AFRICAN HEALTH PROFESSIONS

Regional Collaborative for Nurses and Midwives

ARC West and Central

2nd Summative Congress

Abidjan Cote d'Ivoire July 2016

PEPFAR

EMORY NELL HODGSON WOODRUFF SCHOOL OF NURSING

Commonwealth Nurses and Midwives Federation

ACKNOWLEDGEMENTS

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AFRICAN HEALTH PROFESSIONS REGIONAL COLLABORATIVE

PARTNERSHIP FOR EXCELLENCE IN AFRICA'S HEALTH WORKFORCE

Abidjan Cote d'Ivoire 25-26 July 2016

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARC	African Health Professions Regulatory Collaborative
ART	Antiretroviral therapy
ARV	Antiretroviral
CAGs	Community ART groups
CDC	US Centers for Disease Control and Prevention
CFR	Case fatality ratio
CNMF	Commonwealth Nurses and Midwives Federation
CPD	Continuing Professional Development
DRC	Democratic Republic of the Congo
ECSA	East, Central and Southern Africa
ECSA-HC	East, Central and Southern Africa Health Community
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
HIV	Human Immunodeficiency Virus
ICN	International Council of Nurses
IAC	International AIDS Conference
IHI	Institute for Healthcare Improvement
LARC	African Regional Collaborative for Laboratory Personnel
M&E	Monitoring and evaluation
MOH	Ministry of Health
MTCT	Mother to child transmission
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
NNA	National nursing association
PDSA	Plan, do, study, act
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	Preventing mother to child transmission (of HIV)
QI	Quality improvement
QUAD	Representative from Ministry of Health, Nursing and Midwifery Council, Academia, and Professional Association or Union
SOPs	Standing Operating Procedures
TB	Tuberculosis
UNDP	United Nations Development Program
URC	University Research Company
US	United States of America
VL	Viral load
WHO	World Health Organisation

PARTNERSHIP FOR EXCELLENCE IN AFRICA'S HEALTH WORKFORCE

Improving the performance of nurses and midwives providing Option B+ and paediatric HIV services at high volume sites

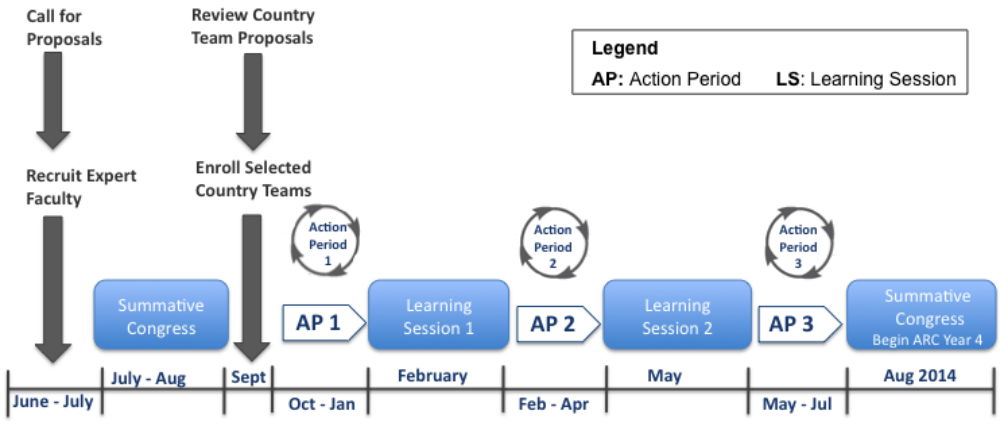
Abidjan Cote d'Ivoire 25-26 July 2016

1. EXECUTIVE SUMMARY

The United States Centers for Disease Control and Prevention (CDC) under the US President's Emergency Plan for AIDS Relief (PEPFAR); Emory University's Lillian Carter Center for Global Health and Social Responsibility; the East, Central and Southern Africa Health Community (ECSA-HC), and the Commonwealth Nurses and Midwives Federation established a collaboration in 2011 titled: *The African Health Professions Regulatory Collaborative* (ARC), which created 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 was to improve health professional standards and practice in the region using local solutions and peer-based learning.

The ARC conceptual framework is adapted from the Institute for Healthcare Improvement (IHI) model for breakthrough organisational change. The IHI 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 (see figure 1).

Figure 1: IHI Breakthrough Improvement Model (adapted for ARC)



The ARC quality improvement collaborative model calls for an annual summative of all eligible countries; the awarding of grants up to the value of US$10,000 for time limited and targeted projects to improve nurse delivered HIV services; two learning sessions throughout the life of the projects; in-country technical assistance for project implementation; and impact evaluation. The learning sessions provide a platform for technical presentations by experts; for sharing progress updates, tools, experiences, and challenges between country teams; and for working sessions. The ARC faculty provides mentorship and support throughout the course of the country's year-long projects.

From 2011 to 2015, ARC brought together representatives from 17 ECSA countries for an annual Summative Congress. During the four years of ARC Phase I, 32 quality improvement grants were awarded to enhance the provision of HIV prevention, care and treatment services. During the year of their grant, countries attended two learning session to monitor and share the progress of their projects and to gain additional skills in project management. Reports from the meetings and successful outcomes of the projects are outlined on the ARC website: http://www.africanregulatorycollaborative.com.

The success of the ARC initiative in the east, central and southern Africa region resulted in a proposal to expand the initiative to west and central Africa. This new region for ARC activity was requested by the CDC Paediatric PMTCT Technical Working Group with the objective to improve the performance of nurses and midwives providing paediatric ART services at high volume sites in the countries of Cameroon, Cote d'Ivoire, and the Democratic Republic of the Congo. Bringing together nursing and midwifery leadership teams from each country has two aims: first, to help break down silos between professional institutions within country and thus empower national level leadership to come together to own and lead improvements to nursing and midwifery in their countries; and second, to allow for regional dialogue and technical exchange to help advance context-appropriate and harmonized approaches to nursing and midwifery in the West and Central Africa region.

The ARC initiative in West Africa was launched in Yaounde Cameroon 21-23 July at a Summative Congress. Representatives from Cameroon, Cote d'Ivoire, and the Democratic Republic of the Congo attended the Summative and were invited to submit proposals for funding that would improve the capacity of nurses and midwives to provide Option B+ and paediatric HIV prevention, care and treatment. The proposals were designed to be accomplished within twelve months.

The Cameroon project aimed to provide continuing education for nurses and midwives offering PMTCT, Option B+, and paediatric HIV prevention, care and treatment at three high volume sites in the country. The project from the Democratic Republic of the Congo aimed to improve the quality of health data from nurses and midwives monitoring women on Option B+ as well as children with HIV in three hospitals located in the town of Kinshasa. Cote D'Ivoire's project aimed to develop a process for task sharing for nurses and midwives to support the implementation of Option B+ and paediatric care of children infected with HIV.

The first learning session for Year 1 of the ARC initiative in west and central Africa was held in Douala Cameroon 20-22 October 2015. Representatives from the Democratic Republic of the Congo, Cote d'Ivoire, and Cameroon attended the learning session along with invited guests and technical experts and ARC faculty members.

The second learning session for Year 1 of the ARC initiative in west and central Africa was held in Douala Cameroon 5-7 April 2016. Representatives from the Democratic Republic of the Congo, Cote d'Ivoire, and Cameroon attended the learning session along with invited guests and technical experts and ARC faculty members.

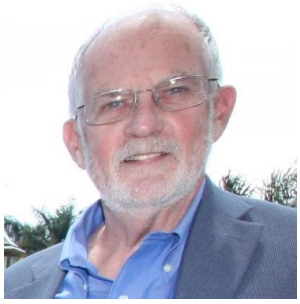
2. INTRODUCTION TO 2ND SUMMATIVE CONGRESS

The 2nd Summative Congress for ARC West and Central was held 25-26 July 2016 in Abidjan, Cote d'Ivoire. The Summative provided an opportunity for the three countries: Cameroon, Cote d'Ivoire, and the Democratic Republic of the Congo, to share the final reports of their Year 1 projects and plan for Year 2 project initiatives. The specific objectives of the Summative Congress were to:

- To provide a regional forum for learning and building expertise related to the latest guidelines and emerging models of care in Option B+ and pediatric HIV care and treatment.
- To present final reports and lessons learned on each of the three countries' ARC projects at high volume sites.
- To review instruments and methods for facility assessments and to prepare country teams to conduct site-level assessments.
- To prepare ARC QUADS to develop quality improvement proposals for year 2 of ARC activities.
- To foster collaboration and promote networking between nursing and midwifery leaders within each country and the region.

In addition to the country team representatives, the Summative was attended by technical experts and guests from CDC Cote d'Ivoire, PMTCT PEPFAR Cote d'Ivoire, the Cote d'Ivoire Ministry of Health, the Cote d'Ivoire University Research Company, and members of the ARC faculty.

3. GREETINGS FROM ARC PARTNERS



Professor Kenneth Hepburn welcomed participants to the ARC West and Central Year 1 Summative Congress. He said he was looking forward to the final project presentations. This was a learning year, he said, and he was interested in hearing from country teams what they accomplished, what were there challenges, and how they overcame them. He said the Summative Congress was also a preparation for ARC Year 2 which was characterised by the introduction of high HIV volume site facility assessments which participants would hear more about later. Professor Kenneth Hepburn introduced ARC Faculty attending the meeting, technical experts and guests.

Ms Jessica Gross gave a brief recap of the successful ARC East, Central and Southern Phase 1 and Phase 2 and emphasised the importance of the facility assessments which would form part of Year 2 for ARC West and Central. Ms Gross also shared with participants the plans for a site visit, organised by the Cote d'Ivoire team, which would provide participants with the opportunity to role play the administration of each of the three modules for the facility assessment.

Ms Jill Iliffe welcomed participants to the Summative Congress on behalf of the Commonwealth Nurses and Midwives Federation and said she was looking forward to the presentations of the final project reports. Ms Iliffe explained that one of her roles as an ARC faculty member was to prepare the report of the meeting and to maintain the ARC website where presentations from each meeting could be found.

4. OPENING REMARKS

Dr Serigne N'Diaye, CDC Division of Global Health Protection, Cote d'Ivoire

Dr Serigne N'Diaye welcomed participants to the Cote d'Ivoire and the meeting on behalf of CDC Cote d'Ivoire. Dr N'Diaye gave a brief overview of the situation in relation to HIV in Cote d'Ivoire and the activities of CDC, working with the Ministry of Health, to reach the goal of an AIDS free generation. Dr N'Diaye emphasised the important contribution that nurses and midwives make and commended the ARC initiative in contributing to improving the services that nurses and midwives provide to adults and children with HIV.

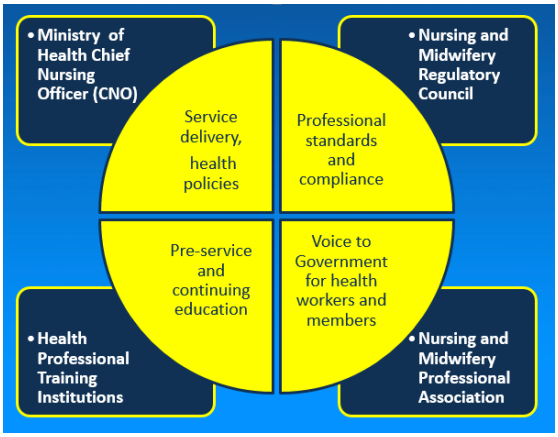
5. ARC and LARC UPDATE

Dr Muadi Mukenge, ARC Project Director, Emory University

Dr Mukenge said her presentation would cover the key activities and successes for ARC Phase I; the key aims and activities of ARC Phase II; and the objectives and new grants for the LARC initiative. The partners in the ARC initiative are the Centers for Disease Control and Prevention (CDC); Emory University, Nell Hodgson School of Nursing; the East, Central and Southern Africa Health Community; the Commonwealth Nurses and Midwives Federation; and the ARC Secretariat.

The ARC initiative has four major components: grants, technical assistance, learning sessions, and evaluation. The key representatives in the country teams, called QUADS, comprise a representative from the Ministry of Health, usually the Chief Nursing Officer; the Registrar of the Nursing and Midwifery Regulatory Council; a senior representative of nursing and midwifery training institutions; and the President of the national nursing and midwifery professional association.

Figure 2: The QUAD



ARC Phase I extended from 2011 to 2015. The aim was to ensure nurses' participation in HIV care; improve regulation for HIV service delivery; and support nursing and midwifery leaders. Initially, ARC Phase I focused on east and southern Africa. The ARC West and Central Collaborative was launched in July 2015. From 2011 to 2015 in ARC East and South, 7 countries established CPD programs; 12 countries advanced their CPD programs; 5 countries developed, reviewed or revised their scopes of practice (SOP); 3 countries reviewed and updated their Acts and Regulations; 1 country decentralised their regulatory council services; and 2 countries develop entry to practice exams.

ARC Phase II is proposed to extend from 2016 to 2018 and aims to support quality improvement of HIV care at priority, high-high volume sites. In ARC, the focus was on improving nurse-led PMTCT and Option B+ services and pediatric HIV care. In LARC, the focus is on addressing bottlenecks in the viral load scale-up.

In ARC East and Southern, eleven countries were awarded grants. The focus for Tanzania was on implementing their task sharing policy. The focus for Lesotho, Rwanda, Uganda, and Zambia was on clinical mentoring. Kenya, Zimbabwe and Swaziland focused on quality improvement and assurance. The focus for Malawi was on data quality and data use, while Ethiopia and Mozambique focused on improving patient and provider interaction.

In ARC West and Central there are three projects:

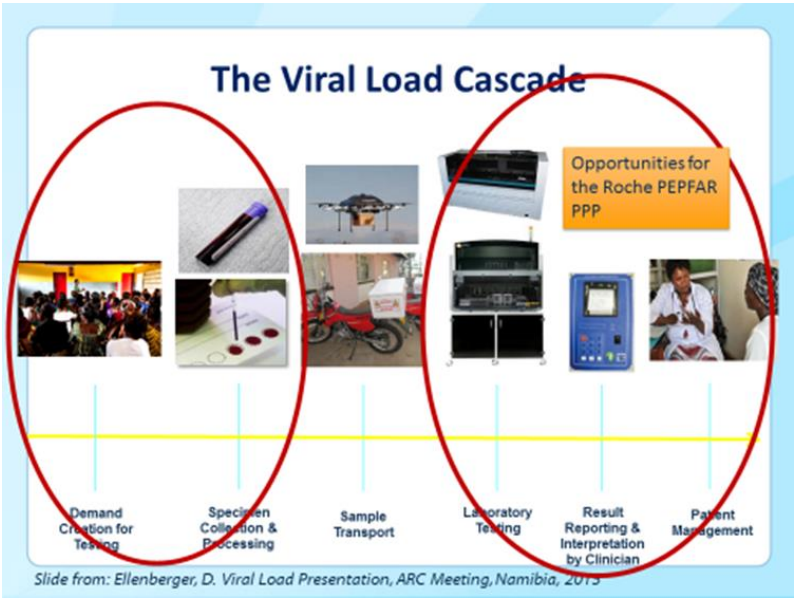
- **Cameroon**: The project is focused on conducting on-site CPD for nurses and midwives providing PMTCT B+ and pediatric HIV services.
- **Cote d'Ivoire**: The project focus is on facilitating task sharing (ie: NIMART) for PMTCT and pediatric HIV services.

- **Democratic Republic of the Congo** (DRC): The project focus in on improving PMTCT and paediatric HIV clinical documentation by nurses and midwives at three hospitals in Kinshasa.

LARC (African Regional Collaborative for Laboratory Personnel) was launched in February 2016 with the objective to support viral load scale-up in six countries: Kenya, Malawi, Mozambique, Swaziland, Tanzania, and Uganda.

Viral load monitoring measures the amount of virus in the blood. CD4 monitoring assesses the *chance* of infection while virological failure is the first indication that ART is not working (before immunological or clinical failure). This makes viral load monitoring is the strategy of choice to be able to identify treatment failure early; avoid drug resistance; and avoid unnecessary switches to 2nd line treatment.

Figure 3: The Viral Load Cascade



The LARC projects focused on particular aspects of the viral load cascade. The Kenya project focused on improving specimen collection. In Malawi the focus was on increasing patient demand for VL testing using community groups; Mozambique focused on implementing MOH VL guidelines, training staff and improving workflow; Swaziland focused on training laboratory staff and nurses to read viral load results and recognize high VL results for better patient follow-up. Tanzania focused on improving the quality of VL reporting by clinicians; and Uganda focused on developing, implementing and enforcing standing operating procedures (SOPs) to assure VL results are used for clinical decision-making in timely manner.

A key feature of ARC Phase II is a change to the evaluation of the impact of projects with the introduction of baseline and endline facility assessments. As will be explained by Ms Jessica Gross in a later presentation, the evaluation has three components: an interview with supervisors of nurses and midwives; a survey questionnaire completed by nurses and midwives; and an inventory of programs, policies, tools, and systems available to support nurses and midwives.

6. HIGHLIGHTS FROM THE 2016 INTERNATIONAL AIDS CONFERENCE

Dr Ekra Alexandre CDC Cote d'Ivoire

Dr Ekra explained that he was not able to attend the 21st International Conference on AIDS. The themes of the conference were: PMTCT; Progress toward the 90-90-90 targets; Quality management and quality improvement; and Models of care. Dr Elra noted that there were no sessions at the conference on human resources for health or capacity building of health care providers.

Dr Ekra shared with participants, summaries of relevant papers which were provided on the International Aids Conference (IAC) website, however emphasised that the points of view presented are those of the rapporteurs of the different sessions and do not necessarily reflect his views or those of his organisation. He also advised that as the presentations are not yet available on the IAC website, he could not share them with participants or support or illustrate the arguments, discussions and conclusions made by the rapporteurs. Dr Ekra shared highlights from a number of the papers or the information of participants.

Author: Felicita Hikuam
Summary: The session explored approaches to addressing challenges in PMTCT, Option B+ programmes through promotion of adherence and retention of mothers and infants in PMTCT and ART programmes through e.g. use of cell phone technology and employing innovative means to increase viral load testing in hard to reach settings.
Highlights:

- Viralogical suppression is key for the prevention of vertical transmission and keeping mothers alive.
- Virologic testing rates and adherence must be increased significantly by, amongst others, increasing access of rural populations to virological testing and using innovations such as mobile phone technology, to enable women to interact with the health system to ensure patient satisfaction.
- Limiting loss to follow-up can be achieved through identifying and supporting mothers at risk of defaulting, providing counselling and tracking those who miss antenatal appointments. Self-reported antenatal adherence could also be useful in low-resource settings to target interventions at women at risk of defaulting.

Author: Felicita Hikuam
Summary: A session on the impact of exposure to various interventions (including a peer mentor mother model, a systems engineering intervention, infant defaulter tracing, community and civil society involvement as well as policy change) on the elimination of vertical transmission of HIV from mother to child
Highlights:

- Peer to peer support results in improved PMTCT and other health outcomes.
- Follow-up activities to trace mothers and infants lost to follow-up also result in increased retention.
- Systems engineering, through analysis and improvement of service delivery systems along the PMTCT cascade, can optimize PMTCT coverage.
- Infant defaulter tracing of HIV-exposed infants improves retention, HIV diagnosis and ART initiation for these infants.
- A multipronged approach including leadership; coverage; integration; a decentralized M&E system and community involvement can contribute to significant progress towards PMTCT targets.
- The first 6 months postpartum are crucial for follow up to reduce vertical transmission.

Author: Lynette Lowndes
Summary: The session heard that policy is changing to test and treat, countries are using the 90-90-90 targets, PEPFAR and Global Fund are backing test and treat and 90-90-90, viral load access is increasing and communities are embracing earlier treatment
Highlights:

- Research in Haiti shows that same-day ART initiation is feasible and beneficial. It improves retention with virologic suppression and decreases mortality. It also is believed to increase the sense of hope, optimism, and connectedness to health care providers
- A review of viral suppression rates in a HIV program in Central and Eastern Kenya shows that good viral suppression rates can be achieved but are yet to reach the 90 target, females have better viral suppression than males, viral suppression is lower in younger clients, especially adolescents, and better in those above 25 years of age.

Author: Lynette Lowndes
Summary: This oral poster discussion focused on approaches to quality improvement and lessons learnt across programme areas ranging from PMTCT, voluntary male medical circumcision training, HIV and malnutrition amongst HIV-exposed infants, improving male partner testing in PMTCT and increasing linkage to HIV care.
Highlights:

- Gillian Dougherty reminded us of the need to focus on both service expansion and quality if we are to reach the 90-90-90 targets by 2020.
- The session highlighted continuous quality improvement focusing on leadership, team engagement, customers, processes and data, while also addressing the human side of change.
- A simple model for improvement was presented by Raymond Mause based on the questions - what are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in an improvement?

Author: Karine Dubé
Summary: The topic of this abstract-driven session was to create win-win synergies in service integration. Case studies covered family planning and HIV – particularly in areas of high HIV prevalence, HIV and TB responses, gender-based violence and HIV prevention, HIV and diabetes and/or hypertension.
Highlights:

- The session covered a number of great examples of successful integration in resource-limited settings. The key is to reduce the number of "missed opportunities" for service integration.
- Different models of integration were presented, including the one-stop shop model as well as internal referrals.
- The key message is that impactful service integration will require a focus on human resources for health – including training and capacity building.
- Further, organization of services, service delivery, financing and addressing systems-level barriers will be critical.

Author: Chris Mallouris
Summary: Scaling up treatment (reaching more people living with HIV, treat all) brings new demands on health systems given current capacity challenges. Differentiated models of care and using community ART groups for stable patients allow for simplified, people-centered solutions and alleviate burdens to and decongested health systems.
Highlights:

- Community ART Groups (CAGs): Original fears included fear of losing clients after diagnosis. But, after 15 months 98% retention in care and 86% still receiving care from CAGs (Zimbabwe). One client can represent a number (eg: 6) of peers. "Expert clients" trained.
- Other models include "Fast track drug pick up" and "Facility-based treatment clubs" (Swaziland)
- Community-based participation and ART delivery also empowers community members to demand treatment as well as build treatment literacy skills (importance of and when to demand viral load testing, TB screening, etc).

Author: Venita Ray
Summary: This session discussed differentiated model of care in order to implement the new WHO guidelines recommending 'treat all' and meeting the 90-90-90 goals and ending the epidemic by 2030. Panelist offered evidenced-based service delivery models that reflect a patient-centered approach with community engagement.
Highlights:

- Retention in care remains a major challenge; 50% drop after 5 year diagnosis. One size treatment does not fit all.
- PLHIV require ART in the community and not walk long distances to clinics and take long times waiting for services (given capacity limits of health system).
- As HIV care beings to be normalized, partnerships between patients and providers can address issues of over-burdened health systems while addressing simultaneously discrimination in health care settings.

7. REMARKS FROM WHO COTE D'IVOIRE

Dr Marie Catherine Barouan, Director of HIV and TB, WHO Cote d'Ivoire

Dr Barouan referred participants to the World Health Organisation (2010) Communicable Disease Epidemiology Profile Cote d'Ivoire (http://apps.who.int/iris/bitstream/10665/70300/1/WHO_HSE_GAR_DCE_2010.3_eng.pdf) which gives an overview of infectious diseases in Cote d'Ivoire including HIV and TB. The consequences of decades of political instability and armed conflict are reflected in the poor rankings of Côte d'Ivoire on the United Nations Development Programme (UNDP) Human Development Index (166 out of 177 countries) and the Human Poverty Index (92 out of 108 countries). The latter index in particular reflects severe deprivation in health by measuring the proportion of the population not expected to survive to age 40 years.

HIV infection is reported throughout the country, but the prevalence is higher in urban areas (5.4%: 7.4% among women, 3.2% among men) than in rural areas (4.1%: 5.5% among women, 2.5% among men). In emergency situations, exposure to distress, violence, lack of resources, and altered social networks may be associated with high-risk sexual behaviour and sexual violence. Lack of information and education, and shortages of basic commodities for preventing HIV, such as condoms, can also increase the risk of HIV transmission.

Lack of education and communication results in decreased opportunities for prevention among those not infected with HIV. Important materials for HIV prevention, such as condoms, are likely to be lacking in an emergency situation. Without adequate medical services, STIs, if left untreated in either partner, greatly increase the risk of acquiring HIV. Interruption of programmes preventing mother-to-child transmission. Lack of testing and counselling services delays diagnosis. Failure to treat concomitant opportunistic infections or illnesses and interruption or delayed commencement of antiretrovirals risk increasing the burden of illness and death among those already infected. Health-service quality may be compromised, with increased chances of transmission in the health-care setting owing to failure to observe universal precautions and to unsafe blood transfusion.

The repertoire of antiretrovirals available is currently limited in Côte d'Ivoire. Coverage of antiretrovirals in Côte d'Ivoire has increased from <5% (2004) to about 30% (2007). Coverage of antiretrovirals to HIV-positive pregnant women for the prevention of mother-to-child transmission (PMTCT) is about 12% (7). Antenatal testing for HIV is poor with only 51% and 21% of women offered counselling in urban and rural settings, respectively. In the west, this is as low as 6%. Only 7% of the women who were counselled for HIV testing at an antenatal visit were tested and received the results of the test. In 2006, 11.2% of pregnant women Côte d'Ivoire infected with HIV received antiretrovirals; this increased to 17.2% in the first half of 2007. Most children living with HIV acquire the infection through mother-to-child transmission (MTCT), which can occur during pregnancy, labour and delivery or during breastfeeding.

In the WHO African Region, TB is the leading cause of death among people living with HIV. The rise in multidrug resistant TB and extremely drug-resistant TB in and beyond the region underlines the pressing need for sustained coordinated clinical care and research.

Globally, Côte d'Ivoire is among the 15 countries with the highest incidence of TB. The impact of the HIV epidemic and years of civil war resulting in major disruptions in health services have severely worsened the disease burden. In 2006, the incidence of TB was 420 cases per 100,000 population per year, with a prevalence of 747 per 100,000, higher than the overall prevalence for the WHO African Region. The HIV prevalence in incident case of TB is 13.62% in Côte d'Ivoire, although this is probably an underestimate since the tracking of HIV among TB patients is relatively recent.

Population displacement disrupts existing TB-control activities, resulting in an increased risk of transmission. Movement of untreated TB patients into new areas spreads the disease. Movement of susceptible persons (e.g. immunosuppressed, malnourished, HIV-infected persons) into TB-endemic areas or camps increases the risk of acquisition. Treatment interruptions, treatment failure, treatment relapse and non-adherence to combination therapy lead to persistent reservoirs of TB and increase the risk of multidrug resistant TB. Overcrowding and poor indoor ventilation contribute to increased risk of transmission.

People affected by TB who cannot access health services for diagnosis and treatment remain infectious, thereby increasing transmissibility. Directly-observed therapy is a key component to maintaining drug adherence. The case-fatality ratio (CFR) is high without proper treatment. Interruption of treatment is one of the most important causes of development of multidrug-resistant TB. The vaccination of newborns is part of the national immunization schedule. In 2006, the estimated coverage of BCG was 77% in Côte d'Ivoire.

8. COUNTRY REPORTS

DEMOCRATIC REPUBLIC OF THE CONGO

The Democratic Republic of the Congo (DRC) project aims to improve the quality of health data by nurses and midwives caring for women on Option B+ as well as children with HIV in three hospitals located in the town of Kinshasa.

The team from the Democratic Republic of the Congo

The DRC project progress report was delivered by Mr Louis Djeko. The DRC provided the following statistics of their human resources for health profile.

- Number of physicians: 7,505 (Public: 6,246; Private: 1259)
- Physician index: 1 for 9993 (unequally distributed across the country)
- Number of nurses: 63,682 (Public: 60,332; Private: 3350)
- Nurse index: 9 per 10000 (unequally distributed across the country)
- Ratio nurse physician: 9 nurse for 1 physician
- Number of birth attendants: 1837 (Public: 1555; Private: 282)
- Number of lab technicians: 2315 (Public: 2160; Private: 155)
- Other health professionals: 6095 (Public: 5339; Private: 756)

DRC explained that Option B + was adopted in Kinshasa in 2014. The quality of the data that generate the patient's individual information or the test results are collected and is a direct determinant of the impact of the best management of HIV-positive women and children exposed and infected in the health facilities.

The main objectives were to:

- Make records of HIV + pregnant women and children exposed and infected up to date, comprehensive and timely for decisions to improve the quality of care;
- Establish a data quality monitoring system as a pilot phase in all three hospitals.

The DRC team explained that 46% of women were tested but only 29% of those tests were returned. The quality of the data was lacking. Three main activities were conducted:

- Development of data collection tools and approval by the QUAD,
- Interaction with nurses and midwives collecting the data,
- Training of investigators,
- Organisation of data collection,
- Data entry and coding,
- Analysis of data and sharing with stakeholders,
- The holding of the 6 QUAD meetings.

The project has sensitized the Ministry of Health on the quality of data on Option B+ and paediatric HIV and the use of documents which are obsolete with difficulties of the traceability and reliability of the data but especially on the quality of archiving and data security. The project has provided an overview of the quality of services.

The way the DRC team addressed the challenges were:

- Capacity building of nurses and midwives in the management of health data on the B + option and pediatric HIV in high-volume sites.
- Organising a system for archiving health data on the B + option and pediatric HIV in high-volume sites.
- Improving the transmission of national health information system reports in targeted structures.
- Organising the Steering Committee for quality assurance of nursing and midwifery in targeted structures.

CAMEROON

The Cameroon project aims to provide onsite continuing education for nurses and midwives offering PMTCT, Option B+ and paediatric HIV prevention, care and management in high volume sites.

The Cameroon team

The Cameroon project progress report was delivered by Ms Annie Hortense Atchoumi. The overall aim of the Cameroon project is to improve the capacity of nurses and midwives in the management of pediatric HIV and Option B+ and the quality of service provision in three sites with high attendance for HIV.

The specific objectives of the project are to:

1. Improve coordination between the QUAD and stakeholders;
2. Strengthen the on-site capacity of nurses and midwives in quality care, PMTCT and Option B+ and paediatric HIV care in three high volume sites;
3. Improve the organization of adequate care in collaboration with the institution.
4. Improve mentorship and monitoring of performance on quality management at each site.
5. Participate in capacity building activities for QUAD members.

Activities undertaken included:

- Organisation of meetings of the QUAD and stakeholders.
- Three capacity building workshops for 15 nurses and midwives on PMTCT, Option B+, and paediatric HIV care.
- Selection of three mentors for training, one from each of the three project sites.
- Organisation of three capacity building workshops for six staff on internal supervision.
- Organisation of six internal supervision visits, two for each site.
- Organisation of external supervision of the three facilities.

Moving forward, the QUAD intends also to organise scale up of the approach taken to participatory collaboration in other health facilities. A meeting of the QUAD plus and other stakeholders is planned to share the results of the project.

COTE D'IVOIRE

The Cote D'Ivoire project aims to facilitate the creation of a task sharing policy to support the implementation of Option B+ and paediatric care of children infected with HIV.

The team from Cote d'Ivoire

The Cote D'Ivoire report was delivered by Mrs Kadidia Sow. Cote d'Ivoire explained that their country was limited to the north by Mali and Burkina Faso; to the west by Liberia and Guinea; to the east by Ghana; and to the south by the Atlantic Ocean. The population was estimated at 25,232,905 inhabitants in 2012. The political and administrative capital is Yamoussoukro, however Abidjan remains the economic capital of the country.

The specific objectives of the Cote D'Ivoire project are to:

1. Promote the signing and dissemination of a circular note on the effective implementation of task shifting and HIV treatment to nurses and midwives;
2. Start revising or creating scopes of practice for nurses and midwives to include the treatment of PLWHIV;
3. Help create a framework document specifying the roles, responsibilities and duties to be delegated to nurses and midwives;

4. Conduct a quick assessment of the two sites where the task sharing pilot will be implemented;
5. Raise nurses and midwives' awareness of the effective implementation of task shifting HIV treatment at the two sites.

Cote d'Ivoire reported they had contributed to the dissemination of the circular note to nurses and midwives on task shifting and HIV treatment. Analytical tools have been produced, notably those for the collection of situational analysis data. Three sites had been identified and evaluated and assessment tools had been developed. They had been involved in awareness raising among the staff at the three facilities; and in preparing and validating their report. They had also purchased essential equipment for the successful implementation of their project. As a result of these activities, Cote d'Ivoire considered that there had been significant impact, including improved maternal screening; improving access to care (reducing wait times); and more enthusiasm from nurses and midwives in carrying out their activities. Nurses and midwives feel more responsible and valued, hence their effective involvement.

The QUAD were also able to reinforce the provision of equipment at the various hospitals such as the need for a wall thermometer at Port-Bouet General Hospital; a screen for privacy at Koumassi General Hospital; and a computer for the pharmacy at Abbo General Hospital. All these needs were met after the visit of the QUAD.

Treatment protocols and guidelines had been distributed to all providers and at the national level: training of service providers on the delegation of tasks organized by PEPFAR implementing partners and introduction of the module on delegation of tasks relating to Option B+. Patients had also been motivated by attend treatment centres through the involvement of community workers.

Cote d'Ivoire noted there was strong political commitment through the signing of a directive on the delegation of tasks and the existence of a directorate in charge of nurses and midwives in the Ministry of Health and Public Hygiene, as well as the adoption of the new WHO recommendations 2013 on Option B+ and delegation of tasks. Additionally, the development, signing and dissemination of guidelines for new WHO recommendations; updating providers (midwives, doctors, nurses) on the new guidelines; and the training of nurses and midwives on task delegation and Option B+.

The project is important to Cote d'Ivoire as it contributes to the decline in the HIV prevalence rate; improving the care of PLHIV; involvement of nurses and midwives in the implementation of PMTCT, Option B+, and paediatric HIV care; and increase attendance at centers for care.

The project's management encountered some difficulties that the QUAD CI members had to overcome. These include: unavailability of members of the QUAD CI for the various meetings resulting in the appointment of alternate members; late convening of meetings which was resolved by scheduling regular meetings on the 2nd Wednesday of each month; and difficulty in bringing together QUAD and QUAD Plus for holding certain meetings. Overall there were 26 QUAD meetings; 1 QUAD plus meeting; 1 working group meeting; and 10 stakeholder meetings.

The project allowed all the different associations of state nurses and midwives to collaborate and to be the actual actors of this project. Technical support was received from project partners: CDC and EGPAF.

Moving forward the QUAD plan to strengthen networking of our activities with all other corporate associations in the country. This networking will involve sharing all information about the project. The Cote d'Ivoire team consider that the level of collaboration between members of the QUAD is strong. In addition to face to face meetings, they share information by SMS, phone, and email to retain effective project management. The Cote d'Ivoire QUAD felt they needed more support in training of trainers for monitoring and evaluation at the sites and further training of QUAD members in task sharing, Option B+, and paediatric HIV care.

9. FACILITY ASSESSMENT PROCEDURES AND MODULES

- *Ms Jessica Gross, Senior Nurse Advisor, CDC Atlanta*

Ms Jessica Gross explained that the purpose of the facility assessments was to identify bottlenecks to nurse and midwife-led PMTCT and pediatric HIV services at high-volume sites within high-burden communities. The facility assessments would also assist in identifying opportunities for project proposals. The baseline data and the endline data collected were an essential component of ARC II evaluation. In collaboration with the CDC country office and the Ministry of Health, teams should select one to three sites with a high HIV patient load.

The site or sites should be "typical" of high volume sites – it shouldn't be so unique that the findings of the assessments and of any subsequent improvement projects wouldn't be scalable.

Ms Gross then went through the three modules which comprised the facility assessment tools, shared the tools, and the instructions. Module 1 targets nursing and midwifery supervisors; module 2 is a survey or nurses and midwives; and Module 3 is an audit of programs, policies, and tools which support nursing and midwifery practice.

Module 1: In depth interviews with nursing and midwifery supervisors.

To prepare for the interviews, review tools and instructions and work with the facility to schedule data collection in advance. Administer to 2-3 supervisors of nurses and midwives (at least one of whom is preferably a nurse or midwife. The interview team actually administers the tool, asks the questions and records the answers.

Module 2: Nurses and midwives survey

The survey is to be administered to 5-15 nurses and/or midwives, depending on the size of the facility (5-15 for each facility). The nurse or midwife completes the form, not the interviewer, although the interviewer should stay in the room while the nurses and midwives are completing the form to answer any questions or clarify any queries. Any questions should be asked privately and answered privately and the nurses and midwives should not talk to each other while they are completing the survey form.

Module 3: Survey of programs, policies, materials, tools, and systems

One questionnaire administered for each facility. One or more supervisors are interviewed together. The interviewer should ask the questions. Respondents should have knowledge of nursing protocols, CPD, data systems, task-sharing, etc. Allow supervisors to discuss a question before deciding on an answer. For open-ended questions, record a summary of the majority responses. Note the consensus or any major disagreements.

All three modules should be administered at each facility. Enter the data into the data forms provided by Emory and use the information from at least one facility, to inform the project proposal.

Ms Gross took participants through the different parts of each module and provided them with a planning form to use as a tool to plan the facility assessments and submit the results to Emory University in a timely manner.

10. ESTABLISHING A NURSING COUNCIL

- *Ms Jill Iliffe, Executive Secretary, Commonwealth Nurses and Midwives Federation*

Ms Iliffe discussed with participants why is it important to have nursing and midwifery specific legislation and regulation and a nursing and midwifery regulatory board or council? Some of the reasons include: Self-regulation in relation to standards and education; control of own practice and scope of practice; taking responsibility for the profession; ensuring orderly and consistent organisation of the profession; protection for the nurse or midwife; protection of the public from unsafe practice or negligence (for example, reduced cost from provision of quality care, less adverse outcomes and fewer readmissions); and increased client satisfaction.

GETTING STARTED

Ms Iliffe explained that establishing a nursing and midwifery council or preparing nursing and midwifery legislation can be a lengthy process. You need to be familiar with how legislation is formulated in your own country (what is the process) and look at legislation from other health professions either nationally or internationally. The ICN has a Model Nursing Act which can be used as a guide. The consultation needs to be inclusive of all stakeholders to avoid opposition. Countries should allow a minimum of one year but it can take much longer.

TYPES OF LEGISLATION

Ms Iliffe said there are three basic types of legislation:

- Primary legislation: sets out the overall structure of the legislative powers and requires an Act of Parliament or equivalent. During the preparation stage of primary legislation before the draft legislation comes into effect the draft legislation is known as a Bill. Once in effect, the Bill becomes an Act. Any changes to primary legislation need to go back to Parliament so it can be a lengthy process.

- Secondary legislation or Statutory Instrument (sometimes known as 'order', 'rules', 'regulations', or 'directives') adds the detail to the primary legislation on which it is based. Secondary legislation allows the provisions of an Act to be subsequently brought into force or altered without Parliament having to pass a new Act. Secondary legislation is easier and quicker to change and is used for those aspects of legislation that are more likely to change over time.

- Case law: includes legal judgements which may affect practice but are not based on explicit written statute; examples of how law has been interpreted in the past.

SCOPE OF NURSING PRACTICE

The drafters of the legislation nneed to be very familiar with the scope of nursing practice right across the country in all settings. Legislation is for all, not just those working in an urban environment or in a hospital setting. Legislation needs to be clearly defined within a country context so that legislation enables practice and supports dynamic changes to practice over time.

PRINCIPLES

Ms Iliffe shared with participants the principles for nursing legislation from the International Council of Nurses Model Nursing Act.

- **Relevance:** the over-riding purpose of legislation is service to and protection of the public. The purpose should be made clear in the introduction sections of the legislation. Too much detail in

legislation can impede change, reduce flexibility, and minimise its intended effect. Each aspect should be carefully examined to make sure it is relevant to be included.

- **Definitions:** regulatory standards should be based on clear definitions of professional scope and accountability. A definition of nursing and nurses should be included and the role and function of the nurse and their relationship with other health care professionals, particularly doctors, should be clear and unambiguous.

- **Professional integrity:** Nurses are a key resource in any health care system. Any legislation should allow for the maximum development of nurses and nursing in order for them to use their knowledge and skills to best advantage in the delivery of effective health care.

- **Multiple interests:** While nursing must manage its own affairs, this must be done in conjunction with other key players such as government, employers, other professionals, professional associations and unions, academia, and consumers. Nursing does not exist in a vacuum and there will be many others who have a legitimate role in relation to the organisation and delivery of nursing care.

- **Representation:** All professions need increasing external scrutiny to ensure that the public protection role is effectively met. Representation on regulatory boards or councils should be representative of other interests, such as academia, professional associations, lawyers, and consumers.

- **Flexibility:** legislation should be sufficiently broad and flexible to achieve its objective and at the same time permit freedom for innovation, growth and change. It should not be too general so it is open to different interpretation or too specific. Controls and restrictions should be kept to a minimum so they do not impose unnecessary burdens on those trying to implement the system.

- **Efficiency and congruence:** regulatory systems should operate in the most efficient manner ensuring coherence, coordination and congruence among their parts.

- **Universality:** regulatory systems should promote universal standards of performance and foster professional identity and mobility to the fullest extent compatible with local need.

- **Interprofessional equality and compatibility:** regulatory systems should recognise the equality and interdependence of professions offering health services. Nursing legislation should match that of other health practitioners in the country.

FACTORS INFLUENCING PROGRESS

A number of factors can positively or negatively influence the progress of drafting and finalising legislation. For example: you need to have clarity of purpose and know what you want to achieve and have a clear focus on your goal. There has to be professional, political, and public commitment to the legislation. The drafters need to have expertise in the content and have the support of the legislators and it is always important to know if there is any opposition to the legislation and if so, why, what are their arguments, and how can you change their attitudes.

RESOURCES

Establishing a regulatory body and associated legislation, Ms Iliffe said, must be adequately resourced if it is to succeed. Resources need to be both human and financial. There is the initial cost of gaining support, lobbying, and drafting the legislation and the initial cost of setting up the regulatory body: premises from which to operate (rent and overheads), staff (Registrar, professional and administrative staff) and running costs. Government may be prepared to provide initial funding. Then there is the ongoing costs of the work of the regulatory body: premises, overheads, staff, committees - usually expected to be self-funding within 3-5 years, from registration and re-licensure fees

COMPONENTS OF LEGISLATION

Nursing legislation usually has the following components:

1. **Name:** the name of the legislation should be unambiguous and describe as accurately as possible what the legislation covers. It must also give the date when the legislaiton is made and the date it is to come into effect.

2. **Table of contents:** legislation is normally divided into sections or parts and is then further sub-divided into articles or clauses which relate to a specific issue relevant to that section or part.

3. **Protection of title:** Providing the legislation is appropriately drafted, the title 'nurse' or 'midwife' can be protected by law and therefore used only by those legally authorised to practice nursing or midwifery. Protecting the title 'nurse' allows the public to distinguish legally qualified nurses from other nursing or health care providers. It is preferable in legislation to protect the title 'nurse' rather than the more restrictive 'registered nurse'.

4. **Council (however titled):**
   - Name
   - Principle functions (protect the public; registration and relicensure, education, scopes of practice, standards, conduct).
   - Membership (elected, appointed, representative).
   - Powers: Effective disciplinary processes and positive management of poor practice.
   - Funding: how the regulatory body or council is to be funded.
   - Committees (investigation and discipline; fitness to practice; standards, education, practice, registration, CPD, etc).
   - Membership of committees.
   - Relationship of committees to council.

5. **Registration**
   - Appointment and role of Registrar.
   - Establishment and maintenance of the register.
   - Divisions in register (student, enrolled nurse, registered nurse, registered midwife, specialist nurses, advanced practice nurses).
   - Registration criteria (pre-entry examination); how is your name placed on the register.
   - Period of registration (1-5 years, life).
   - Criteria for renewal of license to practice.
   - Fees to be paid.
   - Lapse from the register and reinstatment.
   - Removal from the register.
   - Access to register for external parties.

6. **Education and training**
   - Entry criteria to a nursing program (age, academic level, length of schooling).
   - Pre-entry educational program (academic level, lenth of program, content, percentage mix of theory and practice, qualifications of teachers, education standards).
   - Post-registration education (specialist, advanced practice).
   - Continuing professional development.
   - Accreditation of nursing educational institutions.
   - Accreditation of nursing courses (pre-entry, post-registration).

7. **Practice**
   - Practice standards.
   - Scope of practice.
   - Code of ethics.
   - Code of conduct.

- Fitness to practice: appropriate checks and balances to effectively manage issues of competence, conduct, ethics, and health issues.

8. **Discipline of registrants**
   - How allegations are to be dealt with such as misconduct, lack of competence, conviction for a criminal offence, physical or mental health problems, fraudulent entry on the register etc.
   - Investigations.
   - Use of experts.
   - Rules of evidence.
   - Disclosure.
   - Decisions.
   - Appeals.

9. **Offences under the Act:** for example if someone holds themselves out to be a nurse fraudulently.

10. **Liability:** how those covered by the Act are to meet professional indeminity or legal liability protection claims.

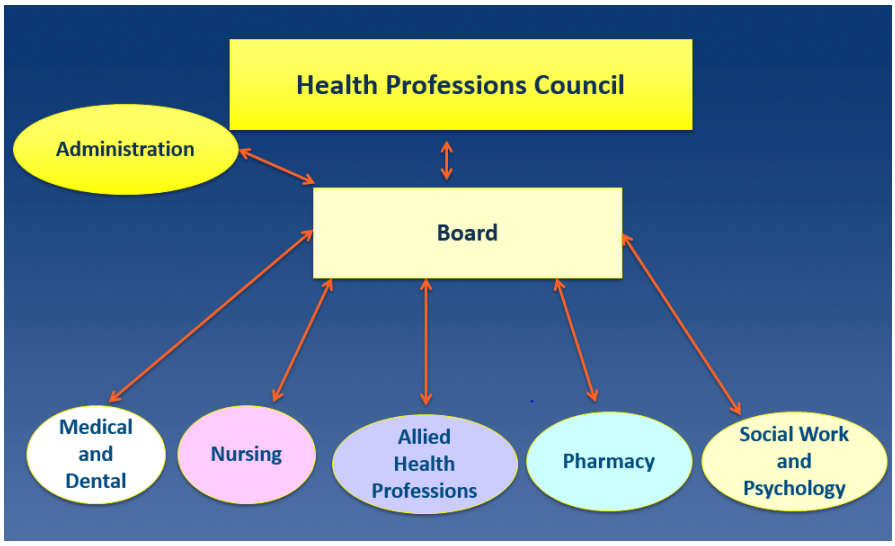
11. **Exemptions or exclusions:** there is usually a clause which allows, in certain limited circumstances, an individual to 'nurse' without a license eg emergency situations.

12. **Transitional arrangements:** if new law affects those who are already part of the system being changed the legislation needs to make sure individuals are not disadvantaged; where legislation replaced existing legislation transitional arrangements may need to be specified.

Ms Iliffe said that legislation covering midwifery usually followed the same pattern as that for nursing. In some countries the legislation included both nursing and midwifery. In other countries it was separate legislation. It was usual however for councils which covered nursing to also cover midwifery because of the close link between the two professions. It was unusual globally to have two separate councils.

Ms Iliffe concluded by saying there was a global trend to have Umbrella Health Councils so that all health professions were covered by the one council but with separate sections for each health profession. This provided standardisation across the professions however it was important that within an Umbrella Health Council, the professions had autonomy in determining their own standards and scopes of practice. Ms Iliffe provided a diagram of what an Umbrella Health Council might look like.

Figure 4: Umbrella health professions council



11. IMPLEMENTING A QUALITY IMPROVEMENT PROJECT

- *Dr Youssouf Dosso, Senior Technical Advisor, University Research Company, Cote d'Ivoire*

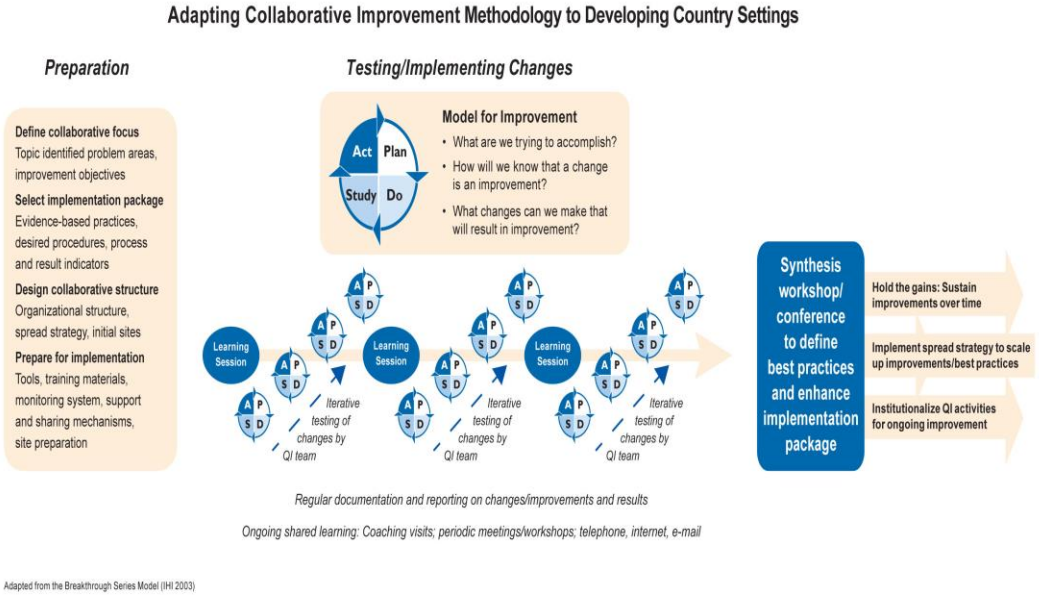
The University Research Company (URC) is an American public health agency specialising in improving the quality of care. URC is a technical partner of PEPFAR, responsible for implementing USAID quality improvement projects. URC has been working in Cote d'Ivoire since 2008 with two projects: Health care improvement (2008-2013); and Application of science for strengthening and improving systems (2013-2017).

URC uses two approaches to quality improvement:

1. Quality assurance which is based on the search for conformity between practices and benchmarks.
2. Continuous quality improvement which is a collaborative approach involving structured effort of mutual learning by a network of teams to adapt a model of best practice care to a major health problem. This approach gives significant results in a short period of time and at a reduced. Then best practices are extended and disseminated.

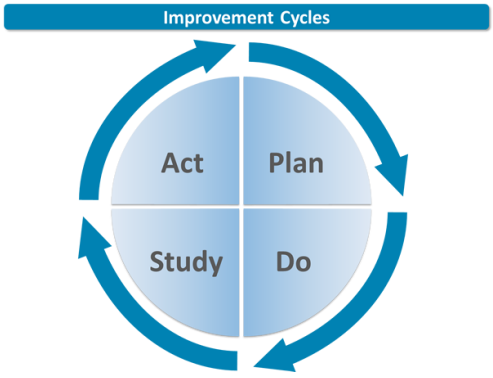
Dr Dosso shared with participants a model for adapting collaborative improvement methodology in developing country settings.

Figure 5: Adapting collaborative improvement methodology to developing country settings



Dr Dosso shared with participants the PDSA improvement cycle.

PDSA improvement cycle



Dr Dosso said, using the PDAC cycle allows for a structured approach to quality improvement.

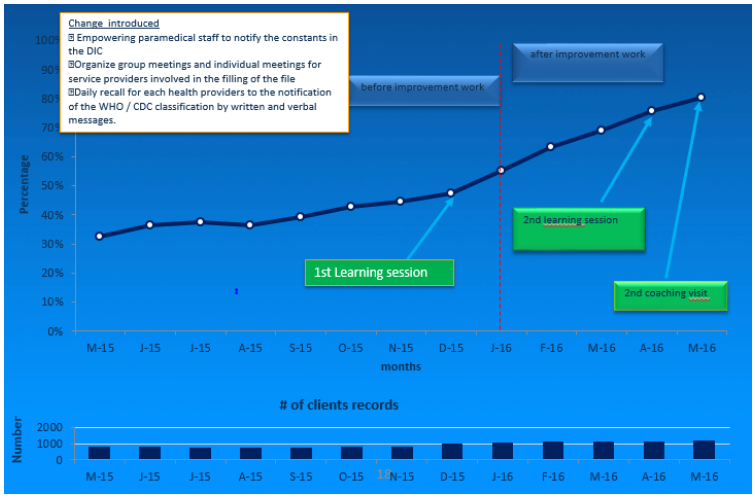
- Set targets for improvement
- Define the implementation package for improvement
- Organise the improvement activities
- Provide indicators to monitor improvement or maintenance of learning outcomes
- Identify barriers
- Test changes
- Document the best changes
- Extend best practices across the organization

Dr Dosso shared with participants the key features and results from a URC project in Cote d'Ivoire.

Figure 7: Project intervention areas and statistics

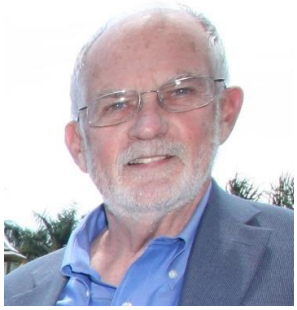
- Seven PEPFAR partners.
- Nine out of 30 regions.
- Twenty out of 82 districts.
- Seventy five out of 529 facilities.
- 20 Quality Improvement teams.
- 10,779,000 out of a total population of 25,236,000.

Figure 8: Results -percentage of medical records with all the items entered on 59 sites



12. ARC YEAR 2 GRANT PROCESS

- *Professor Kenneth Hepburn, ARC Principal Investigator, Emory University*



Professor Hepburn introduced a new element in the evaluation of the ARC initiative, facility assessments, and said he appreciates that it is something new, however the facility assessments are essential to inform the focus for grant funded projects; evaluating the impact of the ARC initiative; and assuring ARC sustainability. He shared the timeline which was that the facility assessments needed to be completed by 1 September. Country proposals were due 15 September. Feedback and responses from Emory University would be sent late September and grant awards would be made mid-October.

The focus of the projects should be activities that will result in measurable improvements in the quality of the performance of nurses and midwives providing PMTCT, Option B+, and paediatric ART services at one or more high HIV volume sites. The projects should demonstrate the potential for scalability.

The projects should demonstrate key linkages between the results of the facility assessment and the project aims. Outcome measures should be linked to demonstrate that the assessed needs have been met. The project proposal should demonstrate essential cooperation and collaboration between each country team member's institution, the country CDC office, the proposed project sites, and any other relevant organisations or institutions.

The structure of the proposal is similar to the structure for the previous year and ARC faculty are available to assist and clarify questions. The elements include:

- Face Page

- Problem statement: Two pages identifying the improvement issue the project will address; why it is a problem in the country and at the site and why the problem is significant; how it will improve nursing and midwifery service provision in at least one high HIV volume site; and how the improvement might lend itself to implementation at other high HIV volume sites.

- Objectives and methods: Identify specific measurable objectives and for each objective list the key activities and the individual responsible for carrying out each activity. Describe the anticipated inputs, outputs and outcomes for the project activities and explain how the team will measure and monitor progress toward the project's objectives and activities (ie: indicators). Professor Hepburn said countries should consider using a table to outline this information.

- Timeline: The proposed timeline is 15 August 2016 to 14 November 2016 for action period 1. 15 November 2016 to 14 March 2017 for action period 2; and 15 March 2017 to 14 July 2017 for action period 3.

- Feasibility (2 pages): How likely is it that the project will enhance specific components of HIV service provision at one or more high HIV volume sites? Why is success likely? What are the strengths, capacities, resources, and experiences of each team member, any expert resources, or any partnerships, or other country resources and initiatives? What is the plan for team collaboration and governance? What are the challenges or risks to the project and each project activity and how might these be met or addressed?

- Budget and Justification (2 pages): An itemized budget for the total amount of the proposed project including how will the awarded funds finance project activities and justification for proposed project expenditure.

- Program Management (1 page): Identify the authorized institution to receive the funds; identify a team coordinator who will be the link between the team and Emory University. Propose a schedule for conference calls with the ARC faculty to discuss project implementation progress and challenges; and outline specific areas or activities where your team might require technical assistance from ARC.
- Technical Appendix - Facility Assessment (2 pages): Summarise the findings from the facility assessment and identify the areas most affecting the site's capacity to provide adequate and/or appropriate care. Offer a rationale for the choice of the project and the indicators of success for the project's identified objectives.
- Letters of Support (1 page per letter): Provide a letter of support from the agency of each team member; letters of support from relevant persons or agencies that will contribute to the feasibility of your project. Provide a letter of support from the CDC country office that acknowledges the proposed activity and its alignment with PEPFAR goals.

The scoring which will be used by Emory University to assess the projects are 20% for country collaboration; 25% for the approach taken; 20% for the significance of the project; 25% for feasibility; and 10% for the writing.

13. CLOSING REMARKS

- *Ms Jill Iliffe, Executive Secretary, Commonwealth Nurses and Midwives Federation*

Ms Iliffe said this Summative meeting marks the end of the first year of ARC West and Central and the beginning of our second year together. I would like first, on behalf of the ARC Faculty and all participants to thank our colleagues from Cote d'Ivoire for hosting this meeting. I know you gave a great deal of support with the administrative arrangements to make sure everything ran smoothly, especially for the DRC team. It was great to have so many guests yesterday from Cote d'Ivoire Ministry of Health, CDC and WHO and I hope they enjoyed joining us as much as we enjoyed having them join us.

The highlights from the 2016 International AIDS Conference gave us some really useful information which was greatly appreciated by those of us who could not be there and the presentation stimulated much discussion.

Most importantly, this meeting was the opportunity for you to share the final report from your projects. All teams gained valuable information about care, and care deficits, in your countries and as a team and as individuals you learned so much implementing your projects, especially about project management and financial management. You came to the learning sessions to listen, share, learn and challenge each other and you have done all those things. You connected with each other, you connected with your colleagues, and you connected and raised your profile with other key people in your respective countries.

But it was not always easy. You are all busy people with important and busy jobs. Fitting in project work was challenging and you are now more aware of the realities for next time. And it is very pleasing that there will be a next time, a Year 2 for ARC West and Central. Another opportunity to develop a project, or build on your Year 1 project, to improve HIV care and treatment and nursing and midwifery care.

We spent a lot of time during the past two days looking at and becoming familiar with the Year 2 assessment tools, the project guidelines, and the proposal process. And what a wonderful opportunity we were given by Cote d'Ivoire to trial the facility assessment tools. We want to thank Cote d'Ivoire for your organisation of the site visit.
Please convey our sincere thanks and appreciation to the hospital staff for so generously and graciously making their time available to us. We learned so much from this exercise and the assessment tools are now much more familiar and less complicated as they first appeared. This was such a valuable activity.

The presentation this afternoon on implementing a quality improvement project, drew all the various threads together. Why are we here? Why are we undertaking projects? Because we have identified care deficits and we want to make positive change. That is why your projects are called 'quality improvement projects'. The facility assessments will help you identify the deficit you want to address and point you to the indicators that will help you measure whether quality has been improved.

We had a quick look at establishing nursing and midwifery legislation and regulation to support nursing and midwifery practice. This is a conversation we need to continue next time we meet. Nursing and midwifery practice will only be enhanced if nurses and midwives are setting the standards for education and practice.

It is good to know we will meet again, so this is not goodbye, but au revoir. There is work to be done with the facility assessments, identifying the issue you want to address in your Year 2 projects, and submitting your project proposal. I am looking forward so much to seeing what you decide to address in Year 2.

On your behalf I would like to thank the staff of Care and Health for looking after us so well – Alexi, Ninon and Nick – and for making sure the transport, audio visuals, printing, and other administration was seamless and smooth. Thank you for your active participation in this Summative and for your collegiality. Safe journey home and take care of yourselves so you can take care of your people.

14. SITE VISIT

The Cote d'Ivoire team made arrangements for participants and ARC faculty to visit a local high HIV volume health facility and for participants to role play the different modules they would be using in the facility assessments. At the debrief session following the site visit, all participants were appreciative of the opportunity to practice administering the different modules and said they learned a great deal which would assist them when they did the facility assessments in their own country.

Role play for Module 1: interview with nursing and midwifery supervisor

Role play for Module 2: implementation of suvey to nurses and midwives

Role play for Module 3: interview with supervisor regarding programs, materials and systems.

ARC faculty with staff at the site visit and with Ms Marie Thérèse Nobah-Bello, PMTCT Advisor, PEPFAR, Cote d'Ivoire

African HEALTH PROFESSIONS Regional Collaborative FOR NURSES AND MIDWIVES

ARC West and Central Africa Collaborative
Summative Congress 25-26 July 2016

Improving the performance of nurses and midwives providing Option B+ and pediatric HIV services at high volume sites

Meeting Objectives

- To provide a regional forum for learning and building expertise related to the latest guidelines and emerging models of care in Option B+ and pediatric HIV care and treatment.
- To present final reports and lessons learned on each of the three countries' ARC projects at high volume sites.
- To review instruments and methods for facility assessments and to prepare country teams to conduct site-level assessments.
- To prepare ARC QUADS to develop quality improvement proposals for year II of ARC activities.
- To foster collaboration and promote networking between nursing and midwifery leaders within each country and the region.

Monday, July 25

08:00-08:30 Registration

08:30-08:40 Orientation to simultaneous translation

08:40-09:00 **Welcome Remarks**
- *Moderator:* Kenneth Hepburn, Principal Investigator ARC, Emory University

09:00-09:20 **Greetings from ARC Partners**
- Kenneth Hepburn, Emory University **(Introduction of ARC Faculty, Special Guests, Technical Advisors)**
- Jessica Gross, ARC Initiative Lead, CDC Atlanta
- Dr Serigne N'Diaye, DGHP Cote d'Ivoire
- Jill Iliffe, Executive Secretary, Commonwealth Nurses and Midwives Federation (CNMF)

09:20-9:40 **Greetings from Country Host**
Moderator: Marie-Thérèse Nobah-Bello, Consèillere PMTCT Advisor, PEPFAR, Cote d'Ivoire
- Director General, Cote d'Ivoire Ministry of Health

09:40-10:00 **Introduction of Participants**
Moderator: Muadi Mukenge, ARC Project Director, Emory University

10:00-10:30 **ARC/LARC Update**
Moderator: Jessica Gross, CDC Atlanta
- Muadi Mukenge, ARC Project Director, Emory University

10:30-11:00 **Refreshment Break**

11:00-11:30 **Highlights from the 2016 International AIDS Conference – New Horizons**
Dr Ekra Alexandre and Judith Edge, CDC-Cote d'Ivoire

11:30-12:30 **Differentiated Models of Care**
Moderator: Dr Ekra Alexandre, Prevention Care and Treatment Branch Chief, CDC Cote d'Ivoire
- Marie-Thérèse Nobah-Bello, Consèillere PMTCT Advisor, PEPFAR Cote d'Ivoire

12:30-13:30 **Lunch**

13:30-13:40 **Remarks from WHO Cote d'Ivoire**
- Dr Marie Catherine Barouan, Director HIV and TB

13:40-15:10 **Country Final Reports**
- Cameroon
- Cote D'Ivoire
- DRC

15:10-15:40 **Refreshment Break**

15:40-17:40 **Facility Assessment Procedures and Modules**
Moderator: Jessica Gross, CDC Atlanta
- Instructions
- Review of Modules
- Submission of Planning Form

17:40-18:00 **Evaluation**
Moderator: Muadi Mukenge, ARC Project Director, Emory University

Tuesday, July 26

08:00-08:30 **Depart for Site Visit**

09:00-11:00 **Site Visit at Health Facility and Role Play of Modules**
Moderator: Marie- Thérèse Nobah-Bello, PMTCT Advisor, PEPFAR, Cote d'Ivoire
- Conversation with nurse supervisor
- Conversation with nurses
- Role play with simulation

11:00-11:30 **ARC West Photo and Return to Conference Hotel**

11:30-12:00 **Refreshment Break**

12:00-13:30 **Debrief of Site Visit**
Moderator: Muadi Mukenge

13:30-14:30 **Lunch**

14:30-15:00 **Establishing a Nursing Council**
Moderator: Muadi Mukenge, Emory University
- Jill Iliffe, CNMF

15:00-16:00 **Implementing a Quality Improvement Project**
Moderator: Muadi Mukenge, Emory University
- Dr. Melly Traoré, Chief of Party, University Research Co., Cote d'Ivoire

16:00-16:45 **ARC Year 2 Grant Process**

Moderator: Kenneth Hepburn, Emory University

- Muadi Mukenge, Emory University

16:45-17:00 **Summary Remarks and Closing Remarks from Participants**

- Jill Iliffe, Executive Secretary, Commonwealth Nurses and Midwives Federation

17:00-17:15 **Presentation of Certificates and Close of Meeting**

Moderator: Kenneth Hepburn and Muadi Mukenge, Emory University

17:15-17:30 **Evaluation**

Moderator: Muadi Mukenge, ARC Project Director, Emory University

17:30-18:00 **Refreshment Break**