improve performance so that the care provided is as effective and as safe as possible. The core activities of quality assurance are: designing and defining quality; measuring quality; and improving quality.
Ms Jacobs outlined ten steps in the quality assurance process:
1. Planning for quality assurance,
2. Setting standards,
3. Communicating standards,
4. Monitoring,
5. Identifying the problem,
6. Defining the problem operationally,
7. Choosing a team,
8. Identifying the root causes,
9. Developing solutions and actions, and
10. Implementing and evaluating the quality improvement effort.

Ms Jacobs explained that quality assurance needs to be an integral part of the way any institution operates, by being embedded into its core values; by the provision of an enabling environment; and by the provision of leadership, policy and resources.
Institutionalising quality assurance, Ms Jacobs explained, is a process that evolves over time as the capacity for quality assurance matures.

**Figure 4: The process of quality assurance institutionalisation**

Ms Jacobs defined quality improvement as an organisational approach to improve the quality of care and services using a specified set of principles and methodologies. It is a continuous, ongoing process which represents a strategic and systematic approach to meet the needs of those we serve by applying simple, proven and effective quality improvement tools and methodologies in the areas of: safety, effectiveness, patient-centredness, timeliness, efficiency and equity.

Ms Jacobs explained that there are some basic differences between quality assurance and quality improvement.

**Figure 5: Quality assurance and quality improvement**

<table>
<thead>
<tr>
<th></th>
<th>QUALITY ASSURANCE</th>
<th>QUALITY IMPROVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation</td>
<td>Measuring compliance with standards</td>
<td>Continuously improving processes to meet standards</td>
</tr>
<tr>
<td>Means</td>
<td>Inspection</td>
<td>Prevention</td>
</tr>
<tr>
<td>Attitude</td>
<td>Required, defensive</td>
<td>Chosen, proactive</td>
</tr>
<tr>
<td>Focus</td>
<td>Outliers: 'bad apples' Individuals</td>
<td>Processes Systems</td>
</tr>
<tr>
<td>Scope</td>
<td>Medical provider</td>
<td>Patient care</td>
</tr>
<tr>
<td>Responsibility</td>
<td>Few</td>
<td>All</td>
</tr>
</tbody>
</table>

Applying quality improvement means asking a number of questions:

1. Why do you need improvement (purpose of improvement effort)?
2. What are you trying to accomplish (improvement aim)?
3. What change will lead to an improvement (developing and testing changes)?
4. How do we know if there is improvement (measurement data)?
Ms Jacobs concluded by explaining the 'PDSA' cycle of: plan, do, study and act and encouraged country teams to apply the PDSA model when reviewing their proposals.

**Plan:** objectives; questions and predictions (why?); planning (who, what, where, when); plan for data collection; communicate the change and engage the stakeholders.

**Do:** carry out the plan; document problems and unexpected observations; and begin data analysis.

**Study:** complete the analysis of the data (impact of intervention); compare data to predictions; and summarise what was learned.

**Act:** take action based on results; what changes are to be made; and next cycle?

### 6. SESSION 3

**Country team break-outs**

During this session each country team was provided with an opportunity to meet with a member of the ARC initiative or a technical expert to discuss their proposal. There were two areas for discussion:

**Track 1:** Feedback on Regulatory Function Framework;

**Track 2:** Feedback on Grant Reporting.

**Country**

<table>
<thead>
<tr>
<th>Country</th>
<th>Grant Reporting</th>
<th>Regulatory Function Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>LESOTHO</td>
<td>Ms Carey McCarthy</td>
<td>Ms Kitty MacFarlane</td>
</tr>
<tr>
<td>MALAWI</td>
<td>Ms Carey McCarthy</td>
<td>Ms Patricia Riley and Ms Jessica Gross</td>
</tr>
<tr>
<td>MAURITIUS</td>
<td>Ms Carey McCarthy</td>
<td>Mr Peter Shayo and Dr Maureen Kelley</td>
</tr>
<tr>
<td>SEYCHELLES</td>
<td>Ms Carey McCarthy</td>
<td>Mr André Verani and Peggy Vidot</td>
</tr>
<tr>
<td>SWAZILAND</td>
<td>Ms Carey McCarthy</td>
<td>Ms Alexandra Zuber and Dr Joyce Kamdonyo</td>
</tr>
</tbody>
</table>

Ms Jacobs concluded by explaining the 'PDSA' cycle of: plan, do, study and act and encouraged country teams to apply the PDSA model when reviewing their proposals.

**Plan:** objectives; questions and predictions (why?); planning (who, what, where, when); plan for data collection; communicate the change and engage the stakeholders.

**Do:** carry out the plan; document problems and unexpected observations; and begin data analysis.

**Study:** complete the analysis of the data (impact of intervention); compare data to predictions; and summarise what was learned.

**Act:** take action based on results; what changes are to be made; and next cycle?
Mr André Verani is from the US Centers for Disease Control and Prevention in Atlanta, Georgia; Mr Peter Shayo is consulting advocate and legal adviser for the East, Central and Southern Africa Health Community; and Ms Genevieve Howse is a legal practitioner and legislation adviser from Howse Fleming Consulting based in Melbourne, Australia.

**MR PETER SHAYO** presented a case study from Tanzania’s Nurses and Midwives Act 2010 titled: *Regulation of Health Profession*. Mr Shayo explained that the purpose of legislation was to protect, promote and preserve public health, safety and welfare through regulation and control of nursing and midwifery education and practice. The Tanzania Nursing Council is comprised of: a Chairperson appointed by the Minister of Health and Social Welfare from among the senior registered nurses; a Registrar (who is the Secretary and CEO of the Council) appointed by the Minister (must be a senior registered nurse or midwife); the Chief Nursing and Midwifery Officer; a representative from the training section of the Ministry of Health and Social Welfare; the State Attorney from the Attorney General’s chambers; and two members of the public, one of whom must be a woman. The Council has the authority to co-opt a person who has special knowledge and skill to provide expertise on a particular issue.

The role of the Council, among other things, is to issue licences for nurses and midwives; caution, censure, suspend or terminate nurses and midwives convicted of malpractice, negligence or improper conduct; remove the names from the register of nurses and midwives who have died or who have not practised in Tanzania for the past five years; and advise the Minister of Health and Social Welfare on matters concerning nurses and midwives. There is a system for investigating complaints against nurses and midwives who have the right to be heard and of appeal.

The Council also approves new schools for nurses and midwives; and establishes standards and grants licences for nursing homes and maternity clinics. The Council is supported by several committees which are answerable to the Council, for example: Finance; Education and Professional advancement; Ethics and Discipline; Research; and Registration and Enrolment. The Council is a legal entity in its own right and is capable of suing and being sued and of acquiring and disposing of immovable and movable property.

Proof of attendance at CPD activities is one of the criteria for the renewal of licence. The nurse or midwife is responsible for maintaining a record of their CPD activities. The Council also makes rules requiring nurses and midwives to have practised for a prescribed period in order for their licence to be renewed.

The title for **MR ANDRÉ VERANI’S** presentation was: *Measuring law for health: frameworks and practice*. Mr Verani shared with participants the health system building blocks determined by the World Health Organization (2010) which are: service delivery; health workforce; health information systems; access to essential medicines; financing; and leadership and governance. Mr Verani explained that there are two sets of indicators for monitoring health system governance (WHO 2010):

- **Rules-based indicators** measure whether countries have appropriate policies, strategies and codified approaches for health system governance.
- **Outcome-based indicators** measure whether rules and procedures are being effectively implemented or enforced, based on the experience of relevant stakeholders.


Mr Verani asked participants which building blocks applied to their project: how they had assessed whether their country has appropriate policies – rules based (*compare to ICN and ICM gold standard*) and how they had assessed whether their country’s policies are implemented - outcomes based (*collect data from health workers, patients*). Mr Verani explained the interaction and interdependence between the law and health.
Mr Verani went on to explain the ARC framework and how the partnership between Ministries of Health, regulatory councils, professional associations and training institutions linked to professional standards, pre-service and continuing education, service delivery and health policies and provided a voice to government for members and patients.

Mr Verani used Malawi’s CPD programme as an example of how all these aspects linked together:

**Figure 8: The ARC framework**

<table>
<thead>
<tr>
<th>Law</th>
<th>Regulatory body established by law</th>
<th>Regulation of profession</th>
<th>Measurement of CPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses and Midwives Act 1995</td>
<td>Nurses and Midwives Council Malawi</td>
<td>Continuing Professional Development</td>
<td># of nurses and midwives (HRIS) # aware of CPD requirements # in compliance # not compliant # penalties for non-compliance # penalties issued by type # disaggregation by facility, district, province, cadre, etc</td>
</tr>
</tbody>
</table>
Mr Verani concluded by advising participants to regularly undertake reality checks of their progress involving stakeholders to make sure they stayed on track to achieve their objectives.

**Figure 10: The reality check**

The presentation by **Ms Genevieve Howse** focused on how the law can help to provide a better practice environment. Ms Howse told participants that legislation and regulation are mechanisms to strengthen the profession of nursing and midwifery. She asked the questions: *Why regulate the health professions?* and *Why get involved in the process of legislation review?* Ms Howse explained that she used the term ‘regulation’ to cover the full range of legal instruments by which governing institutions, at all levels of government, impose obligations or constraints on their constituents: constitutions, parliamentary laws, subordinate legislation, decrees, orders, norms, licenses, plans, codes and even some forms of administrative guidance.

The statutory regulation of health professionals is a mechanism to protect the public by setting minimum standards of education, experience, clinical and ethical competence for entry into a profession. It represents sound stewardship, good governance and effective health workforce management. The WHO endorse the development of regulatory systems and processes for the accreditation, licensing and certification or credentialing of all categories of the health workforce, including professional codes of practice and cross-border recognition of health worker competencies; and the promotion of professional and regulatory body responsibility for self-regulation and continuous quality improvement (WHO 2009). Regulation can create a system which protects the public by dealing with poor performers and enhance the power of the profession to take its place at the policy table, such as: advising government on human resources issues; participating in health planning; using the experience of the profession to inform health system strengthening; advocating for resources; and explaining the need for various education policies.

Ms Howse suggested that current laws are not supporting contemporary nursing and midwifery practice in Africa and review is timely. Existing legislation is based on older British laws to regulate health practitioners; was drafted at a time when health issues and ideas about professional practice were quite different; is set in a medical model more suited to an urbanised, industrialised society; has little or an inadequate statement of purpose or objectives; and does not have an African focus. Ms Howse further suggested that it is not always necessary to detail education, scopes of practice, and standards in legislation when there are more flexible instruments available that can be more easily amended and which can simply be referred to in legislation. The policy development, implementation and monitoring process can establish criteria for standards of education; competencies; professional standards; scope of practice and practice standards; and CPD requirements, for example, however legislation should support policy. Policy can also provide clarity in the role and the powers of the regulatory body. For example:

- setting standards of practice and education with details in codes and regulations,
- investigative powers,
- formal hearings to be done by body with nursing expertise and some community representation (no need for doctors),
- more flexible sanctions, and
- the relationship to government and involvement in broader national health policies and strategies.
Continuing professional development can use mechanisms such as codes and regulations for making CPD mandatory for nurses and midwives; making it easier for the regulatory body to make changes as more is learned about what works. CPD should include quality assurance activities; practice based learning; teaching; and research. Regulator bodies may have a three or five year cycle for CPD activities with an annual minimum requirement. Some regulatory bodies also require 'recency of practice' whereby a nurse or midwife has to have undertaken a specified amount of practice over a set period of time for renewal of practising licence.

Ms Howse suggested that some areas of legislative reform which countries in the East, Central and Southern Africa region might explore are:

- Mutual recognition of registration (country laws need to align);
- Emergency recognition of registration;
- Laws to enable information sharing about practitioners whose names have been removed from the register for, for example, ‘unprofessional conduct’.

Ms Howse reminded participants that effecting legislative change is not easy because it involves engaging with the political process and questions such as:

- Is the Minister interested in the issue?
- Does she/he have the necessary political influence?
- Have you a high level champion in the Ministry of Health?
- What is the progress of the parliamentary cycle?
- When is an election due?
- Do your stakeholders support you?
- Where is public opinion?
- If the government has expressed interest in a reform agenda, have they allocated funding for implementation? Is it recurrent?

When planning to review or amend legislation it is important to have a clear idea of what the issue is you are addressing and what the change is you want to make.

Does the Ministry of Health and the Minister support the review and any necessary legislative amendment? Do other stakeholders, associations, consumers and the academic community support the changes? It is important to develop a consultation and communication strategy and consult all stakeholders, including consumers, about the issue.

Before the proposed changes are finalised, do a ‘reality test’ with some key stakeholders. Note the parliamentary cycle so that the proposed changes are submitted in a timely manner. Approval is usually required from other portfolios in government such as Attorney-General, Treasury, Public Service Commission etc. Any costs whether once only or recurrent and how reforms are to be funded, need to be made clear as well as consequential amendments to other legislation (eg drugs and poisons, public sector management etc). Are regulations required?

Political will to support the changes must be maintained over a long period and many things can interfere: reshuffles; change in Ministry of Health personnel; outbreak of disease; political scandal; even a coup.

The Minister of Health or another Minister will need to champion the bill in cabinet. Political will to advance health issues, needs to survive in cabinet with other agendas which are about money, power and political gain. Political will to advance health is very fragile. Never relax and never give up. It will be hard however important decisions are made in the policy debate and the voice of the profession of nursing and midwifery must be heard.
Ms Veena Pillay is the Academic Executive from the Foundation for Professional Development. Ms Jill Iliffe is the Executive Secretary of the Commonwealth Nurses Federation and is providing technical assistance to the ARC project in the area of CPD as well as writing the reports relating to the project.

**MS JILL ILIFFE** presented an overview of continuing professional development (CPD) from a global perspective and the steps involved in developing a national CPD programme. The presentation began with the clarification of some terms. Ms Iliffe explained that, in her presentation, registration is when your name is entered on the register on completion of your initial qualification as a nurse or midwife and you are issued with a ‘licence’ to practise. Some countries grant lifelong registration and consequently there is no requirement for renewal of your licence to practise. Some countries require renewal of your licence annually (or each 3 years or 5 years) with or without a requirement for mandatory or voluntary CPD. Some countries also have practice requirements (eg that you have practised in your profession for a set number of hours or a set period of time over the previous three to five years) and require proof of ‘recency of practice’. Ms Iliffe suggested that countries who are contemplating developing a national CPD programme needed to ask themselves the question: how is CPD to be linked to registration and licensure?

There are very many different names for CPD: continuing nursing education (CNE); continuing professional education (CPE); continuing medical education (CME); continuing education (CE); lifelong learning (LLL); in-service education (ISE); and staff development (SD), to name a few. In her presentation, Ms Iliffe explained, the term CPD has been used to include all the other terms. CPD also has many different definitions, although most definitions are inclusive of the key elements: that CPD is a continuous and planned process, and one which builds on and enhances existing education and experience for the benefit of the individual nurse, midwife, patient and profession. Ms Iliffe suggested that there is no ‘perfect’ definition of CPD and that countries seek out a range of definitions of CPD and choose those that suit their particular circumstances. She shared some definitions with participants:

*A range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice* (Health Professions Council of the United Kingdom 2009).

*The means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives* (Nursing and Midwifery Board of Australia 2009).

*The means for maintaining and updating professional competence to ensure that the public interest will always be promoted and protected as well as ensuring the best possible service to the community* (Health Professions Council of South Africa 2011).

*CPD is the purposeful maintenance and improvement of a professional’s knowledge and skills to remain competent in their chosen profession for the benefit of themselves, their patients or clients and the wider profession* (New South Wales Nurses Association 2010).

Ms Iliffe stated that nursing and midwifery regulatory authorities have a mandate to protect the public from incompetent or negligent practitioners. This mandate gives them the authority to impose conditions on the nurses and midwives they regulate to ensure that they provide safe and competent care.
The Institute of Continuing Professional Development (2011) notes that the world in which all professionals practise is changing; that clients are becoming more knowledgeable and more demanding; that new and emerging technology affects all aspects of our life; and that these changes demand constantly evolving knowledge, skills and understanding and an increasing demonstration of a commitment to lifelong professional learning. The Institute goes on to say that a: commitment to CPD is also an acknowledgement that becoming professionally qualified is not an end in itself - it is merely the beginning.

CPD, according to the NSW Nurses Association (NSWNA 2010), is a critical mechanism in ensuring that all members of the nursing and midwifery professions are able to deliver high quality nursing and midwifery care and services and keep pace with health care developments that affect their practice. The Association notes that the knowledge needed to function effectively as a professional nurse or midwife continues to expand and change while consumer demand and expectations continue to increase. They conclude that, as registered health practitioners, nurses and midwives have a professional obligation to maintain their competence and to aim for continuous improvement in the standard of service they provide.

The constantly changing nature of the health system and health service delivery and the need for new knowledge and skills to meet changing needs is also emphasised by the Health Professions Council of South Africa (2011) who maintain that the knowledge, information and skills acquired by health care professionals as students or interns become obsolete at some point in time and that in order to protect the public, health care professionals must commit themselves to lifelong learning to keep their knowledge and skills up to date.

Ms Iliffe outlined some of the principles on which CPD is based as:

✓ CPD is a continuous process and actively seeks to improve skills, knowledge and performance.
✓ Learning needs should be defined and agreed in collaboration with line manager but owned and managed by the individual learner.
✓ CPD should be based on a rigorous and continuous analysis of professional learning needs.
✓ CPD activities should be planned in advance through a personal development plan, and should reflect and be relevant to current and future professional practice and performance.
✓ CPD acknowledges varying learning styles and includes a wide range of formal and informal learning activities.
✓ CPD is self-directed; it is based on learning needs identified by the individual; builds on an individual’s existing knowledge and experience; links an individual’s learning to their practice; and includes an evaluation of the individual’s development.
✓ CPD requires professionals to identify their learning needs based on an evaluation of their practice against recognised professional standards; develop a learning plan based on the needs identified; participate in CPD activities which meet these learning needs; and reflect on the value of these activities to their practice.

The scope of CPD activities should include both formal and informal learning activities. CPD activities should be: relevant, current, available, accessible and affordable. Some possible CPD activities were identified as:

✓ formal educational programmes,
✓ short courses (face to face or online),
✓ presenting at or attending conferences, seminars or workshops,
✓ publishing articles,
✓ reading professional journals and books,
✓ keeping a self-reflection journal,
✓ developing policies, protocols or guidelines,
✓ supervised practice for skills development,
✓ acting as a mentor or preceptor,
✓ conducting research, and
✓ participating in committees (eg quality improvement, occupational health and safety).
Ms Iliffe maintained that everyone involved in health care delivery has a responsibility to ensure safe and competent practice: employers (public or private); regulatory authorities; professional associations; governments; and individuals. Whether CPD was voluntary or whether there was a mandatory requirement included in nursing and midwifery regulation depended on the individual country. Many countries who had previously had a voluntary model (such as Australia, New Zealand and the United Kingdom) had now moved to a mandatory model reflecting the necessity for regulatory authorities to demonstrate accountability to protect the public. Whether voluntary or mandatory, Ms Iliffe stated that individual nurses and midwives have an ethical responsibility to their patients and clients, their professions, and themselves to practise competently and safely. CPD should be an integral part of their professional life.

In determining how much CPD nurses and midwives should be required to undertake, Ms Iliffe explained that requirements are a minimum only and vary considerably across the world. Some countries count hours of involvement in active CPD learning with one hour of learning generally equalling one CPD point; other countries allocate points to particular activities and require nurses and midwives to accumulate a specified number of points each year. For example, Australia requires 20 hours of active involvement in CPD activities annually; New Zealand requires 60 hours over three years; South Africa requires 30 points annually; with the United Kingdom requiring 35 hours over three years. When determining the requirement, countries should consider what is feasible and achievable in their own situation and not be influenced by what the requirements are of other countries. Ms Iliffe stressed that CPD requirements should be: reasonable; achievable; fair; accessible (including cost considerations); transparent; flexible; and inclusive (of a range of CPD providers).

Ms Iliffe noted that some countries have developed a process for accrediting CPD content and/or CPD providers while others have not (eg South Africa has an accreditation process while the United Kingdom does not). A process of accreditation is not an essential part of a national CPD programme however any process of accreditation developed should include both formal and informal (self-directed and experiential) learning. Establishing accreditation criteria and assessing applications involves personnel, time and cost which may not be recovered from fees charged for the accreditation of applications. Countries need to consider their capacity to undertake the accreditation process before including this aspect in their national CPD model. CPD models should be seen as dynamic and subject to amendment and change over time as the needs of nurses, midwives, regulatory authorities and the public change.

All national CPD models should include a monitoring and evaluation component even if they are voluntary rather than mandatory. Some countries monitor each nurse or midwife to ensure they are complying with the CPD requirement; other countries randomly select a meaningful sample of nurses and midwives to monitor on a regular basis, usually annually. Regulatory authorities need to provide nurses and midwives with a clear expectation of the documentation they are required to keep to demonstrate their compliance with the CPD requirement as well as the additional evidence they will be required to produce if they are audited. If the CPD programme is a mandatory one, penalties for non-compliance will need to be determined; as well as an appeals process; and mechanisms for deferments and exemptions. The way in which the programme is to be evaluated should also be determined when the programme is implemented.

**MS VEENA PILLAY** from the Foundation for Professional Development (FPD) gave a comprehensive overview of the work of the FPD, particularly as it related to their CPD activities. The FPD was established in 1997 by the South African Medical Council however it became an independent legal entity in the year 2000. The vision of the FPD is to create a better society through education and development and their mission is to improve society through ensuring the availability of workers, skilled professionals, and managers, who can deliver service to the public that is affordable, evidence based and congruent with international best practice. FPD has three focus areas: community engagement; education; and research.

The community engagement focus area supports projects that provide HIV, AIDS and TB related services in predominantly the public sector through salary support for clinical and managerial staff; purchasing of equipment; renovation of facilities; and training and mentorship of staff. Through their community engagement, FPD provides support to 60 provincial ART Clinics in 5 provinces; operates two NGO clinics; has initiated 142,000 patients on ART to date and will initiate a further 30,000 patients in 2011; and annually does 180,000 HIV tests.
The African Health Placement project aims at filling vacancies in the public sector by recruiting local and foreign health care professionals. To date 1,784 doctors have been recruited and placed in rural hospitals (50% locally qualified and 50% foreign qualified). FPD through their African Health Replacement programme can recruit and register a doctor from a developed country in 3 to 4 months.

The Compass Project aims to assist communities to effectively respond to health and social needs through epidemiological and demographic estimates of service needs; identification and mapping of service providers across sectors; and through organisational development and knowledge sharing activities. To date Compass has mapped over 20,000 HIV service providers; produces an annual report on the need for HIV Services in Tshwane; provides secretariat services for the Tshwane Mayoral AIDS Council and provides organisational development opportunities for over 500 NGOs.

Another project, titled: That’s it, is a public-private initiative aimed at strengthening TB services and the linkage between HIV and AIDS and TB services. The project supports 204 TB treatment sites and 20,000 patients on ART.

FPD also has a maternal and child health unit which is based in Polokwane and which supports 450 antenatal clinics in Limpopo Province.

Additionally, FPD runs a PEPFAR Fellowship programme to recruit newly qualified Master’s degree students to spend 12 months with AIDS service organisations. To date this has placed around 120 Fellows, with an absorption rate of 70 per cent.

There is also a HIV hotline in partnership with the University of Cape Town Medicine Information Centre, which provides a toll free service for treatment related enquiries.

FPD’s educational focus has three streams. Their health sciences school offers short courses; mentoring programmes; distance courses; and online courses for doctors, nurses, allied health workers and counsellors. Their business school offers formal accredited programmes; international programmes; short courses; distance courses; and customised company programmes for supervisors, middle managers, senior executives and administrative staff. Their schools programme provides short courses for educators, school principals, governing bodies and administrative support staff. FPD averages 30,000 students each year and has 27 full time employees.

FPD courses are designed to remove barriers to education by being held as close to where students live and work as possible; by being offered at low or no cost to the participant; by reducing time away from work through combining assessed self-study with classroom sessions; and by access to continuing learning through an alumni programme for all students. All eligible CPD programmes qualifying for CPD points are accredited with the Health Professionals Council prior to them being scheduled.

FPD provides courses outside the South African border to eight other African countries.

All CPD courses are entered into a central data base. There is a strong focus on quality assurance and all courses are evaluated. Regular QA meetings are held throughout the year; there are monthly reviews on all student evaluations; and an annual review of all study materials, assessments and resources. This ensures ongoing improvements to systems, standards and procedures. This is also strict compliance with regulatory bodies.

FPD’s research focus is currently on infectious diseases; maternal and child health; educational methodology; and operational research.

Further information about FPD can be obtained from: http://www.foundation.co.za/.
This focus on this session is on total quality management using quality improvement tools such as the histogram, process mapping, brainstorming, benchmarking, fishbone diagram and Gantt charts.

Total quality management (TQM) means that an organisation’s culture is defined by and supports the constant attainment of customer satisfaction through an integrated system of tools, techniques and training. This involves the continuous improvement of organisational processes, resulting in high quality services. TQM tools help organisations to identify, analyse and assess data that is relevant to their organisations. These tools can identify procedures, ideas, statistics, and cause and effect concerns.

(a) HISTOGRAM

Figure 11: Histogram

A vertical bar chart depicts the distribution of a data set and can be used to graphically represent a large data set or process results and determine if a current process was able to produce positive results.

(b) PROCESS MAPPING

Process mapping is a graphic representation of how a process works, showing the sequence of steps. Process mapping:
* Describes the sequence of steps in a process,
* Makes the process clear and understandable,
* Reduces complexity,
* Eliminates unnecessary duplication,
* Eliminates loops,
* Rationalises the steps of the process,
* Helps to guide discussion on identifying problems, and
* Reduces waste.

Figure 12: Process mapping key
Ms Jacobs gave an example of a process map for a patient attending for a mammography. Process maps can be developed for any quality issue using the key above.

**Figure 13: Process mapping or flow chart**

When using a process map or flow chart, Ms Jacobs suggested the following questions need to be asked:
- Does this step need to be done?
- Where are the delays?
- Is the sequence of steps appropriate?
- Are there missing steps?

(c) BRAINSTORMING

Brainstorming is used to collect ideas from a group without regard to the validity of those ideas. The rules are that: all group members have equal input into the process; there are no ‘dumb’ ideas; and a moderator is used to enforce the rules and record the ideas. Each idea should be written on a flip-chart or board and the ideas are then prioritised without holding any discussion.

(d) BENCHMARKING

Benchmarking is a technique for learning from the success of others in an area where you are trying to make improvements. Benchmarking is useful when trying to develop new services or seeking options for potential solutions. Benchmarking is replicating, not copying. If using benchmarking you need to identify other groups or organisations that have valued services. Visit these sites and talk to managers and workers to identify the processes and problems. To be successful, you need to: know your own processes; choose the right partner; use benchmarking to stimulate creative thinking and change; and act on the results.
(e) FISHBONE (cause-effect) DIAGRAM

The fishbone diagram is a tool used to discover all the possible causes for a particular effect. It can be used as a first step in problem solving by generating a comprehensive list of possible causes. It leads to greater understanding of the problem and can be developed through brainstorming. The head of the fish is the quality problem identified. Ms Jacobs gave an example of a fishbone diagram where ‘no CPD’ was the quality issue to be addressed.

Figure 14: Fishbone diagram

(f) GANTT CHART

A Gantt chart provides a graphical illustration of a schedule that helps to plan, coordinate, and track specific tasks in a project. A Gantt chart assists planning by showing all activities that must take place and when they are scheduled to be carried out and provides a graphic guide for carrying out a series of activities, showing the start date, duration, and overlap of activities; it is most useful in planning and monitoring activities. If using a Gantt chart you need to list all the activities; determine when each activity must start; and for each activity mark the starting date and completion date.

Figure 15: Gantt chart

Ms Jacobs concluded by saying that a flow chart or process map is the best tool when trying to identify or quantify a problem. If trying to determine the root cause, then a fishbone cause and effect diagram is the best tool. When trying to develop and select potential solutions, then brainstorming and benchmarking are the tools of choice. Gantt charts are most useful when trying to implement quality improvement interventions.
10. SESSION 7  
Country team action planning

During this session, country teams worked together, supported by resource persons, and drawing on the learning about quality improvement tools, to refine their proposals to ensure that objectives were achievable and measurable and that the proposed actions would achieve the objectives in the required time frame.

Teams used process mapping and fishbone diagrams to review and refine their proposals capturing the discussion on either a computer or flip-chart paper.

Countries found both process mapping and the fishbone diagram helpful in focusing the discussion and their ideas and were able to identify gaps in the planning and implementation of their projects.

LESOTHO TEAM

MALAWI TEAM

MAURITIUS TEAM
11. **SESSION 8**  
*Country team revised action plan presentations*

Having refined their proposals, country teams presented their revised proposals to the larger group for peer feedback and comment. This provided the opportunity for teams to explain any changes they had made to their proposal and give the rationale for those changes. It also provided the opportunity for other countries to make suggestions or ask for clarification on particular issues.

**LESOTHO TEAM**  
The Lesotho Team used a fishbone diagram and a flow chart to clarify their model. The major issue identified was that there is currently no national CPD programme for nurses and midwives in Lesotho. Following the session the Lesotho team felt more organised; they felt their plan had been improved and that they had identified more activities and organised them in a sequential manner. The team identified a number of issues to be addressed:

* How to develop a national CPD programme for Lesotho and obtain technical assistance.
* How to inform nurses and midwives about the new requirements.
* How to determine the scope of the CPD activities.
* How to achieve ‘buy-in’ from employers; engage all stakeholders; and obtain Ministry of Health endorsement.
* How to accommodate nurses and midwives working in remote locations.
* How to establish a data base of CPD activities that nurses and midwives can access.
* How to monitor compliance with the CPD requirement.
* How to ensure any change in regulations are consistent with the Public Service Regulations.
* How to develop a communication strategy and when to launch the programme.
MALAWI TEAM

The major issue for the Malawi team was the low uptake of their existing CPD programme. The Malawi team used process mapping and a fishbone diagram to identify a number of issues which needed to be addressed:

* The availability of CPD and ease of access particularly for nurses and midwives working in rural areas.
* Revisiting the CPD guidelines.
* The time nurses and midwives had available to undertake CPD activities considering their workloads.
* The attitude and motivation of nurses and midwives to be involved in CPD activities.
* Whether cost is a barrier to nurses and midwives undertaking CPD.
* Whether nurses and midwives had set any personal CPD goals.
* Whether the CPD being offered suited different learning styles.
* What constitutes CPD and what should be counted?
* Whether there was a need to enlarge the scope of available CPD activities.
* The need to develop an inventory of CPD activities.
* The need to motivate and support CPD facilitators.
* The need for employers to encourage and support nurses and midwives to undertake CPD activities.
* How to engage the academic institutions to support and offer CPD.
* The need to enlist the support of ‘champions’ to promote the importance of CPD to nurses and midwives.
* Impact of annual CPD requirement on frequency of renewal of practising licence.
* The need to develop penalties for non-compliance and to develop guidelines for exemptions from CPD in certain circumstances.
MAURITIUS TEAM
The Mauritius proposal is to include the qualifications and scope of practice of nursing and midwifery educators in the legislation governing nurses and midwives. To achieve this, a number of issues were identified that needed to be addressed, including:

* Obtaining legal expertise in writing the draft changes to the legislation.
* Obtaining midwifery expertise to ensure that the legislation meets the needs of midwives also.
* Briefing all stakeholders and gaining their support with particular attention to unions and the private sector.
* Communicating the proposed changes and the rationale to nurses and midwives generally and their respective associations.
* Discussing the proposed changes with the State Law Office and the Pay Research Bureau and gaining their support.
* Briefing relevant politicians.
* Scheduling consultations once the draft changes are available to provide opportunity for comment and input and for sign-off.
* Timing the proposed changes so they fit within the government schedule for reform of legislation.
* Ensuring there is sufficient political will to support the proposed changes through the legislative process to the gazettal stage.
SEYCHELLES TEAM
The priority for the Seychelles team is to amend their Seychelles Nurses and Midwives Act to include a specified role for the Registrar of the Seychelles Nurses and Midwives Council and ensure that the position was occupied by a nurse or midwife. The Seychelles team considered that their problem was well defined and their goal clear. As a result of the revision of their action plan, some activities were amended and some new activities added. Some responsibilities were reallocated and time lines adjusted. The team identified a number of ongoing challenges, such as:

* Legislative change takes a long time and the time lines for the project are quite short.
* The team lacks legal expertise.
* Technical assistance with the drafting of the legislation will be necessary.
* The team has minimal resources, for example there is no secretarial support for the project and team members have their own roles to fulfil.
* The team does not have the knowledge and skill to complete the project without technical assistance.
* There is little local support from the bureaucracy for the change.
* There are misconceptions regarding the role of the SNMC and many nurses view the Council as punitive.
* Need to develop a comprehensive communication strategy.
* Need to disseminate draft legislation when ready to all stakeholders for their input.
* Need to brief the Minister for Health when final draft is ready for his support and to table draft in Cabinet and to Council of Ministers.
* Need to lobby members of the National Assembly.
**SWAZILAND TEAM**

The primary objective for the Swaziland proposal was to develop a national CPD programme. The Swaziland team had already conducted a needs assessment as part of the project and the results were currently being analysed prior to a report being generated. The Swaziland team identified a number of issues still to be addressed:

- Organise technical assistance to develop the CPD programme.
- From the needs analysis identify priority areas for training and develop training modules as required.
- Develop a communication and marketing strategy.
- Sensitise nurses to the CPD model and requirements including both public and private sectors.
- Identify resources required.
- Inform stakeholders, particularly donors, to gain financial and other support.
- Explore options for the development of an electronic data base for CPD programme.
- Identify scope for CPD programme and requirements.
- Determine accreditation standards and criteria for training and providers.
- Meet with training providers to gain support for CPD programme.
- Plan launch and implementation of programme.
Ms McCarthy explained to country teams that they should see the development of their proposals as taking place in stages and that it was necessary to work logically through all the stages to establish a sound foundation on which to achieve their objectives.

The staged process was likened to the stages children go through from being a helpless baby, to learning to sit and learning to crawl, before they learn to walk.

Ms McCarthy gave some examples of what those stages might look like in relation to CPD:
* developing a national policy recognising the importance of CPD and gaining the support of all stakeholders;
* developing a national CPD model;
* developing a range of options for meeting CPD requirements with nurses and midwives compliant; and
* effectively monitoring compliance.

**Figure 16: CPD as a staged process**
Ms McCarthy went on to give an example of a staged process for reviewing or amending nursing and midwifery legislation and regulation:

* recognising the need for legislative change and gaining the support of all stakeholders;
* drafting the necessary changes;
* gaining approval for the proposed changes; and
* having the changes incorporated into legislation.

**Figure 17: Legislation review as a staged process**

Ms McCarthy concluded by encouraging country teams to reform their proposals into achievable stages, taking small steps and moving forward toward their primary objective.

### 13. SESSION 10
**ARC grants administration and management**
Dr Maureen Kelley

Dr Maureen Kelley provided country teams with instructions and examples for completing the ARC work plan reporting template (see Attachment 3) and the ARC budget reporting template (see Attachment 4). Dr Kelley explained that the budget reporting template had built in formulas to assist with the reporting process.

Dr Kelley advised that the key objectives of the project should be listed in the work plan reporting template along with the activities that will occur to accomplish each objective. For each activity, the person responsible should be listed along with the time period in which the activity will be conducted and the target date for completion. If an activity is delayed, then the revised due date should be entered. Under the status column, countries should indicate if the activity has been completed, is in progress, or delayed.

Countries were provided with an opportunity to practice completing the forms, ask questions about the forms and clarify anything that was unclear to them. Dr Kelley reassured countries that the CDC ARC team was always available to assist with any difficulties in completing the required reports.
14. **SESSION 11**  
*Closing remarks*  
Ms Peggy Vidot and Ms Patricia Riley

Ms Patricia Riley and Ms Peggy Vidot congratulated countries once again on the success of their proposals and thanked them for their commitment and their hard work over the past three days.

The invited speakers, resource people and the ARC/Emory University team were also thanked for their significant input and for sharing their time and expertise. Country proposals had been reviewed and refined and were stronger and more achievable as a result and the opportunity had been provided and taken to clarify many issues.

The aim of the ARC project is to improve care by enhancing professional standards and practice in the region using local solutions and peer-based learning and by investing in nursing and midwifery education and nursing and midwifery regulation. The success of the projects will improve care and justify the investment in nursing and midwifery education and regulation in Africa.

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**Strengthening nursing and midwifery regulation and practice through south-to-south collaboration**

**Regulation improvement: principles and planning**

**MEETING AGENDA**

24-26 June 2011, Durban, South Africa

**Learning Session Objectives:**

1. To equip ARC country teams with improvement principles and tools to revise and strengthen their action plans.
2. To engage global and regional experts in the provision of technical assistance to strengthen ARC country team action plans.
3. To facilitate interactive sessions to foster peer learning in nursing and midwifery regulation

**Day 1:  Friday, June 24**

0800-0900  **Registration and Reimbursement**
Mark Staniland, Commonwealth Secretariat

0900-1000  **Official Welcome and Greetings**
Facilitator: Peggy Vidot, Commonwealth Secretariat
- Chalone Savant, PEPFAR Provincial Liaison
- Frances Day-Stirk, President-Elect International Confederation of Midwives
- Joyce Kamdonyo, East, Central and Southern Africa Health Community (ECSA-HC)
- Peggy Vidot, Commonwealth Secretariat
- Pat Riley, Centers for Disease Control and Prevention (CDC)
- Carey McCarthy, CDC

1000-1030  Refreshment Break

1030-1200  **Country Teams Project Progress**
Facilitator: Jessica Gross, Emory University
- Swaziland
- Seychelles
- Malawi
- Mauritius
- Lesotho

1200-1300  Lunch

1300-1630  **Interactive introduction to quality improvement and its application to strengthening nursing and midwifery regulation**
Introduction: Maureen Kelley, Emory University
Presenter: Donna Jacobs, University Research Corporation

**Learning objectives:**
1. To develop a basic understanding of relevant improvement principles and methods.
2. To be able to explain the purpose of relevant improvement tools and how they may apply to strengthening health profession regulation.

**Working objectives:**
1. To develop and refine country team regulatory improvement goals.
2. To identify quality improvement approaches that could be applied in country projects.

1630-1700  Refreshment Break
1700-1830  
**Country Team Break-Outs**  
Track 1: Feedback on Regulatory Function Framework  
Track 2: Feedback on Grant Reporting

1700-1730  
Seychelles (Carey McCarthy); Lesotho (Kitty MacFarlane); Malawi (Patricia Riley and Jessica Gross); Mauritius (Peter Shayo and Maureen Kelley); Swaziland (Alexandra Zuber and Joyce Kamdonyo)

1730-1800  
Seychelles (André Verani and Peggy Vidot); Mauritius (Carey McCarthy)

1800-1830  
Lesotho (Carey McCarthy)

0800-0830 (Saturday)  
Swaziland (Carey McCarthy)

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**Day 2: Saturday, June 25**

0830-0930  
**Panel: Revising nursing and midwifery legislation**  
Facilitator: Peggy Vidot, Commonwealth Secretariat  
Presenters: André Verani, CDC Atlanta  
           Peter Shayo, ECSA-HC  
           Genevieve Howse, Howse Fleming Legal

**Learning objectives**
1. To facilitate country team discussion of legal aspects of regulatory reform and implementation.
2. To identify common elements of health practitioner registration laws.
3. To discuss policy issues for nursing and midwifery regulation in Africa.
4. To introduce options for regulatory reform.

0930-1030  
**Panel: Continuing Professional Development (CPD)**  
Facilitator: Patricia Riley, CDC Atlanta  
Presenters: Jill Iliffe, Commonwealth Nurses Federation  
           Veena Pillay, Foundation for Professional Development

**Learning objectives**
1. To provide an overview of CPD experiences globally.
2. To review the draft regional CPD toolkit.
3. To provide participants with information regarding the Foundation for Professional Development’s structure, accreditation of regulatory bodies, operations, quality assurance and donor management.

10.30-11.00  
Refreshment break
Applying quality improvement tools to nursing and midwifery regulation (break-outs by country team)
Presenter: Donna Jacobs, University Research Corporation

Learning objective:
1. To develop a basic understanding of improvement tools and how tools can help identify improvement opportunities in regulatory processes.

Working objectives:
1. To develop a process map or a fishbone diagram of regulatory processes in each country setting.
2. To identify opportunities for regulatory input and process improvement.

Interactive Country Team Action Planning
Moderator: Kitty MacFarlane, CDC
Facilitator: Donna Jacobs, URC

Learning objectives:
1. To develop change ideas for improvement in legislation and CPD projects with related technical experts and develop project-related improvement aims.
2. Understand how to apply quality improvement and measurement approaches, such as change ideas and indicators, to strengthen action plans.

Working objectives:
1. To develop and revise action plans responsive to regulatory improvement goals.
2. To develop and define indicators for country team improvement projects.
3. To provide opportunities for peer-to-peer learning.

Day 3: Sunday, June 26

Revised Action Plan Presentations
Facilitator: Alexandra Zuber
* Lesotho
* Malawi
* Swaziland
* Mauritius
* Seychelles
1030-1100  Refreshment break

1100-1145  Validation of Regulatory Function Framework
Facilitator: Carey McCarthy, CDC Atlanta

1145-1230  ARC Grants Administration and Management
* Guidelines on project progress and budget reporting
Facilitator: Maureen Kelley

1230-1300  Closing Remarks and Meeting Evaluation
Facilitators: Peggy Vidot and Patricia Riley

1300-1400  Lunch
# ATTACHMENT 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>Lesotho</td>
<td>Ms Mantsebo Elizabeth Moji</td>
<td>Chief Nursing Officer</td>
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<tr>
<td>Lesotho</td>
<td>Mrs Tjoets Veronica Lehana</td>
<td>Training Institution</td>
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<tr>
<td>Lesotho</td>
<td>Ms Flavia Mamohapi Moetsana-Poka</td>
<td>Registrar LNC</td>
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<tr>
<td>Lesotho</td>
<td>Mrs Nthabiseng ’Makhulu Lebaka</td>
<td>President LNA</td>
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<tr>
<td>Malawi</td>
<td>Mrs Sheila Bandazi</td>
<td>Director Nursing Services Ministry of Health</td>
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<tr>
<td>Malawi</td>
<td>Mrs Martha Mondiwa</td>
<td>Registrar Nurses and Midwives Council</td>
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<tr>
<td>Malawi</td>
<td>Mr Jonathan Abraham Gama</td>
<td>President National Organisation of Nurses</td>
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<tr>
<td>Malawi</td>
<td>Mrs Rose Anthualimba Wasili</td>
<td>Principal St Joseph's College of Nursing</td>
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<tr>
<td>Mauritius</td>
<td>Mr Bholanath Jeewuth</td>
<td>President of Nurses Union</td>
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<tr>
<td>Mauritius</td>
<td>Ms Linda Glynis Maureen Coralie</td>
<td>Principal Midwife</td>
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<td>Mauritius</td>
<td>Mr Devraj Bhudoye</td>
<td>Secretary of Nurses Association</td>
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<td>Mauritius</td>
<td>Mr Anil Kumar Suggun</td>
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<td>Mauritius</td>
<td>Mr Harilall Mungroo</td>
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<td>Seychelles</td>
<td>Mrs Bella Henderson</td>
<td>Chief Nursing Officer</td>
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<td>Seychelles</td>
<td>Mrs Winifred Jeanneton Agricole</td>
<td>Registrar SNMC</td>
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<td>Seychelles</td>
<td>Miss Marie-Antoinette Hoarau</td>
<td>President NNA</td>
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<td>Seychelles</td>
<td>Mrs Beryl Sherley Camille</td>
<td>Representative NIHSS</td>
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<td>Swaziland</td>
<td>Ms Thembisiile Gladys Khumalo</td>
<td>Chief Nursing Officer</td>
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<td>Swaziland</td>
<td>Ms Glory Msibi</td>
<td>Registrar, Swaziland Nursing Council</td>
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<td>Mr Bheki Mamba</td>
<td>President, Swaziland Nurses Association</td>
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<td>Swaziland</td>
<td>Dr Ruth Nkosazana</td>
<td>Dean Faculty of Health Sciences</td>
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<td>Tanzania</td>
<td>Mr Gustav Moyo</td>
<td>Registrar Nurses and Midwives Council</td>
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<td>ECSA</td>
<td>Mr Peter Shayo</td>
<td>Advocate, ECSA</td>
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<td>ECSA</td>
<td>Ms Joyce Kamdony</td>
<td>Midwifery Coordinator ECSA</td>
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<tr>
<td>Speaker</td>
<td>Ms Genevieve Howse</td>
<td>Advocate, LaTrobe University</td>
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<tr>
<td>Speaker</td>
<td>Ms Donna Jacobs</td>
<td>University Research Centre, South Africa</td>
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<td>Speaker</td>
<td>Ms Veena Pillay</td>
<td>Foundation for Professional Development</td>
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<td>CNF</td>
<td>Ms Jill Iliffe</td>
<td>Commonwealth Nurses Federation</td>
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<td>ComSec</td>
<td>Ms Peggy Vidot</td>
<td>Commonwealth Secretariat</td>
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<td>ComSec</td>
<td>Mr Mark Staniland</td>
<td>Commonwealth Secretariat</td>
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<tr>
<td>CDC</td>
<td>Ms Patricia Riley</td>
<td>Team Lead</td>
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<tr>
<td>CDC</td>
<td>Ms Alexandra Zuber</td>
<td>Health Advisor</td>
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<tr>
<td>Emory University</td>
<td>Dr Maureen Kelley</td>
<td>Associate Clinical Professor, Emory University</td>
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<tr>
<td>CDC</td>
<td>Ms Carey McCarthy</td>
<td>Research Fellow</td>
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<tr>
<td>CDC</td>
<td>Ms Kitty MacFarlane</td>
<td>Senior Program Manager</td>
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<tr>
<td>CDC</td>
<td>Mr Andre Verani</td>
<td>Public Health Lawyer</td>
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<tr>
<td>Emory University</td>
<td>Ms Jessica Gross</td>
<td>Public Health Consultant</td>
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<tr>
<td>JHPIEGO</td>
<td>Ms Stacie Stender</td>
<td>Regional Technical Advisor, PEPFAR</td>
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<tr>
<td>PEPFAR</td>
<td>Ms Chalone Savant</td>
<td>Advisor</td>
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**ATTACHMENT 3: Meeting Evaluation Results**

**Q1: Please indicate your primary professional role**

- Registrar or regulation: 5/20 = 25%
- Professional organisation/union: 4/20 = 20%
- Education: 5/20 = 25%
- CNO: 4/20 = 20%
- Other: 2/20 = 10%

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

- Public Sector: 16/20 = 80%
- Private Sector: 3/20 = 15%
- Other: 1/20 = 5%

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**FRIDAY 24 JUNE 2011**

**COUNTRY TEAMS PROJECT PROGRESS**

**Q3: In general, how important was it to hear about other ARC projects and progress?**

- Not important: 0/20 = 0%
- Important: 1/20 = 5%
- Very important: 19/20 = 95%

**Q4: How important is it to share both progress and challenges in your project with other ARC teams?**

- Not important: 0/20 = 0%
- Important: 1/20 = 5%
- Very important: 19/20 = 95%

**Comments:** There were 14 comments. All except one was on the theme of the importance of south to south teaching and learning and the value of sharing experiences and challenges in the region: *Sharing experiences helps teams to learn from each other and facilitates more collaboration.*
QUALITY IMPROVEMENT FOR STRENGTHENING NURSING AND MIDWIFERY REGULATION
Ms Donna Jacobs

Q5: As a result of this session I learned relevant quality improvement principles and processes
Do not agree 0/20 = 0%
Partially agree 3/20 = 15%
Completely agree 17/20 = 85%

Q6: As a result of this session I can explain how quality improvement principles can be applied to strengthening health profession regulation
Do not agree 0/20 = 0%
Partially agree 6/20 = 30%
Completely agree 14/20 = 70%

Q7: As a result of this session our team can identify quality improvement processes that can help us reach our project goal
Do not agree 0/19 = 0%
Partially agree 3/19 = 16%
Completely agree 16/19 = 84%

Comments: There were 13 comments, all positive with one suggestion that presenters of long lectures should schedule breaks in their presentations.

COUNTRY TEAM BREAK OUT SESSION: Grants Management

Q8: Was it helpful to have feedback and suggestions on activity reporting including introduction to the new reporting template?
Not helpful 0/18 = 0%
Helpful 4/18 = 22%
Very helpful 14/18 = 78%

Q9: Was it helpful to have feedback on budget reporting?
Not helpful 0/18 = 0%
Helpful 4/18 = 22%
Very helpful 14/18 = 78%

Comments: There were 14 comments, all were positive or neutral and several noted benefits of having a template that could also be used for other projects. Two noted that more time was needed.

COUNTRY TEAM BREAK OUT SESSION: Team Planning for Quality Improvement

Q10: How helpful was it to meet as a team with a facilitator(s) to talk about quality improvement processes for your project?
Not helpful 0/20 = 0%
Helpful 2/20 = 10%
Very helpful 18/20 = 90%

Comments: There were 10 comments, all were positive and most were related to facilitators clarifying concepts and helping to reinforce learning from the previous presentations.
SATURDAY 25 JUNE

PANEL: REVISING NURSING AND MIDWIFERY LEGISLATION
Mr André Verani, Mr Peter Shayo, Ms Genevieve Howse

Q11: In general, the material presented during this panel was important for all participants to learn.
Do not agree 0/20 = 0%
Partially agree 2/20 = 10%
Completely agree 18/20 = 90%

Q12: 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 0/20 = 0%
Partially agree 2/20 = 10%
Completely agree 18/20 = 90%

Q13: As a result of this session I am confident I can identify key issues to consider for planning regulatory revisions or changes.
Do not agree 0/20 = 0%
Partially agree 4/20 = 20%
Completely agree 16/20 = 80%

Comments: There were 15 comments; all were positive. A typical example is: The session was very fruitful and was beyond my expectation. At the end of the session I had really enhanced my knowledge on legislation.

PANEL: CONTINUING PROFESSIONAL DEVELOPMENT
Ms Jill Iliffe, Ms Veena Pillay

Q14: In general, the material presented during this panel was important for all participants to learn.
Do not agree 1/20 = 5%
Partially agree 3/20 = 15%
Completely agree 16/20 = 80%

Q15: 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 1/20 = 5%
Partially agree 4/20 = 20%
Completely agree 15/20 = 75%

Q16: As a result of this session I am confident I can identify key issues to consider as I develop CPD programs.
Do not agree 1/19 = 5%
Partially agree 3/19 = 16%
Completely agree 15/19 = 79%

Comments: There were 13 comments; all were positive except one which noted that ‘international forums should not be used for advertising (referring to Ms Veena Pillay’s presentation). Most positive comments noted new knowledge gained as a result of the panel. One example is: Already after the session we were able to apply the information to our presentation.
APPLYING TOTAL QUALITY IMPROVEMENT TOOLS
Ms Donna Jacobs

Q17: This session helped our team identify where quality improvement tools and processes can be applied to our project plans.
Do not agree 0/20 = 0%
Partially agree 6/20 = 30%
Completely agree 14/20 = 70%

Q18: As a result of this session our team will be able to improve the quality of our project by applying tools learned.
Do not agree 0/20 = 0%
Partially agree 6/20 = 30%
Completely agree 14/20 = 70%

Comments: There were 14 comments; 3 neutral and 11 positive. An example of a neutral comment was: *Will have to see if the tools yield results.* An example of a positive comment was: *These tools are easy to use and it permits a maximum number of participants to have their say.*

INTERACTIVE COUNTRY TEAM ACTION PLANNING

Q19: The format of this session was effective for identifying specific actions steps to advance our project plans before the next learning session.
Not effective 0/19 = 0%
Effective 4/19 = 21%
Very effective 15/19 = 79%

Q20: Scheduling time for teams to share updated project plans after applying quality improvement tools was an effective strategy to support shared learning.
Not effective 0/20 = 0%
Effective 5/20 = 25%
Very effective 15/20 = 75%

Comments: There were 10 comments; 1 neutral and all others positive. An example of a neutral comment was: *We learn from each other.* An example of a positive comment was: *All participants take part in the debate and the resource persons were very helpful.*

REGULATORY FUNCTION FRAMEWORK: Presentation of Framework and Validation of Input
Carey McCarthy

Q21: Identifying the key regulatory functions and stages of development has practical application for me as a nursing and midwifery leader.
Do not agree 0/20 = 0%
Partially agree 5/20 = 25%
Completely agree 15/20 = 75%

Q22: I agree it is important to generate evidence on the impact of the ARC initiative through research and evaluation.
Do not agree 0/20 = 0%
Partially agree 6/20 = 30%
Completely agree 14/20 = 70%

Comments: There were 11 comments which were all positive or neutral. An example of a positive comment is: *Helped us to use information from this initiative to inform other stakeholders regionally.*
SUNDAY 26 JUNE

REVISED ACTION PLAN PRESENTATIONS
Alexandra Zuber

Q23: As a result of this session, I can identify possible areas of collaboration with other teams during the next action cycle.
Do not agree 0/20 = 0%
Partially agree 5/20 = 25%
Completely agree 15/20 = 75%

Comments: There were 7 comments which were all positive or neutral, noting both the value of south to south collaboration as well as how some aspects are country specific.

ARC GRANTS ADMINISTRATION AND MANAGEMENT
Jessica Gross

Q24: As a result of this session I will be able to use the Excel budget template to report project expenditures.
Do not agree 1/18 = 6%
Partially agree 5/18 = 28%
Completely agree 12/18 = 66%

Comments: There were 12 comments which were all positive or neutral, including one participant who did not agree with the statement. That participant acknowledged no Excel ability and therefore did not agree that he/she would be able to use the template.

OVERALL WORKSHOP EXPERIENCE

Q25: Workshop Objectives: In your opinion, were the workshop objectives met?

1. Equip ARC country teams with improvement principles and tools to revise and strengthen action plans
   Objective not met 0/20 = 0%
   Objective mostly met 1/20 = 5%
   Objective fully met 19/20 = 95%

2. Engage global and regional experts in the provision of technical assistance to strengthen ARC country team action plans
   Objective not met 0/19 = 0%
   Objective mostly met 2/19 = 11%
   Objective fully met 17/19 = 89%
3. Facilitate interactive sessions to foster peer learning in nursing and midwifery regulation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective not met</td>
<td>0/20 = 0%</td>
</tr>
<tr>
<td>Objective mostly met</td>
<td>2/20 = 10%</td>
</tr>
<tr>
<td>Objective fully met</td>
<td>18/20 = 90%</td>
</tr>
</tbody>
</table>

Comments: There were 13 comments; all were positive with one neutral comment: *I was delegated to attend at the last minute.* The value of peer to peer learning, having the opportunity to work with in-country colleagues, and appreciation for learning tools to help execute the projects were recurrent themes.

Q26: Meeting venue: The meeting venue met my requirements for optimal work and rest.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not meet minimal</td>
<td>0/20 = 0%</td>
</tr>
<tr>
<td>Met requirements</td>
<td>9/20 = 45%</td>
</tr>
<tr>
<td>Exceeded requirements</td>
<td>11/20 = 55%</td>
</tr>
</tbody>
</table>

Comments: There were 16 comments which were generally positive. Many comments were regarding internet access at the hotel (only via credit card) and a few regarding noise levels at the hotel.

Please share your comments or suggestions on any other topic below:

There were 13 comments, examples of which appear below.

Maybe the time for this period was too short. There was a lot to learn and share. We have been given many new skills which we will implement. I wish we could have had more time with the legal experts to explore the areas of relevance to specific nursing and midwifery Acts.

The workshop was well organised and provided insight and the progress of countries team work. After the facilitators’ presentations, our team was able to improve on the project and the group work and presentations helped to improve on the country’s project.

The topics covered were relevant and informative. The countries benefited a lot from the sessions.