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THE AFRICAN REGULATORY COLLABORATIVE SUCCESS STORY

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The Commonwealth Nurses Federation (CNF), founded in 1973, is a federation of national nursing and midwifery associations in Commonwealth countries.

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The CNF is facing some significant challenges at the moment. Many of you will be aware that the Commonwealth Secretariat, the administrative arm for the Commonwealth, proposed in their new strategic plan, that health and education would no longer be areas of work that the Commonwealth Secretariat would be involved in.

This is particularly concerning when the health statistics from the majority of Commonwealth countries are consistently poorer than those of the rest of the world and when Commonwealth countries are struggling to meet the Millennium Development Goals by 2015. In the strategic plan discussion paper, the Commonwealth Secretariat states their work will be based around the two pillars of democracy and development, however you cannot achieve either democracy or development with an unhealthy population. Good health is the fundamental foundation on which democracy and development is built.

Rather than abrogate its responsibility for health and education, the Commonwealth Secretariat should be leading the way in promoting universal access to health care, as well as a primary health care approach to preventing ill health; health screening; early intervention; affordable health; and equity in access to health care. The Commonwealth Secretariat should be leading the way and initiating discussion with member states about global goals post the MDGs and using the unique opportunity the Commonwealth provides to influence the global health and development agenda.

The Health Section of the Commonwealth Secretariat has, in the past, made a significant contribution to addressing health issues. It was the Health Section of the Commonwealth Secretariat that initiated the development of the *Commonwealth Code of Practice for the International Recruitment of Health Workers* and it was the lobbying of the Health Section which resulted in the World Health Organisation *Global Code of Practice on the International Recruitment of Health personnel*.

The Health Section also initiated the highly successful African Regulatory Collaborative to improve standards and regulation in the east, central and southern Africa region.

Working together, there are so many positive things to be achieved between the CNF and the Commonwealth Secretariat. There is an opportunity for using the CNF networks for valuable data collection about the nursing and midwifery workforce. The Commonwealth Steering Committee for Nursing and Midwifery which has so much potential to coordinate nursing and midwifery across the Commonwealth and provide input to Commonwealth Health Ministers on nursing and midwifery issues has not met for several years. The CNF has made submissions to the Commonwealth Secretariat to review its position on health however without a change in position; the CNF will be severely affected.

As significant an impact for the CNF is the decision of the Commonwealth Foundation to cancel its annual funding grant to Commonwealth accredited civil society organisations. The CNF has relied on this annual grant for many years to fund its administration and many of its projects. Instead, the Commonwealth Foundation expects small associations like the CNF to compete for funding with other larger international NGOs. The Commonwealth Foundation proudly boasted that their last 'call for expressions of interest' attracted 600 applications. At a time when many people in the Commonwealth are questioning its relevance, the decision to abandon organisations that have committed themselves to Commonwealth principles and values by seeking Commonwealth accreditation is very hard to understand and very disappointing.

On a very positive note, the Canadian Nurses Association (CNA) has made a decision to rejoin the CNF. This is wonderful news. The CNA has in the past provided CNF Presidents and Board members and we have missed their valuable input, knowledge and expertise.

Make a note in your diary for the 2nd Commonwealth Nurses Conference in London 8-9 March 2014 (see back page). The Inaugural Commonwealth Nurses Conference was a great event with wonderful papers and even more wonderful networking. The 2nd Commonwealth Nurses Conference will be even better. Make sure you plan to be there.

SUCCESSFUL 10TH ECSACON SCIENTIFIC CONFERENCE



The East, Central and Southern African College of Nursing (ECSACON)

A very successful ECSACON 10th Scientific Conference was held in Port Louis, Mauritius 5-7 September 2012 attended by over 200 nurses and midwives. The Conference was hosted by the Mauritius Nursing Association (MNA).

ECSACON is a professional body for nurses and midwives in the east, central and southern Africa region. ECSACON is described as a 'college without walls', based in Arusha, Tanzania with the ECSA Health Community. ECSACON works to promote quality of care and excellence in the nursing profession within the region and facilitate sharing of expertise and human resources among members states.

The theme for the conference was: *Acceleration toward attainment of Millennium Development Goals through revitalising primary health care: nurses and midwives sharing high impact interventions.* Dr Judith Shamian, Chief Executive Officer of Victorian Order of Nurses Canada, which is Canada's largest national not-for-profit charitable home and community care organisation and immediate past president of the Canadian Nurses Association gave the keynote address.



Judith Shamian from Canada

Sub-theme keynote addresses were delivered by Mr Bagooaduth Kallooa, Ms Sheila Matinhure, Dr Leslie Mancuso, Brigadier General Dr Gerald Gwinji and Ms Jill Iliffe.

The conference was preceded by two workshops from 2-4 September 2012 on: *Fertility awareness methods of family planning* in collaboration with the Institute for Reproductive Health, and *Scaling up access to community based family planning* in collaboration with Fhi360.

A very moving opening ceremony was attended by representatives from the Government of Mauritius. The International Council of Nurses and the International Confederation of Midwives were also represented. A wide range of concurrent sessions were available including sessions on: reducing maternal and infant mortality, essential newborn care, improving child health and nutrition, managing premature births, unsafe abortion, health system strengthening, nurse migration, continuing professional development, cervical screening, and family planning. Dr Leslie Mancuso introduced conference participants to *Mama Natalie* a birthing simulator together with baby made by Laerdal and participants had the opportunity for some hands-on practice.

Highlights of the conference were the excellent presentations from nurses and midwives from the ECSA region demonstrating a broad range of knowledge and a very high standard. The conference provided a unique opportunity for nurses and midwives across the region to network and share experiences in lovely surroundings. The Mauritius Nursing Association were wonderful hosts.



President Mrs Monethi-Seeso



Senior Program Officer Alphonse Kalula



Lighting the lamp



President of MNA Mr B Kallooa



JUDITH SHAMIAN presents keynote speech at ECSACON conference



The keynote address at the 10th Scientific ECSACON Conference was given by Dr Judith Shamian, Chief Executive Officer of VON Canada. VON stands for Victorian Order of Nurses. VON Canada is Canada's largest national not-for-profit charitable home and community care organisation. Dr Shamian's presentation was titled: *Acceleration toward attainment of the Millennium Development Goals (MDGs) through revitalising primary health care: nurses and midwives sharing high impact interventions*

Dr Shamian gave a dynamic keynote address. She reminded participants that according to the World Health Organisation (WHO) the following four areas have to be addressed in order to achieve primary health care reform: universal coverage; service delivery; public policy; and leadership. Kates et al proposed a primary health care framework with six elements: population focus; patient engagement; partnerships with other community organisations; team work; performance measurements and quality improvements; and innovation. What this results in is:

- * better health,
- * better care,
- * better value, and
- * better nursing.

Dr Shamian explained that primary health care has the potential to repair, build and strengthen families, communities and countries and that this is true regardless of which country you come from – primary health care (going back to the basics, essentially – but evidence informed) is the key to sustainable health and health care for all. The dynamic role of nurses and midwives is what is going to make the difference if the MDGs are going to be achieved by 2015.



Of all the MDGs, the least progress has been made on MDG 5 – reducing maternal mortality by three quarters by 2015.

Dr Shamian discussed possible reasons for the failure to meet MDG 5. A lack of universal access to nursing and midwifery services. Nurses and midwives are not working to their full scope of practice. A lack of knowledge and insufficient education and skills acquisition. A lack of interprofessional collaborative models to support nursing and midwifery and an inadequate geographical distribution of trained health workers. Significantly, there is also an insufficient production of nurses and midwives globally.

Additionally, there are few incentives for nurses and midwives to practice in primary health care settings and a lack of access in primary health care settings to basic resources, such as technology. There is limited policy emphasis at government level on primary health care and a biomedical model which promotes acute care interventions rather than early intervention and health education.

Dr Shamian argued that the contribution of nurses and midwives is essential in moving the primary health care renewal agenda forward. Nurses and midwives can and do make a fundamental and critical contribution to the health of the population, through primary health care, when policy, funding, leadership and professional structures enable them to do so.



Dr Shamian reminded participants that it is a long journey for nurses and midwives to be acknowledged for the essential contribution they make to primary health care. If nurses and midwives genuinely want to make a difference they need to be at the table; speak out; work together; be strategic; lead, persevere; form national, regional and international partnerships; and above all, not give up.



Dr Judith Shamian is the immediate past President of the Canadian Nurses Association and has been nominated for President of the International Council of Nurses 2012-2017. <http://www.vonc.ca>

WHY CULTURE MATTERS in reducing the burden of NCDs and CDs in Africa

Collins Airhihenbuwa and Juliet Iwelunmor

In 2011, non-communicable diseases (NCDs) such as diabetes and hypertension were recognised at a UN high-level meeting 'as a threat to the achievement of internationally agreed upon goals' (United Nations 2011). The statistics are startling. For example, as of 2011, there were 366 million people living with diabetes and this is expected to rise to 522 million by 2030 (Whiting et al 2011). Currently, over 600 million people are hypertensive (Sacco et al 2011) and this is predicted to increase to a total of 1.56 billion people by 2025 (Lago et al 2007). In 2008 alone, NCDs and their risk factors were responsible for 36 million deaths, with nearly 80 per cent of these deaths occurring in low- and middle-income countries (WHO 2011). Also, nowhere is death and disability due to NCDs rising more rapidly than in sub-Saharan Africa, where it is projected that these diseases will outpace reductions in infectious diseases, contributing to a rising 'double-burden' of disease (Alwan et al 2011).

The underlying causes of NCDs are preventable risk factors such as tobacco use, unhealthy diets and physical inactivity, mediated by societal and environmental factors coupled with globalisation and rapid urbanisation. Research indicates that consumption of foods high in saturated and industrially produced trans fats, salt and sugar are responsible for 14 million deaths or 40 per cent of all deaths every year from NCDs, while 3.2 million deaths are attributable to insufficient physical activity (Beaghole et al 2011; Sacco et al 2011). To alter the course of the epidemic, as called for at the UN high-level meeting, there needs to be a major paradigm shift in current intervention strategies. It is time to move beyond individual-level lifestyle-focused policies and interventions to address the collective contexts (ie culture) that influence individual behaviours. Given the available evidence about the influence of culture on health and health behaviours, in this paper we highlight the role culture can play in the design of interventions aimed at reducing the global burden of NCDs such as diabetes and hypertension.

The objectives of the paper are: (1) to discuss why culture matters for priority actions to tackle the NCDs crisis; and (2) to propose a cultural model to support the management and control of NCDs such as hypertension and diabetes, drawing from lessons learned with applying the model in HIV and AIDS research.

Cultural determinants of management and control of NCDs

Whether it is hypertension or diabetes, available evidence demonstrates that culture plays a vital role in determining how these diseases are interpreted or managed by individuals. Culture is essentially a building block for constructing personal understandings of health and illness whether in relation to perceptions people may have about their health or in describing their health-seeking practices. Indeed, at the centre of the priority actions aimed at substantially reducing the burden of NCDs in Africa, considerations of culture are as important as the comprehensive package of primary prevention, sound leadership, health-care interventions and improved surveillance (BeLue et al 2009).

To reduce the burden of hypertension, primary prevention through a reduction in population-wide salt consumption is a top priority action (Beaghole et al 2011). However, reducing salt intake cannot be separated from cultural factors influencing nutrition-related beliefs and attitudes toward the use of salt in food preparation. In many parts of West Africa, bouillon cubes such as Maggi or Knorr are used in almost every household to enhance or intensify the taste of food (Akpanyung 2005; Nnorom et al 2007). According to Elemo and Makinde (1984), the major active ingredients in bouillon cubes are salt and monosodium glutamate. Yet, while concerns have been raised about their salt content (ibid; Nnorom et al 2007), they continue to be used extensively. A survey by Kerry et al (2005) found that almost all the participants (98 per cent) in Ashanti West Africa, reported using salt during cooking with 52 per cent in the rural villages and 56 per cent in the semi-urban villages adding bouillon cubes. Similarly, in the rural and urban areas of Enugu, Nigeria, Henry-Unaeze (2010) observed that 95.8 per cent of households used bouillon cubes. Although about 71 per cent of the participants were aware of the health problems associated with these cubes, the acquired taste now associated with them seemed a more important factor (ibid). As a result, while mass media campaigns help to create awareness about the health problems of salt consumption (Beaghole et al 2011), these efforts may be futile if the same vigour is not applied to addressing the cultural factors driving patterns and sources of salt intake.

In the context of diabetes management and control, as with hypertension, numerous policies and prevention campaigns are underway to promote the consumption of food low in sugar. While these actions may signal optimism for the management and control of diabetes, their success will also rely on addressing the cultural dynamics that frame everyday management and self-care practices (De-Graft 2004).

Indeed, available evidence indicates that cultural influences play a critical role in shaping how individuals and families perceive, diagnose and manage the disease. For example, in Bafut, Cameroon, Awah et al (2009) observed that there were multiple indigenous labels for diabetes, which was referred to as 'fumbgwuang' or 'shugar' with the prefix 'nighoni' (sickness or disease). 'Nighoni-hugar' thus denotes 'sugar disease' and 'nighoni-fumbgwuang' means 'disease that is sweet'. They noted that these indigenous labels for diabetes subsequently influenced self-diagnosis and management in both traditional and modern biomedical settings. Indigenous diagnostic tools such as divination were also found to be important in guiding the naming, diagnosis and management of diabetes (ibid). The findings of this study underscore how diabetes straddles modern lifestyles and traditional beliefs and how socio-cultural knowledge may influence treatment-seeking choices and practices.

Similarly, in Ghana, De-Graft (2003; 2004) observed that the Twi term 'esikyere yare', which literally means 'sugar disease', was used to describe diabetes with the notion of 'esikafoo yare' (disease of the wealthy). According to De-Graft (2003), rural and low-income urban respondents argued that 'since sugary and fatty foods were common among the rich, in terms of access and acquired taste, diabetes was likely to be more prevalent within this social group.' These eclectic sources of knowledge informed multiple illness action for diabetes whether in relation to drug treatment, dietary management or spirituality.

Like diagnosis, culture also influences caring behaviours. In Dar-es-Salaam, Tanzania, Kolling and colleagues (2010) observed that living with diabetes or caring for someone with diabetes was very much a family matter whether in terms of acquiring medicine, accompanying a family member to a health clinic or in the provision of a healthy diet.

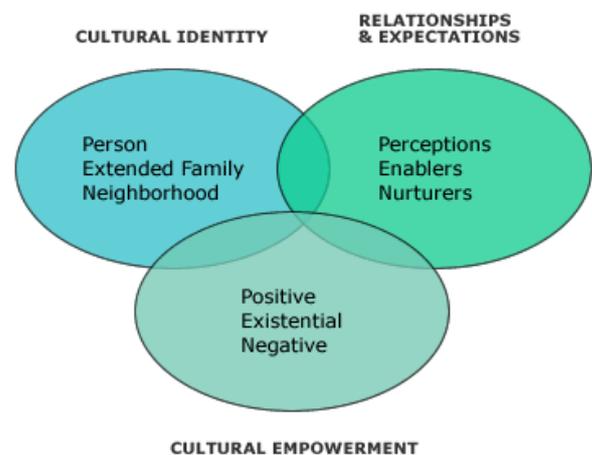
Together, these studies illustrate that culture is central to reducing the burden of NCDs such as hypertension and diabetes. While researchers in and outside of Africa may debate when and where culture should matter, what is no longer in question is the role of culture in decisions about health and well-being. Indeed, public health and development interventions for hypertension and diabetes in Africa will continue to be inadequate and unsustainable until we are resolute about ensuring that these interventions are anchored in culture.

One starting point is the use of the PEN-3 cultural model in the development, implementation and evaluation of health interventions for NCDs.

Cultural response to diseases: lessons from the application of the PEN-3 cultural model

Culture is a collective sense of consciousness with both quantifiable and unquantifiable components. The PEN-3 model (see figure below) was developed in 1989 (Airhihenbuwa 1989) to centralise culture in public health and health education programmes in Africa. It consists of three primary domains: relationships and expectations; cultural empowerment; and cultural identity. Each domain includes three factors that form the acronym PEN: person, extended family, neighbourhood (cultural identity domain); positive, existential, negative (cultural empowerment domain); and perceptions, enablers, nurturers (relationships and expectations domain). The PEN-3 emphasises behaviour within the broader context of culture to discern the roles, values and norms that are supportive or not supportive of different types of activities aimed at promoting health. PEN-3 offers a cultural lens for addressing health issues and problems by first identifying the positive aspects of a culture.

THE PEN-3 MODEL



In the 23 years of its application in over 100 studies globally, the most important feature of the model has been the recognition that all cultures have positive aspects to them, particularly in the case of health problems that concern relationships with others and/or the influence of family and community contexts in nurturing the health behaviour of interest. While conventional models of health behaviour change may focus primarily on ways to change negative health behaviours and practices, the PEN-3 model provides the opportunity to examine the values and beliefs that promote the health behaviour of interest or pose no threat to health so that negative values or beliefs are located within the broader context of culture. It shifts away from the exclusive focus on individuals to a much broader emphasis on the relationships and expectations within given contexts and insists that every context includes something positive, something unique and something negative.

Although this paper focuses on the cultural contexts of managing hypertension and diabetes, we can learn important lessons from studies applying the PEN-3 model to HIV and AIDS as they underscore the importance of incorporating culturally relevant factors in the development of effective health interventions. When the PEN-3 cultural model was used to explore factors that influence HIV disclosure among women in South Africa, Iwelunmor et al (2010) revealed there could be both positive (eg acceptance and support) and negative (eg disruptions in mother-daughter relationships) consequences associated with disclosure, while the existential role of motherhood (ie breastfeeding) could influence a participant's decision to disclose. This cultural analysis revealed the importance of viewing mothers from a positive and empowering lens while recognising the unique location of their multiple agencies in the family and community (ibid). In using the PEN-3 cultural model to explore the meaning of HIV and AIDS stigma in South Africa, families and health care centres were found to have both 'positive non-stigmatising values' enabled through supportive roles, 'existential values unique to contexts' such as the importance of food in contextualising relationships, and 'negative stigmatising characteristics' such as blaming HIV and AIDS on women (Airhihenbuwa et al 2009). When stigma is framed within a cultural lens, the priorities for change originate from within the culturally defined group. They are driven by collective understandings of what the major problems are followed by steps on ways these problems ought to be resolved. The contexts of stigma are then transformed through collective discussions that highlight ways to reduce stigma by promoting positive behaviours and changing negative ones (Airhihenbuwa et al 2009; Smith and Mbakwem 2010).

For diabetes, PEN-3 is considered to be an effective strategy to address the cultural bases of diabetes prevention among African Americans in the United States (Cowdery, Parker and Thompson 2010), among Mexican Americans (Melancon et al 2009) and among British Bangladeshis (Grace et al 2008). As illustrated in these studies, at the core of the PEN-3 cultural model is an evaluation of the ways in which culture influences, nurtures or constrains health behaviour change. A key point here is that such evaluations are necessary to understand the ways in which health behaviours are constructed and to develop solutions from within a given culture. Moreover, to overlook the apparent role of culture is to risk ignoring positive actions already engaged by people or actions that pose no threat to health.

PEN-3 cultural model applied to HIV and AIDS, diabetes and hypertension

To fully underscore the key tenets of culture as applied to health outcomes, we present a table (Table 1) that shows briefly the cultural importance of behaviour, drawing on lessons learned in HIV and AIDS to illustrate implications for prevention and management of hypertension and diabetes in Africa. In the table, we crossed one domain of PEN-3 with the three health outcomes of HIV and AIDS, hypertension and diabetes. Under each of the health outcomes, we used signs for positive, existential and negative. Our intent is to highlight key cultural values and practices that should be promoted, acknowledged and/or discouraged. The table also demonstrates how culture can contribute to the overall success of priority actions against diabetes and hypertension. What we want to demonstrate is that every context has something good, something unique and something bad. We should always begin with the positive to affirm and applaud positive actions that exist in the community. We should not blame unique qualities, often represented as culture, for the failure to develop an effective and sustainable intervention. While we focus on the negative to be changed, we should not focus only on the negative without promoting the positive and recognising the unique, existential cultural qualities.

Conclusions

Culture is central to reducing the burden of NCDs in Africa. We have presented a brief description of a cultural model that has been used to address health problems by drawing on lessons learned in HIV and AIDS to inform strategies to reduce the burden of hypertension and diabetes. Since these diseases are intricately linked to behaviours we must engage in to survive and thrive – eating and drinking – the role of culture is even more critical than in behaviours that have no value for life, such as smoking. A critical part of policy and program decisions needed to address these health outcomes requires an excavating of cultural food ways that were discarded, and finding more affirmation in the literature for their health benefits. For example, the nutritional value of coconut as an oil and skin product has never been more lauded as in current times. One only has to recall mothers and grandmothers who made family skin lotions from coconut extracts to acknowledge this cultural production in African countries. Culturally produced foods ranging from cassava and its leaves to yam and palm oil are experiencing resurgence in their value for health. Food preparation patterns of steaming and boiling (never frying) were the norm in many African cultures only to experience a decline in the era of modernity. These practices should be re-examined as cultural practices that are proven to be most sustainable in health promotion and disease prevention. If we are to bring the NCD burden in Africa under control, we must look to African cultures for the way forward.

Table 1: PEN-3, HIV and AIDS, hypertension and diabetes in cultural contexts

	PEN-3	HIV and AIDS	Hypertension	Diabetes
three health outcomes				
PERCEPTIONS	++We should not stigmatise but be supportive of persons living with HIV and AIDS	++Hypertension can be developed at any age by anyone regardless of education level	++Diabetes can be prevented and those who have it can manage it with the support of family and friends	
	==There are language codes used in different cultures to describe HIV	==There are language codes used to hide hypertension	==There are language codes used to lament having diabetes	
	—Knowing about how HIV is contracted has not resulted in changes in risk behaviour such as unprotected sex	—Knowing about high BP has not changed the behaviour of those who have it or those who do not like dietary change	—Knowing about diabetes has not changed the behaviour of those who have it or those who do not like dietary change	
ENABLERS	++Health-care workers are supportive of persons with HIV and AIDS	++Health and nutrition counselling by health-care workers	++Health and nutrition counselling by health-care workers	
	==African cultures are rich with nutritious food including fruits and vegetables that have proven effective in promoting health	==Use of traditional herbs and roots for healing and the role of spirituality in healing	==Use of traditional herbs and roots for healing and the role of spirituality in healing	
	—Health-care providers and government policies that discriminate against persons living with HIV and AIDS	—Lack of screening and treatment for highBP. Lack of the skills and resources for effective stress management and BP monitoring	—Lack of screening and treatment for diabetes. Lack of the skills and resources for effective diabetes management and monitoring	
NURTURERS	++Family members caring for loved ones	++Available and affordable nutritious foods rich in vitamins	++Available and affordable nutritious foods rich in vitamins	
	==Home-based care provided by people in the community	==Value placed on sharing meals together as a family	== ‘esikyere yare’ (Ghana); ‘fumbgwuang’ or ‘shugar’ (Cameroon)	
	—Family rejecting a member of their family at a time they need support because they live with HIV and AIDS	—Cooking with Maggi cubes and bouillon known for excess salt. Local drinks with too much sugar.	—Cooking with Maggi cubes and bouillon known for excess salt. Local drinks with too much sugar	

The table uses colours, in addition to the signs, consistent with universal traffic signals to indicate positive behaviour and contexts: ‘green’ for behaviour that we should continue; ‘yellow’ for existential behaviour to be recognised and acknowledged; and ‘red’ for behaviour to stop until it changes to positive



This paper was prepared for the 2012 Commonwealth Health Ministers’ meeting (CHMM) and published by Nexus Partnerships in *Commonwealth Health Partnerships 2012* on behalf of the Commonwealth Secretariat. It is reproduced in the *Commonwealth Nurse* with the permission of the authors. The theme for the 2012 CHMM was: *Linking non-communicable and communicable disease*.

Dr Airhihenbuwa presented his paper at the Commonwealth Partners’ Forum held in conjunction with the CHMM. The theme for the Forum was: *Culture connects: linking communicable and non-communicable disease*.

The Commonwealth Partners’ Forum was hosted by the Commonwealth Health Professions Alliance, McKinsey and Company, and the Commonwealth Foundation. These groups argue that culture is a significant factor in people’s response to health messages and that in giving messages about non-communicable disease much can be learned from the way messages about communicable disease was framed in a cultural context. Dr Christoph Benn from the Global Fund was the other keynote speaker at the Forum which was moderated by Dr Nicolaus Henke from McKinsey and Company.

Further information and a list of references for this paper are available from: <http://www.chpa.co>.

Collins Airhihenbuwa and **Juliet Iwelunmor** are with the Department of Biobehavioural Health, Penn State University, Health and Human Development. Professor Airhihenbuwa is the Head of Department and the author of the PEN-3 model for health behaviour with a focus on people of African descent.

MAKING A DIFFERENCE: The African Regulatory Collaborative

The African Health Profession Regulatory Collaborative for Nurses and Midwives (ARC) is a four-year partnership between the Centers for Disease Control and Prevention (CDC); the Commonwealth Secretariat; the Lillian Carter Center for Global Health and Social Responsibility at Emory University; the East, Central and Southern Africa Health Community (ECSA-HC); and the Commonwealth Nurses Federation (CNF).

ARC convenes nurse and midwife leaders from participating African countries for the purpose of facilitating south-to-south collaboration around professional regulatory issues, such as scope of practice, licensing, accreditation of training, and continuing education. The ARC initiative was made possible through funding from the United States of America President's Emergency Plan for AIDS Relief (PEPFAR).

Objectives

ARC has four overarching objectives for meeting global standards for education and practice. These objectives are aimed at advancing regulatory frameworks, strengthening organizational capacity, and developing nursing and midwifery leadership.

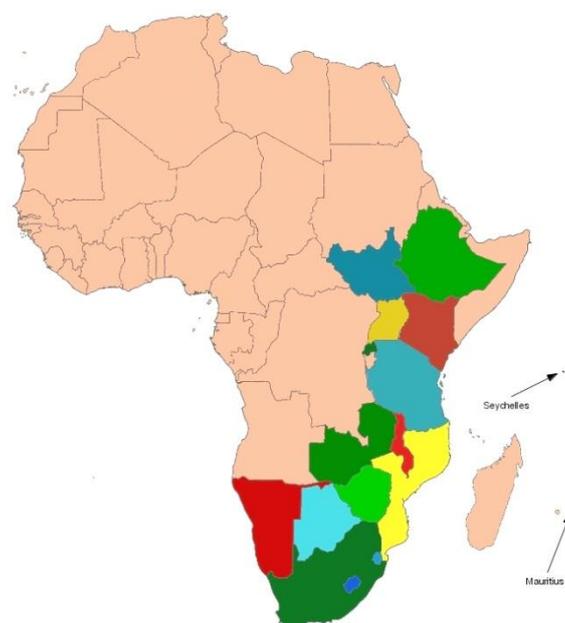
1. Ensure that quality standards of nursing and midwifery practice are harmonized in the east, central and southern Africa (ECSA) region and align with global standards.
2. Ensure that national regulatory frameworks for nursing and midwifery are updated to reflect nationally- approved reforms to practice 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 sustained consortia of African health leadership in nursing and midwifery practice and regulation.

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

¹ The Breakthrough Series: IHI's collaborative model for achieving breakthrough improvement. Cambridge, Massachusetts: Institute for Healthcare Improvement 2003. Available from: <http://www.IHI.org>

During the Learning Sessions, teams from participating organisations come together to learn about and discuss the chosen topic and plan specific changes to implement in their home institutions. During the Action Periods, the teams return to their home institutions and work together on the planned changes. At the conclusion of the collaborative cycle, participating organisations engage in a Regional Congress to share lessons learned and produce publications to share their breakthrough improvements.

Participating countries in the ARC initiative are those in the east, central and southern Africa (ECSA) region: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, the Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.



The first meeting of ARC was held in Nairobi, Kenya in February 2011 with fourteen ECSA countries attending. At the meeting, ARC issued a call to countries for the submission of proposals for small grants (US\$10,000) to work on an aspect of regulatory change. Ten countries submitted proposals with five countries being successful.



Lesotho submitted a proposal to develop a national continuing professional development program (CPD). Malawi submitted a proposal to enhance the implementation of their national CPD program and develop monitoring and evaluation tools.

Mauritius submitted a proposal to insert a mandatory qualification for nurse and midwife educators into their nursing and midwifery legislation. The Seychelles submitted a proposal to review their nursing and midwifery legislation to include a requirement for the Registrar to be a nurse and to clearly outline the Registrar's role and Swaziland submitted a proposal to develop a national CPD program.

Two learning sessions were held for the five countries – Durban, South Africa in June 2011 and Arusha, Tanzania in September 2011 – when the countries were provided with an opportunity to report on their progress; gain feedback from their colleagues; and develop practical skills in project management.



Year 2 of the ARC initiative began with a regional congress in June 2012 in Johannesburg, South Africa with 17 countries attending. Ten countries submitted proposals for small grants with six countries being successful.

Botswana and Tanzania both submitted proposals to develop national CPD programs. Uganda submitted a proposal to develop 'scopes of practice' for their nursing and midwifery cadres. Kenya submitted a proposal to decentralise their regulatory functions in line with the country's new constitution and Swaziland submitted a proposal to implement the national CPD program they developed in ARC Year 1.



The first learning session for the six successful countries was held in Pretoria, South Africa in September 2011. The second learning session will be held in Gaborone, Botswana in February 2012.



The innovative design of the ARC initiative has led to a range of very successful outcomes. One of the most important outcomes has been the strengthening of nursing and midwifery leadership in each country. The ARC proposals require that a high-level consortium - a quad - is established comprising the chief nursing officer, the registrar of the regulatory body, the president or chief executive of the national nursing association and a senior representative of nursing and midwifery education. The quad not only has to submit the proposal but also commit to working together to manage and implement the project. Coming together for the ARC initiative is quite often the first time that the nursing and midwifery leadership in countries have worked together on anything. The positive relationships and understanding that have resulted within the nursing and midwifery leadership has been a significant development with flow on effects to other areas of cooperation.

Another important outcome has been the South-to-South learning and networking. In a positive and collegiate environment, countries learn from and share with each other. The successful outcomes of the different projects will make an immeasurable contribution to nursing and midwifery in each country both now and into the future.

The CNF and CNF members have also benefitted. The CNF has been able to generate income from the services it provides to ARC. The CNF writes the reports of each meeting. These can be found on the CNF website: <http://www.commonwealthnurses.org>. The CNF also provides technical assistance to specific countries, particularly in relation to CPD and scopes of practice and in the future hopes to be able to work with countries to develop competency standards and workload measurement tools. The ARC meetings also provide an opportunity for the CNF to meet with its members in the ECSA region and develop a closer relationship with them.

The ARC initiative is a win-win situation for everyone involved; a wonderful example of what can be achieved when there is vision, commitment and hard work. The CNF is hoping that at the end of the 4 year initiative, funding will be available to replicate the initiative in West Africa.



NURSES AS AGENTS OF CHANGE

Promoting safe care and safe practice in South Africa



Nurses are in a potentially powerful position to be agents of change within their profession and within their country. Nurses are well educated; they are the largest group of workers within the health sector so have the advantage of numbers; they are generally well organised with a national nurses association; and they have a good relationship with the community.

The Commonwealth Nurses Federation in partnership with the Democratic Nursing Organisation of South Africa (DENOSA) conducted a two day workshop for thirty three nurses in Pretoria South Africa 25-26 June 2012 on patient and nurse safety. Workshop participants were nursing leaders across South Africa responsible for ongoing education and were committed to replicating the workshop in their own districts. The workshop was funded through a grant from the Commonwealth Foundation.

The rationale for the workshop is that when nurses are given the opportunity to update knowledge and reflect on what they, as individuals and as professionals, can do to raise the standards of the profession and improve quality of care they become agents of change amongst their peers and within their own workplaces.

Four local leaders, Mr David Makhombe, Ms Judy Mahlelehlele, Ms Thembeke Gwagwa, and Ms Madithapo Masemola, addressed the key themes of the workshop: a safe patient, a safe workplace, a safe profession, and a safe nurse. The workshop was structured as a mix between formal presentations, group work, problem solving, and self reflection.



Mr Makhombe said that, in his view as a patient, the most important issues were dignity, privacy, confidentiality, and respect. He emphasised the importance of nursing care being consistent regardless of whether it was provided in the public or private sector. He used the analogy of the service provided to business class passengers on an aeroplane and the vastly difference service provided to economy class passengers; stressing that this was not how nursing care should be provided; that care should be based on need, not on capacity to pay.

Following reflection, discussion, and voting, participants decided that the most critical factors for patient safety were:

- Adequate resources - functional, high quality, efficient, and effective;
- A safe environment - clean, free of hazards or danger, well ventilated, free from infection, with safe disposal of sharps and waste;
- Safe staffing - adequate in number, well trained, well paid, motivated, competent, knowledgeable, and with a positive attitude;
- Patients who had a sense of belonging – through feeling welcome and through the provision of respect, confidentiality, privacy, dignity, and safe care;
- Good identification of nurses and patients in the care environment, the provision of an information desk, and directional signs;
- A secure environment - access control, metal detectors, and security guards.

Participants were randomly assigned to groups for group work and problem solving exercises.



Ms Judy Mahlelehlele discussed with participants their role in promoting a safe workplace and their rights and responsibilities. Ms Mahlelehlele provided information to participants about the provisions in the South African Health and Safety Act and encouraged participants to be familiar with the legislation which outlined their rights and responsibilities.



Participants decided that the key hazards in their workplaces were infection, injury, and violence. They considered the contributing factors and what action needed to be taken to make workplaces safer for health workers and safer for the people to whom they were providing care. Contributing factors were identified as:

- staff shortages;
- inadequate protection (lack of security staff and unsafe environments);
- lack of resources and equipment (back injuries, needle-stick injuries);
- excessive workloads (burnout, stress, poor judgement);
- lack of skills development;
- lack of management support;
- poor staff compliance; and
- no effective safety committees.

Using prepared scenarios, participants' problem solved potentially unsafe situations in the workplace and how they could be managed.



Ms Thembeke Gwaga, General Secretary of DENOSA, gave an inspiring talk outlining the critical factors in achieving a safe nursing profession in South Africa. Ms Gwaga said that a safe profession is one in which the members delivered safe quality care; where care is well-planned and outcomes oriented; where a caring management environment is fostered and maintained; and where the members receive recognition and respect.

Ms Gwaga explained to participants that a safe profession was comprised of safe practitioners who:

- acknowledged the right of patients to receive safe and high quality nursing care;
- provided patient centred and focused nursing care;
- provided respectful care to patients and clients;
- kept themselves abreast with new developments in nursing practice; and
- strove continuously for safe care and safe practice.

To be safe however, the environment in which members of a profession work, also needed to be safe, which meant the provision of:

- competent staff who adhere to proper work standards and ethics;
- adequate break times for nurses to prevent tiredness;
- adequate staffing (nurse to patient ratios) and equipment;
- good ergonomics - seating, lighting etc;
- safe delegation; and
- written and up-to-date standards, protocols, policies, procedures.

Ms Gwaga concluded by reminding participants that a patient is only safe when the nurse is safe; and a nurse is only safe when the profession is safe.



Ms Madithapo Masemola said that intertwined in the promotion of safe patient care is the critical issue of nurse safety. The key characteristics of a safe nurse were that they:

- acknowledged their own strengths and weaknesses;
- kept abreast of new developments;
- exercised the right to choice;
- provided patient centred nursing care;
- acknowledged patients' rights and took responsibility for their own actions; and
- respected life.

The factors that contributed to an unsafe nurse included:

- Poor staffing levels leading to burnout; stress and tension; and depression and anxiety;
- Long shifts which lead to needle stick injuries; musculoskeletal injuries; medico legal hazards; and infections; and
- Workplace violence such as verbal and physical abuse by patients, relatives, and colleagues.

Ms Masemola concluded by reminding participants that a safe nurse equals quality nursing services leading to a safe patient which leads to healthy communities.



Medical Aid Films (MAF) produces innovative training and education films on maternal, infant and child health. The films are very clear, easy to download, accurate, and informative. The short animated films can be downloaded free from the internet to computers, mobile phones and other digital media. Some of the wonderful films produced by MAF are outlined below but there are many others. Their website is well worth a visit and CNF can highly recommend their films which CNF intends to use in all future maternal and child health training. Films are also available in French and Swahili.

The Global Health Media Project aims to put practical, life-saving knowledge into the hands of health workers at the point of care.

Global Health Media produces short, engaging videos which provide simple and clear messages to help health workers gain the knowledge and basic skills known to save lives. Health workers in poorer countries often lack access to basic information essential to providing effective health care.

The high quality videos have been effectively compressed so they can be downloaded free on a variety of mobile devices to meet the learning needs of frontline health workers in an accessible and cost effective way.



Prevention and management of primary postpartum haemorrhage

As well as explaining how a healthy childbirth should occur, this film teaches what PPH is, how to diagnose it and the steps to follow to prevent maternal death from PPH. It also provides information about how predict a PPH, and how to prevent it.



Basic skills



Inserting a gastric tube



Feeding with a gastric tube



Inserting an IV



Ten steps to safe delivery

This film follows Neema, a village birth attendant, while she helps to deliver a baby in a rural setting where there is no access to trained health workers. It teaches 10 key steps that will lead to a safe delivery, including cutting the cord with a new clean razor blade.



Newborn physical exam



Breathing problems



Referring a sick baby



Umbilical infections



Neonatal Resuscitation

This film teaches the essential steps to safely and effectively perform neonatal resuscitation.

Many more films are available and are free to download. Go to:

<http://www.medicalaidfilms.org>.



Setting up an IV line



Taking a heel blood sample

The videos can be downloaded free to computers, mobile phones and other electronic devices.

For more information and to download go to:

<http://www.globalhealthmedia.org>

MARGARET BRAYTON TURNS 93

Margaret Brayton was the first Executive Secretary of the Commonwealth Nurses Federation. Miss Brayton started at the CNF on the 1st January 1973 and held the position for twenty years. Prior to taking up her appointment with the CNF, Miss Brayton was Regional Nursing Officer of the South Eastern Regional Hospital Board in Scotland for 13 years.



Margaret with Maura Buchanan former President of the Royal College of Nursing

Miss Brayton was a wonderful ambassador for nursing and for the CNF and made a significant contribution to establishing national nursing associations in many Commonwealth countries and to ensuring the CNF was established on firm foundations and sound principles. Margaret made many friends within the Commonwealth during her tenure as Executive Secretary of the CNF and was active in Commonwealth circles until well into her 80's. Margaret now resides in a nursing home where she recently celebrated her 93rd birthday.



Margaret with Maura, Dorothy Turner (Nurses Association of Jamaica UK) and Betty Why (Association of Guyanese Nurses and Allied Professionals UK)

COMING EVENTS



10th CNF Europe Region Conference

Advancing nursing and midwifery through evidence based practice

15-16 March 2013 Larnaca Cyprus

CALL FOR ABSTRACTS

Closing date for abstracts: Friday 14 December 2012

For more information go to:

<http://www.cyna.org>



Tanzania Nursing and Midwifery Council

60th Anniversary Conference

Looking back and thinking ahead

16-19 March 2013 Dar es Salaam, Tanzania

CALL FOR ABSTRACTS

Closing date for abstracts: Sunday 30 December 2012

For more information go to:

<http://www.tnmc.go.tz>



ICN 25th Quadrennial Congress

Equity and access to health care

18-23 March 2013 Melbourne, Australia

REGISTRATION NOW OPEN

For more information go to:

<http://www.icn.ch>

Conference 2014

Commonwealth Nurses Federation

NURSES AND MIDWIVES: AGENTS OF CHANGE

2nd Commonwealth Nurses Conference

Saturday 8 and Sunday 9 March 2014

London United Kingdom

Conference Announcement

The conference will be based around key themes and will provide an opportunity for nurses and midwives to showcase their practice and share their contribution to improving the health and wellbeing of citizens of the Commonwealth.

The conference is being held on the eve of Commonwealth Week 10–14 March 2014; so come and join the celebrations and fun on Commonwealth Day Monday 10 March 2014 and other Commonwealth Week events.



Commonwealth
Nurses Federation