AFRICAN HEALTH PROFESSIONS

Regional Collaborative for Nurses and Midwives

Second Learning Session

Kigali Rwanda March 2017

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

Kigali, Rwanda 21-23 March 2017

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PARTNERSHIP FOR EXCELLENCE IN AFRICA'S HEALTH WORKFORCE

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LIST OF ABBREVIATIONS

ACT	Advancing Children's Treatment
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ANEMO	Associação Nacional dos Enfermeiros de Moçambique
ARC	African Health Professions Regional Collaborative
ART	Antiretroviral therapy
ARV	Antiretroviral
CDC	US Centers for Disease Control and Prevention, Atlanta, Georgia
CNMF	Commonwealth Nurses and Midwives Federation
CNO	Chief Nursing Officer
CPD	Continuing Professional Development
CRC	Compassionate respectful care
CTC	Care and Treatment Centre
DBS	Dried blood spot
DNA-PCR	Deoxyribonucleic acid polymerase chain reaction test
DREAMS	Acronym for: determined, resilient, empowered, AIDS-free, mentored, safe
ECSA	East, Central and Southern Africa
ECSACON	East, Central and Southern Africa College of Nursing
ECSA-HC	East, Central and Southern Africa Health Community
EID	Early infant diagnosis
GBV	Gender based violence
HCW	Health care worker
HEI	HIV exposed infant
HIV	Human Immunodeficiency Virus
HRH	Human resources for health
HRIS	Human resource information system
HTC	HIV testing and counselling
ICAP	International Centre for AIDS Care and Treatment Programs
IEC	Information, education, counselling
IHI	Institute for Healthcare Improvement
LARC	African Regional Collaborative for Laboratory Technologists and Technicians
MCH	Maternal and child health
M&E	Monitoring and evaluation
MOH	Ministry of Health
NCD	Non-communicable disease
NGO	Non-government organisation
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
NNA	National Nursing Association
NNU	National Nursing Union
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLWHIV	People living with HIV
PMTCT	Preventing mother to child transmission (of HIV)
PrEP	Pre-exposure prophylaxis
Q&A	Question and answer
QI	Quality Improvement
QUAD	Four pillars of nursing (administration, education, regulation, practice)
RBC	Rwanda Biomedical Centre
RBM	Results based management
RBF	Results based framework
SAAJ	Adolescent sexual and reproductive health (Mozambique)
SMART	Acronym for: specific, measurable, agreed, realistic, time-based
SOPs	Standard Operating Procedures
STI	Sexually transmissable infection
TA	Technical assistance
TB	Tuberculosis
TSP	Task sharing policy
TWG	Technical working group
UNAIDS	United Nations and AIDS
USA	United States of America
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organisation

1. EXECUTIVE SUMMARY

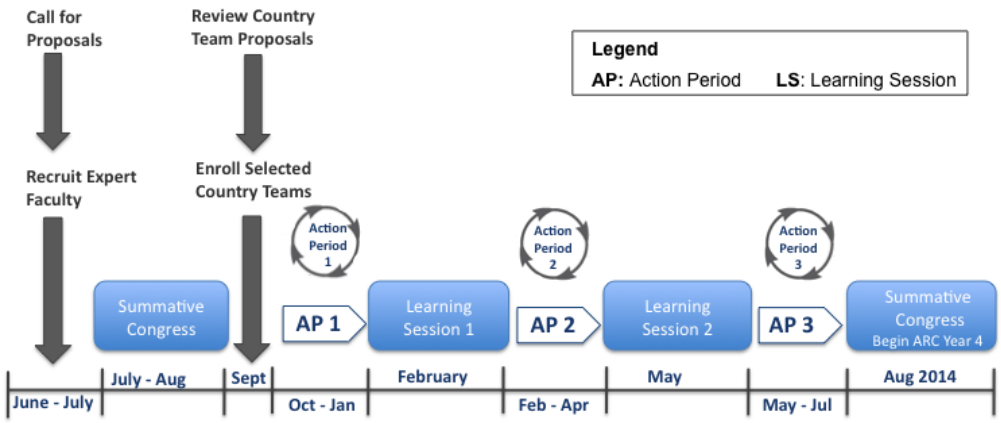
In 2011, the United States Centers for Disease Control and Prevention (CDC) under the US President's Emergency Fund for AIDS Relief (PEPFAR); Emory University's Lillian Carter Center for Global Health and Social Responsibility; the East, Central and Southern Africa Health Community (ECSA-HC), and the Commonwealth Nurses and Midwives Federation (CNMF) established a collaboration 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 leadership for nursing and midwifery. The aim of this collaborative was initially to improve health professional standards and practice in the region using local solutions and peer-based learning.

The ARC initiative was the outcome of a meeting in March 2005 between Emory University, the Commonwealth Secretariat, the CDC, and the ECSA-HC when a number of challenges for the nursing and midwifery workforce were identified. These challenges included the poor attendance at births by skilled health personnel; the acute shortage of nurses and midwives; the lack of country capacity in Africa for scaling up the education of nurses and midwives; and a lack of adequate data to inform policies and workforce planning.

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

The ARC conceptual framework is adapted from the Institute for Healthcare Improvement (IHI) model for breakthrough organisational change. The Institute for Healthcare Improvement Breakthrough Series© model is a short-term (6 to 15 month) learning system in which organisations learn from each other, as well as from 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)



Preliminary discussions on a regional approach to strengthening nursing and midwifery took place in April, 2010 when PEPFAR and the World Health Organization (WHO) launched the *'Educating Nurses for the Future'* initiative. This provided an opportunity to develop the ARC proposal. The concept, to enable countries to expand high quality nursing and midwifery services through strengthening and harmonising midwifery education, regulation, standards and practice in the ECSA region, was finalised at a meeting in Georgia, Atlanta in June 2010. The ARC initiative was launched early 2011.

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

1. Sustain the scale-up of HIV services through strengthened nursing and midwifery regulatory frameworks.
2. Align accreditation, licensing, continuing education, and scopes of practice, among other key regulatory functions, with global guidelines and regional standards.
3. Review legislation and regulation to strengthen the alignment of policy and practice for nurses and midwives.
4. Strengthen the capacity and collaboration of national organisations to perform key regulatory functions and mobilise resources.
5. Foster a sustained regional network of nursing and midwifery regulatory leaders to facilitate the exchange of best practices.

ARC YEAR 1

To achieve these objectives, the collaborative initially brought together representatives from 14 countries in the ECSA region including Chief Nursing Officers, Registrars of Nursing and Midwifery Councils, the Presidents of National Nursing and Midwifery Associations or Unions, and a senior representative of nursing educational institutions. The first meeting of the African Health Professions Regulatory Collaborative (ARC) was held in Nairobi, Kenya from 28 February to 2 March 2011 in collaboration with the Kenya Ministry of Health. Fourteen countries in the ECSA region were represented: Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe, as well as representatives from the CDC, Emory University, the Commonwealth Secretariat, the World Health Organization, the Commonwealth Nurses and Midwives Federation, the International Council of Nurses, the International Confederation of Midwives, and the East, Central and Southern Africa Health Community, and invited guests and speakers.

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

The second meeting of ARC Year 1, which took the form of a learning session, was held in Durban, South Africa from 24 to 26 June 2011. Representatives from the five countries which were successful in their funding applications for an ARC grant attended the meeting. The learning session aimed to provide an opportunity for successful countries to be supported in refining their funding proposals following input from the ARC faculty, from invited technical experts, from the other countries attending the meeting; and to develop action plans that were measurable and achievable.

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

ARC YEAR 2

In February 2012, a call for proposals for Year 2 ARC funding was announced. Ten countries submitted proposals which were subject to a rigorous evaluation process in order to select the countries to receive ARC funding in Year 2 of the initiative.

The ARC Year 2 Summative Congress was held in Johannesburg South Africa 20 to 22 June 2012. Seventeen countries from the east, central and southern Africa region attended the Congress: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The purpose of the Summative Congress was to showcase the regulatory improvements made by the ARC Year 1 grant recipients; facilitate dialogue on key issues facing nursing and midwifery in the region; and announce the successful ARC Year 2 grant recipients. Six countries were successful Year 2 ARC grant recipients: Botswana, Kenya, Swaziland, Tanzania, Uganda, and Zimbabwe.

The First Learning Session for the successful Year 2 ARC grantees was held in Pretoria South Africa 18 to 20 September 2012. The learning session was attended by Botswana, Kenya, Swaziland, Tanzania, Uganda and Zimbabwe who gave an update on the progress of their project and received input and feedback from their peers. The South African QUAD, as meeting hosts, also attended the meeting.

The Second Learning Session for the Year 2 ARC grantees was held in Gaborone Botswana 6 to 8 February 2013. In addition to attendance by the six ARC Year 2 grantees, the Zambia QUAD attended the learning session to share their independent development of a national continuing professional development program.

ARC YEAR 3

The 3rd ARC Summative Congress was held in Nairobi Kenya 30 July to 2 August 2013. Eighteen countries attended the Summative: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Representatives from the Democratic Republic of the Congo also attended the meeting. The purpose of the Summative Congress was to showcase the progress made by the ARC Year 2 grant recipients; facilitate dialogue on key issues facing nursing and midwifery in the region; and announce the Year 3 grant guidelines.

The First Learning Session of the ARC Year 3 initiative was held in Nairobi, Kenya from 4 to 6 February, 2014. Prior to the learning session, the successful ARC Year 3 grant recipients were announced. The successful countries were: Botswana, Lesotho, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Uganda and Zambia. In addition, Mozambique received in-country CDC funding for a regulatory improvement project and was invited to participate in the learning session.

The Second Learning Session of the ARC Year 3 initiative was held in Lusaka, Zambia from 29 April to 1 May 2014. The key objectives of the learning session were to provide specific assistance and technical support to the ARC Year 3 grant countries to advance the implementation of their projects and to provide assistance in the alignment of their regulatory improvement projects to advance their ability to deliver HIV and AIDS prevention, care and treatment services.

ARC YEAR 4

The 4th ARC Summative Congress was held in Windhoek, Namibia 24 to 26 February 2015. The Summative was attended by representatives from: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe.

The purpose of the Summative Congress was to celebrate and share the achievements of the ARC Year 3 grant recipients; provide assistance and technical support to countries in preparation for their ARC Year 4 improvement projects focused on the expansion of HIV services, particularly paediatric HIV services; to share best HIV clinical practices for nurses and midwives; and to share the latest thinking in relation to viral load testing and the impact on HIV care and treatment.

The First Learning Session of the ARC Year 4 initiative was held in Johannesburg South Africa 14 to 16 July 2015. The learning session was attended by successful ARC Year 4 grant recipients: Botswana, Ethiopia, Kenya, Lesotho, Mozambique, Rwanda, Seychelles, South Africa, Tanzania, Zambia, and Zimbabwe. The learning session aimed to share the progress and challenges for Year 4 ARC grant recipients in conducting their projects and provide assistance and technical support for their projects. The learning session also aimed to enhance knowledge and expertise in relation to viral load testing and the potential to enhance HIV care and treatment.

The Second Learning Session of the ARC Year 4 initiative was held in Harare, Zimbabwe from 10 to 12 November 2015. The learning session was attended by the Year 4 grant recipient countries: Botswana, Ethiopia, Kenya, Lesotho, Mozambique, Rwanda, Seychelles, South Africa, Zambia, and Zimbabwe. The Tanzania QUAD, due to national elections, were unable to attend the learning session. The key objectives of the learning session were to share the progress of projects for Year 4 ARC grant recipients; receive south-to-south feedback; and provide specific assistance and technical support to the ARC Year 4 grant countries to advance the implementation of their projects and bring them to a successful conclusion.

FINAL ARC PHASE 1 SUMMATIVE AND LAUNCH OF ARC PHASE II

The final Summative Congress for ARC Phase 1 was held in Johannesburg, South Africa from 16 to 18 February 2016. The Summative was attended by representatives from: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe. Additionally, a representative from countries participating in the ARC West and Central initiative: Cameroon, Cote d'Ivoire, and the Democratic Republic of the Congo also attended the meeting.

ARC Phase II was launched on the last day of the Summative Congress. To more accurately reflect the focus of Phase II, the ARC initiative was renamed: *African Regional Collaborative for Nurses and Midwives.* The focus for ARC Phase II is on contributing to the achievement of the UNAIDS 90-90-90 goals, that by 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained ART; and 90% of all people receiving ART will have viral suppression.

Project proposals submitted by country teams in ARC Phase II needed to consist of quality improvement initiatives which would contribute to the achievement of the 90-90-90 goals. Additional grants, prior to proposal submission, were available to all countries to undertake assessments at one to three high HIV volume facilities to identify bottlenecks in service delivery. The data collected was designed to informed project proposals about deficits which could be addressed to improve quality. Assessment materials were provided by the ARC faculty. Working closely with local clinicians and the local CDC office is an integral component of ARC Phase II.

The first learning session for ARC Year 1 Phase II was held in Entebbe, Uganda 7-9 November 2016. The eleven countries which had been awarded grants: Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Rwanda, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe, attended the meeting. Country teams presented their grant projects which were subject to peer review and technical input from ARC faculty and special guests. The learning session provided countries with an opportunity to review and refine their projects in response to the feedback given.

2. INTRODUCTION TO ARC PHASE II YEAR 1 SECOND LEARNING SESSION

The second learning session for ARC Year 1 Phase II was held in Kigali, Rwanda 21-23 March 2017. The eleven countries which had been awarded grants: Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Rwanda, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe, attended the meeting. The major focus for the meeting was on the monitoring and evaluation of country projects, particularly refining monitoring and evaluation plans and data measurement and project indicators. The specific objectives of the meeting were to:

- Provide a regional learning forum to build expertise to sustainably strengthen health system support structures for quality nursing practice in HIV care.
- Strengthen the ability of nursing and midwifery leaders to successfully implement, monitor and evaluate national quality improvement projects.
- Convene country teams to strengthen leadership capacity in project management, monitoring and evaluation, and effective communication.
- Foster collaboration, promote networking, and disseminate tools between nursing and midwifery leaders within each country and across the region.
- Provide a forum for nursing and midwifery leaders to engage meaningfully with technical advisors in health policy and clinical practice to improve the performance of HIV service delivery.

3. OFFICIAL WELCOME AND GREETINGS


Ms Agnes Waudo


Ms Jill Iliffe


Jessica Gross

- Agnes Waudo, Director, ARC Secretariat
- Jill Iliffe, Executive Secretary, Commonwealth Nurses and Midwives Federation
- Dr Edward Kataika, Director of Programs; East, Central and Southern Africa Health Community (ECSA-HC)
- Jessica Gross, Senior Nursing Advisor, CDC Atlanta
- Mr Andrè Gitembagara, President, Rwanda Nurses and Midwives Union

Ms Agnes Waudo welcomed participants on behalf of the ARC Secretariat and thanked participants for their cooperation in making the administrative arrangements for ARC so smooth and efficient. Ms Waudo introduced the other members of the ARC Secretariat team, Ms Nancy Ruto and Mr Nixon Masinde.

Ms Jill Iliffe welcomed participants on behalf of the CNMF and reminded participants that after each meeting, ARC presentations and the report of the meeting are uploaded to the ARC website. Ms Iliffe said she was looking forward to hearing the progress of the projects. As countries worked toward completing their projects the learning session provided an opportunity to reflect on what has been achieved and what still has to be done.

Ms Jessica Gross welcomed participants on behalf of CDC Atlanta and thanked Rwanda for hosting the meeting. Ms Gross reflected that in this 5th year of the ARC initiative, the focus is on improving the quality of nursing and midwifery HIV care for women, adolescents, children, and neonates. Ms Gross said that four countries: Rwanda, South Africa, Botswana, and Zimbabwe have almost reached the goal of eliminating mother to children transmission of HIV and that nurses and midwives were important contributors to this achievement.

Dr Edward Kataika brought greetings from the ECSA-HC Director General, Professor Yoswa Dambisya who was unable to be present. Dr Kataika said he was very happy to be a part of ARC as the objectives of the initiative align with the ECSA-HC priority of enhancing human resources for health. Dr Kataika said there can be no health without human resources to provide the health care and that ARC is an important partnership for the region and provides a platform for sharing knowledge and best practice. Dr Kataika commended country representatives for their commitment and said he looked forward to the meeting.

Mr Andrè Gitembagara welcomed participants to Rwanda and said the ARC QUAD was very grateful they had been chosen to host the ARC meeting. As a result of their involvement in ARC, Mr Gitembagara said, the QUAD, which had not previously worked together, now worked closely and harmoniously as a team. They had also been able to increase partnerships within their country and with other countries. Mr Gitembagara said that after the genocide in 1994, Rwanda had only 400 nurses; now they have are 15,000 nurses. There was no nurses and midwives' association and no nurses and midwives' council. Now they have a strong and united profession. The academic level of the country had been raised; the incidence of HIV and malaria have been increased; and most of the population are now covered by social insurance.

4. OPENING REMARKS

Dr Sabin Nsanzimana, Head of HIV, AIDS, STI and Blood Borne Infection Division, Rwanda Biomedical Centre

Dr Sabin Nsanzimana welcomed participants to Rwanda on behalf of the Honorable Dr Dianne Gashumba, Rwanda Minister for Health. Dr Nsanzimana encouraged participants to enjoy and beauty of Rwanda and the hospitality of its people.

Dr Nsanzimana said that the Rwanda Ministry of Health is very conscious of the important contribution of nurses and idwives to controlling HIV and moving from emergency care to chronic management. In Rwanda, the incidence of HIV is 3%; 82% of all HIV positive people are on ART; and 86% of those on ART are virally suppressed. Rwanda is not far from reaching its global targets.

As there is a shortage of medical practitioners, nurses and midwives play a major role in HIV care and prevention. As 80% of persons who are HIV positive are seen by a nurse or midwife, they have been educated to prescribe ART, both 1st and 2nd line medications, through task sharing. Next month, Rwanda will be introducing self testing for HIV and putting a greater emphasis on contact tracing and testing. Rwanda is increasingly seeing other infections apart from HIV, such as hepatitis, and mortality and morbidity from NCDs so it is important to move toward long term capacity building for the health system.

Ms Madeleine Mukeshimana, Mr Andrè Gitembagara, Dr Sabin Nsanzimana
Ms Mary Murebwayire, Ms Julie Jimonyo

5. INTRODUCTIONS

Mr Alphonce Kalula, Senior Program Officer, ECSACON

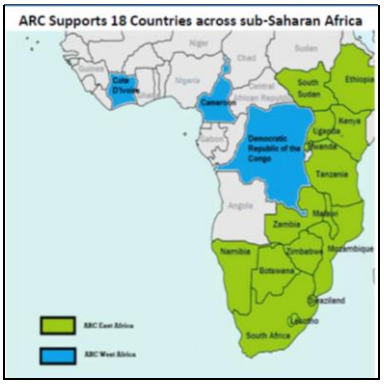
Mr Alphonce Kalula welcomed participants to the meeting and invited participants to introduce themselves to each other. Mr Kalula emphasised that the learning session was an important opportunity for countries which had received project grants to network, share experiences, and learn from each other and from the invited guests and ARC faculty. Mr Kalula also introduced the members of the ARC faculty and special guests who were attending the learning session and commended them for their commitment in supporting the ARC initiative.

ARC Faculty: Agnes Waudo, Kenneth Hepburn, Jessica Gross, Alphonce Kalula, Sydney Spangler, Andrè Verani, Muadi Mukenge, Nancy Ruto, Kethi Mullei, Nixon Masinde, and Jill Iliffe.

6. ARC AND LARC PROGRAM UPDATES

Professor Kenneth Hepburn, ARC and LARC Principal Investigator, Emory University

Professor Hepburn provided country teams with a quick overview and update on the ARC and LARC initiatives. Both initiatives had as their focus supporting quality improvement of HIV care at priority, high-volume sites. The focus for ARC Year 1 Phase II is to improve nurse or midwife led PMTCT, Option B+ services, and paediatric HIV care. The focus for LARC is on addressing bottlenecks in the viral load scale-up. Eleven ARC East grants were awarded in August 2016 with three ARC West grants awarded in October 2016 (see map below).



Professor Hepburn explained that all the seventeen countries in ARC East had been provided with a small grant to conduct facility assessments of one to three high HIV volume sites. The facility assessments consist of three modules: (a) program and materials audit; (b) in-depth interviews with in charge supervisor; and (c) surveys of nurses and midwives. Facility assessments are planned annually to provide pre and post data for the quality improvement grant projects. Professor Hepburn reported that 13 reports had been received to date. Data submission had been completed except for two countries. The 2nd round of data collection would take place in July with countries receiving their contracts and funding in June.

The key focus for the ARC East projects were task sharing (Tanzania); clinical mentorship (Lesotho, Rwanda, Uganda, and Zambia); quality improvement and assurance (Kenya, Zimbabwe, and Swaziland); data quality and data use (Malawi); and patient-provider interaction (Ethiopia and Mozambique). Professor Hepburn reminded countries that their 2nd progress report was due 15 April 2017.

The key focus for ARC West countries were:

- Cameroon: the project focused on onsite CPD for nurses and midwives providing PMTCT, Option B+ and paediatric HIV services.
- Cote d'Ivoire: the project focused on facilitating task sharing for PMTCT and paediatric HIV services.
- Democratic Republic of the Congo: the project focused on improving PMTCT and paediatric HIV clinical documentation by nurses and midwives at three hospitals in Kinshasa.

A key strategy for ARC East was targeted technical assistance which assigned an ARC faculty member to each country to provide technical assistance (TA) for the entire year of the project on a monthy basis consisting of conference calls and technical assistance visits with a focus on learnings from facility assessments, project scope, workplan, tools, indicators, and guidance on challenges.

The LARC initiative (improving communication and working arrangements between laboratory personnel and nurses and midwives) was launched in February 2016 with the objective of supporting viral load scale-up. The LARC initiative targeted six PEPFAR funded countries: Kenya, Malawi, Mozambique, Swaziland, Tanzania, and Uganda. The next learning session for LARC is May 2017.

Going forward for ARC, Professor Hepburn said that countries would be provided with ongoing technical assistance and would be encouraged and given support to publish their projects. The final Summative Congress would be held in July 2017. In concluding, Professor Hepburn reminded participants that the final report for their project was due 14 August 2017.

7. SESSION TWO

Policy brief: Nursing in Sub-Saharan Africa
Mr Andrè Verani, Public Health Lawyer, CDC Atlanta
Ms Agnes Waudo, Director, ARC Secretariat, Nairobi
Dr Byiringiro Rusisiro, Rwanda Biomedical Centre, Ministry of Health, Rwanda

Ms Agnes Waudo, Mr Andrè Verani, Dr Byiringiro Rusisiro

Mr Andrè Verani introduced the session and said the focus would be on nurses, midwives and HIV policy and how to integrate HIV services into maintstream health care, eg: diabetes care and cardiac care, and ensure quality and sustainability. Mr Verani defined integration as an action or process of combining one thing with another to form a whole. Quality is the standards of something as measured against other things of a similar kind; the degree of excellence of something; and sustainability is the ability to be maintained at a certain rate or level.

The presentations from Ms Agnes Waudo and CDr Byiringiro Rusisiro, Mr Verani said, would demonstrate examples of how nurses and midwives were leading the way in integration, quality, and sustainability.

Ms Agnes Waudo explained that the Kenya Task Sharing Project was funded by PEPFAR's Advancing Children's Treatment (ACT) initiative in collaboration with CDC Kenya. The project was implemented by Emory University in collaboration with the Kenya Ministry of Health, regulatory bodies, and key partners in Kenya. The guiding principles were to determine if:

- the task is prohibited by legislation, regulation, or policy,
- is included in the job description authorised by the employer,
- supported by policy, protocol, or guidelines,
- covered by the individual's scope of practice endorsed by their regulatory authority,
- the individual has the competence, experience, resources and supervision available to peror the activity safely,
- support and referral structures are in place in case of an emergency or an adverse outcome.

Five Technical Working Groups (TWGs) were formed to inform and develop the key thematic areas of the Task Sharing Policy (TSP):

1. Introduction, desk review, mapping exercise, evidence and background information for TSP. Provide the aim of the TSP, objectives, situational analysis, process of policy development and acknowledgements.
2. Legal and regulatory policy framework; harmonize national laws, policies, regulations and guidelines to support and enable the task sharing framework.
3. Training, quality care through pre service, in-service training and CPD to equip health workers with the necessary knowledge, skills and competencies.
4. Identify and ensure key service areas targeted by task sharing are comprehensive, work on authorization tables with consultation with relevant service areas.
5. Monitoring and evaluation: Revisit basic guiding principles and objectives of M&E; M&E plan with indicators.

Ms Waudo said the lessons learned were that consultation with a large stakeholders from the health sector built a sense of ownership and sustainability. Having TWGs assigned various roles spread the work and the TWGs worked hard toward success. The MOH Review team needed to be engaged early to orient the team on flow of government policy to save on time; and the consultants played an important role to provide direction to all the TWGs. Challenges included too many competing tasks for senior officers involved in the TWGs; service departments unwillingness to meet the consultant to confirm tasks to be shared; and slow response to emails to share comments on draft TSP documents.

The way forward is to finalise the review of the TSP and TSP guidelines; present to MoH senior management and to MoH; print the documents, launch, and dissemination.

Dr Byiringiro Rusisiro shared with participants the Rwanda Mentorship Program for the health workforce explaining that it was first commenced on a small scale in 2007 but underwent scale-up in 2012 when some health facilities previously supported through PEPFAR were transitioned to the Government of Rwanda. Initially, the mentorship program recruited doctors and nurses to mentor 11 district hospitals and 5 provincial hospitals with the aim of improving quality of care. The program started with 27 mentors (13 doctors and 14 nurses) based at district and provincial hospitals. From 2014, the Rwanda Ministry of Health adopted a decentralisation policy and now all 42 district hospitals across the country have clinical mentors.

The goal of clinical mentoring is to improve the quality of comprehensive HIV and AIDS care, prevention and treatment as well as other infecious diseases, such as TB and malaria, through continuous capacity building of health care providers. Mentors need to be experienced, practicing clinicians, so that they can transmit their skills to their mentees (health care providers).

In Rwanda, Dr Rusisiro said, cinical mentoring is seen as part of the continuum of education required to create competent health care providers providing quality service delivery to PLWHIV, and or patients with other infectious diseases.

The main activities of the clinical mentors are:

- Direct coaching,
- Clinical consultation and case discussion of complicated cases,
- Onsite data verification and data quality assessment,
- Resolving system related issues,
- Organising and conducting onsite training for health care providers, and
- Attending capacity building training and other activities organised at a central level.

The clinical mentorship program allowed fast implementation of HIV national guidelines in 2013 and 2016; dissemination of the 'Treat All' HIV strategy; and key roles in task sharing. The program has contributed to an improvement in the quality of care provided to people with HIV and other infectious diseases.

8. SESSION THREE

Country Reports

Zimbabwe, Zambia, Uganda, Tanzania, Swaziland, Rwanda, Mozambique, Malawi, Lesotho, Kenya, Ethiopia

ZIMBABWE QUAD

- Mr Mafa Simangaliso
- Dr Cynthia Chasokela
- Ms Mercy Chaka
- Ms Abigirl Chibghwa

The Zimbabwe project progress report was presented by Dr Cynthia Chasokela, Director of Nursing Services, Zimbabwe Ministry of Health and Child Welfare. The title of the Zimbabwe project is: *Improving the quality of paediatric and adolescent HIV services.* The sites for project implementation are Pfupajena Clinic (Chegutu District) and St Padre Pio and Katanga Utano Clinics in Norton Town Chegutu District. The Zimbabwe project summary is outlined below.

Figure 2: Zimbabwe project summary

What we expect to accomplish	Knowing if change is an improvement	Change resulting in quality improvement(s)
To provide comprehensive quality paediatric and adolescent HIV care services	**AIM Statement** 1 i) Review the existing general protocols and SOPs used in the care and treatment of paediatric and adolescent clients ii) Identify areas requiring specificity for these clients iii) Develop specific protocols, checklists and SOPs for paediatric and adolescent clients 2. Using specific checklist, protocols and SOPs to develop specific indicators for paediatric and adolescent Quality of care 3. (i) Monitor and evaluate the quality of care provided (ii) Assess the usefulness of the Tools developed	**Our Intervention(s)** Regular and consistent use of SOPs by all members of staff. Staff awareness of input, process and output indicators of the quality of care.

Zimbabwe shared their input, process, output, and outcome indicators which are summarised in the table below.

Figure 3: Zimbabwe M&E indicator matrix

Input	Process	Output	Outcome
1. 7 Trainers were involved in the training of nurses and midwives 2. 23 Nurses and midwives were trained 3. Financial Resources used 4. 3 Supervisors were involved in supervising / following up the nurses and midwives	1. 7 Review meetings with the staff at the health facilities 2. 6 Trainings held in the 4 facilities in identification of indicators for tracking 3. 6 Support and supervision visit conducted 4. 6 Quality indicators identified 5. 4 Checklists developed and 4 SOPs adopted	1. 23 Nurses and midwives were trained 2. 4 SOPs adopted 3. 10 Guidelines used 4. 6 Indicators identified 5. 6 Support and supervision visit were conducted 6. 4 Feedback meeting with clinic nurses and midwives	1. Client Satisfaction 2. Safer working environment and services rendered 3.Current SOPs, Protocol and Guidelines 4. Increased access to quality HIV treatment and care 5. Increased adherence and reduced defaulter rate 6. Zero children living with HIV and AIDS not on treatment

Lessons learned from the baseline data were that SOPs were available at facilities but some were not being utilized; guidelines and mechanisms for monitoring client satisfaction were not in place hence the need to operationalize quality policies, protocols, SOPs, and guidelines; and protocols were not always followed due to lack of knowledge of where to access them from and high workloads. During the next action period, Zimbabwe will review monitoring and evaluation plans and indicators; provide feedback of the meeting to facility staff; review guidelines in line with updated latest guidelines and protocols; strengthen consistent use and adherence to guidelines and protocols; plan for efficacy of tools developed with relevant stakeholders and facility nurses; document project experiences; and write an abstract for presentation conferences on completion of project.

ZAMBIA QUAD

- Ms Jennifer Munsaka
- Ms Emily Chipaya
- Ms Beatrice Zulu
- Ms Judith Chipili
- Ms Mutinta Muleya

The Zambia team project progress report was presented by Ms Beatric Zulu, Acting Registrar for the General Nursing Council of Zambia. The title of the Zambia project is: *Improving the retention of pregnant women, breast feeding mothers, and children on ART, through mentorship of nurses and midwives.* The project was located at three sites: Matero First Level Hospital, Nangongwe Rural Health Centre, and Maramba Urban Health Centre. The Zimbabwe project summary is outlined below (see figure 5). Baseline data at the three facilities was also shared.

Figure 4: Zambia baseline data

SITE	Pregnant or breastfeeding women enrolled	Pregnant or breastfeeding women retained	%	HIV positive infants enrolled	HIV positive infants retained	%
Matero Hospital	398	138	35	12	6	50
Maramba Health Centr	76	49	64	4	2	50
Nangongwe Health Centre	49	47	95	3	3	100

Figure 5: Zambia project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Overarching Goal Implement and monitor a system that allows continuing mentoring of nurses and midwives in improving the retention of pregnant women, breast feeding mothers and infant on ART.	**AIM Statement** Improve the retention rate of pregnant and breast feeding mothers on ART to 85% by May 2017 Numerator - # of mothers retained on ART Denominator - # of mothers enrolled on ART And the retention rate of infants on ART to 90% by May 2017 Numerator- # of infants retained on ART Denominator - # of infants enrolled on ART	**Intervention** Mentoring nurses, midwives and others on the following: • Counseling • Testing • Initiation of ART • Monitoring and follow up of pregnant and breast feeding mothers and infants on ART • documentation

Zambia also shared their input, process, output, and outcome indicators which are summarised in the table below (see figure 6).

Figure 6: Zambia M&E indicator matrix

Input	Process	Output	Outcome
1.List of nurses and midwives to be trained 2. Number of trainers 3. Number of training manuals 4. Amount of money needed for the trainings	1. One Option B + training conducted 2. One mentorship training conducted 3. Mentorship program in the 3 facilities commenced in January, 2017 4. One monitoring and evaluation visit conducted per facility in February 2017.	1. Thirteen nurses and midwives trained in option B+ 2. Thirteen Trained nurses and midwives in Mentorship 3. Fourteen mentees mentored from the three selected facilities (6 Matero, 6 Nangogwe, 2 Maramba) 4. 100% data Collected for the project from all the 3 facilities	1. 100% of the mothers commenced on ART in the month of January, 2017 from the 3 facilities were retained on ART in February 2017.

During the next action period, mentors will to continue mentoring the nurses, midwives and other staff in MCH, ART, outpatient and paediatric unit. The QUAD plans to develop a monitoring and evaluation tool for the summative evaluation; monitor the retention of infants, breast feeding and pregnant mothers on ART; and analyze the data collected and share the report in June, 2017. The QUAD requested technical support for the development of the monitoring and evaluation tool.

UGANDA QUAD

- Ms Beatrice Auge
- Ms Margaret Nyakuni
- Ms Janet Obuni
- Ms Catherine Odeke

The Uganda team project progress report was presented by Ms Janet Obuni, President of the Uganda Nurses and Midwives Union. The title of the Uganda project is: *Using mentorship to improve HIV and AIDS services provided by nurses and midwives to children in Uganda.* The project sites are Mubende Regional Referral Hospital, Masindi General Hospital, and Ndejje Health Centre IV.

The Uganda project summary is outlined below.

Figure 7: Uganda project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Overarching Goal: To improve HIV and AIDS services provided by nurses and midwives to children in 3 selected health facilities in Uganda	**AIM Statement** 1. To increase the knowledge and skills of nurses and midwives on provision of HIV services to children from 9% self expert competence to 80% by end of the project 2. To increase nurses and midwives quality improvement skills to handle challenges faced during the provision of HIV services to children from 0% to 80% by the end of the project 3. To improve the clinical outcomes of HIV+ children accessing care at the 3 health facilities by the end of the project 4. To develop mentorship standards for nurses and midwives providing HIV services by the end of the project	**Your Intervention** **Training on** • HIV prevention, care, and support for children • Quality improvement **Mentorship** • HIV prevention, care and support for children • Quality Improvement

From the baseline data at the three project facilities, the majority of nurses and midwives (74%) considered they were knowledgeable regarding PMTCT and paediatric HIV care (Mubende 63.1%; Masindi 66%; and Ndejje 72%). There was however an overall reported lack of or limited self-competency in providing care to HIV exposed infants, children and adolescents.

Achievements during the action period included:

- Three QUAD plus meetings were held.
- Three meetings were held with their partner Mildmay and a Memoradndum of Understanding signed.
- Orientation meetings with the health facilities on the mentorship module and methodology were held.
- A detailed work plan for the training and mentorship of nurses and midwives in the different health facilities was developed.
- A detailed methodology and implementation plan for the training and mentorship of nurses and midwives in the different health facilities was also developed.

During the next action period the QUAD will orient district health officials on the mentorship module, methodology and work plan; conduct a competence gap assessment of the nurses and midwives at the inception of the mentorship; roll out the training and mentorship in the different facilities as per the work plan; develop monitoring and evaluation tools for the mentorship; conduct monitoring of the mentorship process on every planned mentorship visit; and carry out end project evaluation of the mentorship.

TANZANIA QUAD

- Mr Samwel Ligmas Koyo
- Ms Lena Mfalila
- Mr Ndementria Vermand
- Mr Paul Magesa Mashauri

The Tanzania project progress report was presented by Mr Samwel Ligas Koyo, Senior Nurse with the Tanzania Ministry of Health, Community Development, Gender, Elderly and Children. The Tanzania project was to: *Operationalise the Task Sharing Policy.* The project site is Sengerema Designated District Hospital. The Tanzania project summary is outlined below.

Figure 8: Tanzania project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Overarching Goal To operationalize task sharing policy to enable nurses and midwives to provide NIMART services to people living with HIV and AIDS by July 2017	**AIM Statement** Increase percentage of HIV+ clients enrolled in HIV clinic initiated on ART from 45% to 70% by July 2017 **Metric:** Nominator: Number of HIV+ clients on ART in a month **Denominator:** Total Number of clients enrolled in HIV and AIDS care clinic in a month	**Your Intervention** • Develop job descriptions for nurses and midwives to provide NIMART services according to expanded roles in task sharing policy by November 2016 • Orient CTC staff and hospital management on TSP • Train nurses and midwives on NIMART December 2016 • Conduct mentorship and supportive supervision by Jan 2017

From the baseline data, the percentage of HIV positive clients on ART has increased from 45% to 49%. Prior to the commencement of the project, none of the four nurses at the care and treatment centre were providing ART, now all four are. Tanzania also shared their input, process, output, and outcome indicators which are summarised in the table below (see figure 9). General plans for the next action period are to conduct mentorship and supportive supervision and to improve management of the project using new onitoring and evaluation knowledge and skill.

Figure 9: Tanzania M&E indicator matrix

Input	Process	Output	Outcome
1. NIMART Training Modules 2. Nurses and midwives job descriptions 3. Refresher training on ART and Task Sharing policy 5. BMP at the site	1. Developed NIMART training modules 2. Developed Job descriptions for NM 3. Conducted one refresher training on ART and Task Sharing policy to all clinicians 5. Conducted BMP to identify QI gaps at CTC	1. NIMART training modules developed 2. Task Sharing aligned job descriptions for nurses and midwives developed 3. Refresher training on ART and Task Sharing policy conducted 5. Gaps identified through BMP	1. Nurses and midwives have Competence to provide NIMART services 2. Nurses and midwives knowing new job descriptions to provide NIMART services 3. Nurses and midwives using new job descriptions to provide NIMART services 5. Established opportunity for improvement

SWAZILAND QUAD

- Mr Bheki Mamba
- Ms Glory Msibi
- Dr Ruth Mkhonta
- Ms Thembisile Gladys Khumalo

The Swaziland project progress report was presented by Mrs Thembisile Gladys Khumalo, Chief Nursing Officer, Ministry of Health, Swaziland. The focus of the Swaziland project is on: *Improving the quality of PMTCT and Option B+ services at Luyengo Clinic.* The Swaziland project summary is outlined below.

Figure 10: Swaziland project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Goal Scaling up comprehensive PMTCT / Option B+ services	**AIM Statement** to increase the number of HIV positive women receiving individual pre- test counseling from 0% to 70% by June 2017 **Metric** **Numerator**: Number of HIV positive women receiving pre-test individual counseling **Denominator :** Total number of pregnant women coming for the first Antenatal(ANC) visit	**Intervention:** Process mapping was conducted to identify gaps one of which was pre- counselling. Activities to change the status quo: 1. Refresher training of nurse managers conducted on importance of individual pre- test counseling for pregnant women attending ANC for the first time. 2. Refresher training of nurses conducted on importance of individual pre- test counseling for pregnant women attending ANC for the first time. 3. Introduction of supermarket approach for women attending ANC for the first time and those on Option B+. 4. Protocols for managing women on PMTCT Option B+ developed. 5. Two additional nurses were deployed.

Swaziland shared their input, process, output, and outcome indicators which are summarised in the table below (see figure 11).From their baseline data, Swaziland noted that the 310 pregnant women attended at first booking between April and September 2016. Out of these 107 were reactive: 52 came with a known status and were already on ART and the other 52 were initiated on PMTCT Option B+. Nurses were taken through a pre and post test to measure their level of understanding of PMTCT: three of the six participants who wrote both tests showed relative improvement following the training. Overall basic knowledge was good as indicated by average mark of 75% in the pretest. The Nurse Managers' pre and post test results showed much improved understanding following the training as four of the five managers had significantly improved marks in the post test. One participant achieved less that 50% in the pretest and unfortunately could not attend the whole session and thus did not participate in writing of the post test.

Figure 11: Swaziland M&E indicator matrix

Input	Process	Output	Outcome
1. . Number of QUAD Members present at the meeting 2. Number of clinic staff present at the meeting 3. Number of stakeholders present at the meeting 4. Number of community workers present in the meeting on the 22nd September 2016	Scaling up of comprehensive PMTCT / Option B+ Increased by March 2017	1. Numbers of nurses trained on PMTCT/Option B+ by 30th September 2016 2. Number of questionnaires completed by nurses on the quality of nurse midwife led PMTCT/option B+ services by May 2016 3. Numbers of nurse mangers trained On supportive supervision by 28th September 2016 4. Number of women on PMTCT/ Option B+ identified from the register by 8th September 2016 5. Number of cell phones purchased on 19th September 2016 6. Number of CHW trained on defaulter tracing on the 27th October 2016.	

In the next action period, Swaziland intend to develop IEC materials to be used for community mobilisation; conduct meetings with clinic staff and health committee to plan for community mobilisation; conduct meeting with community health workers to sensitise them on community mobilisation; and conduct the community mobilisation.

RWANDA QUAD

- Ms Julie Kimonyo
- Mr André Gitembagara
- Ms Mary Murebwayire
- Ms Philomène Cyurinyana
- Ms Madeline Mukeshimana

The Rwanda project progress report was presented by Dr Madeleine Mukeshimana, representing academics on the Rwanda QUAD. The focus for the Rwanda project is: *Scaling up nurse and midwife competencies to address paediatric HIV management.* The Rwanda project summary is outlined below.

Figure 12: Rwanda project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Overarching Goal: SCALING UP NURSES AND MIDWIVES COMPETENCIES TO ADDRESS PAEDIATRIC HIV MANAGEMENT	**AIM Statement** -To have carried out a survey in three high volumes sites by the end of December 2016 to explore the areas with gap in knowledge and skills of nurses/midwives in pediatric HIV care o have established a Pa -To have established a Paediatric HIV clinical mentorship program by the end of December 2016 -To have trained 10 nurses/midwives paediatric HIV clinical mentors in 10 selected health facilities by March 2017 -To have initiated the clinical site mentorship approach in all 10 health facilities by end of June 2017.	**Your Intervention** ➢ Establishment of a clinical mentorship training program at HF level ➢ Training of 1nurse/midwife manager in HIV task-sharing ➢ Training of 1 nurse/ midwife manager in pediatric clinical mentorship from each of 10 selected sites ➢ Mentoring nurses/midwives at working place

Rwanda shared their input, process, output, and outcome indicators which are summarised in the table below (see figure 13). What Rwanda learned from their baseline survey was that nurses and midwives had gaps in knowledge and skills in HIV paediatric care and PMTCT B+.

Figure 13: Rwanda M&E indicator matrix

Input	Process	Output	Outcome
Consultant Respondents Protocol Budget Reference documents on HIV/paediatric mentorship programs Trainers, trainees, module, training venues, budget and logistics Clinical mentors Mentees Mentorship tools Mentorship plan	To have conducted a baseline survey on nurses/midwives knowledge and skills in PMTCT B+ and pediatric HIV by end of Dec 2016 QUAD and QUAD plus planning meetings to identify existing modules and design a new module on pediatric HIV and PMTCT B+ Identify trainers, trainees, venue and conducting the HIV task-sharing training and mentorship training on pediatric HIV and PMTCT B+ Mentoring nurses and midwives on pediatric HIV care and PMTCT B+	Protocol approved by RNEC; Approval by RNEC and NHRC; Findings available Availability of the clinical mentorship module 10 nurses/midwives leaders trained in task-sharing and pediatric HIV/PMTCT B + mentorship Improved Knowledge and skills of nurses and midwives working in Pediatric HIV and PMTCT B+	Identified gaps of nurses/midwives knowledge and skills in PMTCT B+ and pediatric HIV Paediatric HIV clinical mentorship program established 10 clinical mentors based at the health facilities available Improved quality of care of Pediatric HIV and PMTCT+ management in the 10 selected sites

Rwanda noted they will build on what they have learned by sharing experiences with colleagues and use their learning to improve their project. They said they will need additional financial support during the monitoring and evaluation step of project and technical support in developing the monitoring and evaluation tool. In the next action period they plan to implement mentorship at the project sites and monitor and evaluate the project.

MOZAMBIQUE QUAD

- Mrs Norgia Machava
- Ms Maria Matavel
- Mr Caetano Apela
- Dr Olga Novela

The Mozambique progress report was presented by Mrs Norgia Machava, academic representative of the Superior Institute of Health Sciences. The goal of the project is to develop and improve clinical services that focus on adolescent sexual and reproductive health (SAAJ) to enhance youth engagement and retention to health services, including education, family planning and ARV treatment and care. The health facilities where the project will be implemented are: Boane, Ressano, Garcia and Bagamoyo. The Mozambique project summary is outlined below.

Figure 14: Mozambique project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
The goals of this project is to develop and improve clinical services that focus on adolescents sexual and reproductive health (SAAJ) to enhance youth engagement and retention to health services, including education, family planning and ARV treatment and care.	1. Increase from 17 to 29 the # of Nurses trained on HIV for children and adolescents by June 2017 2. Reduce from 6 to 0 the # of Health Providers that cited barrier on training at this facility to prepare with the knowledge and skills needed to provide care effectively to adolescents by June 2017 3. Increase from 34% to 44% (Bagamoio) from 27% to 37% (Boane) and from 24% to 34% (Ressano Garcia) the # of Health Providers reporting having confidence in providing HIV services to Children and Adolescent by June 2017 4. Increase from 57 to 67 and from 248 to 263 the # of adolescents aged (10-14) and (15-19) respectively receiving HIV Testing and Canceling (HTC) services for HIV and receiving their test results during the PEPFAR reporting period 5. Increase from 3 to 8 and from 13 to 18 the Number of adults children aged 10-14 and 15-19 respectively, newly enrolled on antiretroviral therapy (ART) 6. Increase from 0 to 2 the # of health facilities basically equipped providing services targeting adolescents (ages 10-19) living with HIV 7. a) Increase from 0- to 3 the # of health facilities having and using a written policy for disclosure of HIV status to adolescents (<16 yrs); youths (>16 yrs) b) Increase from 0 to 3 the # of health facilities with a written Policy for consent for HIV testing and treatment for adolescents (<16 yrs) youths (>16 y	1. HIV training for nurses and midwifes to provide HIV services to children and adolescents; 2. On job training for nurses and midwifes providing HIV services to children and adolescents on viral load and TB 3. On Job training for nurses and midwifes to boost confidence in providing HIV services to children and adolescents 5. Enhancement of testing and counseling services (HTC) for girls and boys at SAAJ sites 6. Advocate and/or provide supplies and equipment for SAAJ sites 6. Advocate and/or provide supplies and equipment for SAAJ sites 7. Advocacy/reproduction of policies on HIV for adolescents and job AIDS

The Mozambique team noted they had trained 38 nurses for HIV for adolescents at Maputo Province in coordination of the partners. They said that monitoring activities helps to ensure compliance and commitment to work. They acknowledged the considerable support provided by CDC Mozambique. In the next action period they will continue training nurses and midwives and conduct monitoring and evaluation activities.

MALAWI QUAD

- Ms Lucy Guluka Gawa
- Mrs Thokozire Lipato
- Mr Raymond Kanthiti
- Ms Lucy Mkutumula

The Malawi progress report was presented by Ms Thokozire Lipato, Director Monitoring, Evaluation, Investigations and Research, Malawi Nurses and Midwives Council. The title of the Malawi project is: *Strengthening HIV exposed infants follow up, early infant diagnosis, and paediatric HIV care.* The project will be implemented at Mitundu Community Hospital. The Malawi project summary is outlined below.

Figure 15: Malawi project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Overarching Goal To Improve retention rate of Infants on EID program	**AIM Statement** Increase the number of infants retained along the EID cascade from 60% to 90% at Mitundu Community Hospital by June 2017. Enrollment Metric :Nominator : Number of exposed infants enrolled in peadiatric HIV care. Denominator: Number of PMTCT Mothers with live births in the Health Area. Retention Metric: Nominator: Number of exposed infants retained in HEI care: Denominator Total Number of Exposed infants enrolled in HEI care.	**Interventions** (a) 90 % of exposed infants enrolled on peadiatric care (b) 90% of exposed infants retained on peadiatric care. Monitoring and evaluation indicators; • Started on NVP • Completed NVP • Started CTX • Completed DNA PCR at 6-9 weeks • DBS samples taken • DBS Results received • DBS results Communicated

The Malawi team also shared their baseline data (see figure 15), noting that there was sometimes confusion in the facility about when the data should be collected and the data source; testing was not done over the weekend; and counsellors were not always available when test results were positive.

Figure 16: Malawi baseline data

Antenatal care	Total number of pregnant women registered	917
	Total number pregnant women tested for HIV	917
	Total number of women HIWV positive	14
	Total number of pregnant women initiated on ART	13
Labour and birthing	Total number of women registered	694
	Total number of women tested for HIV	664
	Total number of women tested HIV positive with live births	15
	Total number of women on ART	14
	Total number of exposed infants on NVP	15

Early infant diagnosis	Total number of exposed infants registered at 2 months	16
	Total number of exposed infants on CPT	13
	Total number of exposed infants tested with results (DNA/PCR)	11
	Total number of exposed infants communicated results	11
	Total number of exposed infants HIV positive	0
	Total number of exposed infants initiated on ART	0
EID outcome	Total number on continued follow-up	15
	Total number discharged uninfected	15
	Total number transferred out	0
	Total number defaulted	7
	Total number died	0

Malawi shared their input, process, output, and outcome indicators which are summarised in the table below.

Figure 17: Malawi M&E indicator matrix

Input	Process	Output	Outcome
1. Mentors identified 2. Experts clients identified 3. Data collectors identified 4. TORs developed 5. data Collection tools developed 6. Financial resource	1. Awareness Meetings with DHMT 2. Periodic data collection 3. Monthly Data Review meetings 4. Trainings of Health workers 5. Mentorship visits conducted in a month 6. Follow-up visits 7. Procurement of material resources	1. # of Health workers trained 2. # of Expert clients trained 3. # of Mentorship visits conducted 4. # of Exposed infants enrolled on EID 5. # of defaulters traced. 6. # of Monthly Data review meeting held 7. # of DHMT meetings done	1. Increased utilization of EID services 2. Improved Documentation/data management 3. Improved Collaboration among health care workers 4. Improved competence/ confidence levels of health workers on EID 5. Improved retention of Exposed infants on EID 6. Improved referral system

LESOTHO QUAD

- Mrs 'Makholu Lebaka
- Ms Semakaleng Phafoli
- Miss Flavia Moetsana-Poka
- Ms Titi Nelly Nthbane

The Lesotho progress report was presented by Ms Flavia Moetsana-Poka, Registrar of the Lesotho Nursing Council. The Lesotho project title was: *Reinforcement of clinical mentorship program for nurses and midwives for TB, HIV and AIDS.* The project is being conducted in six HIV high volume sites: Motebang Hospital; Maluti Adventist Hospital; Berea Hospital; St Joseph's Hospital; Ntsekhe Hospital; and Tebellong Hospital. The project summary is outlined below (see figure 18).

Figure 18: Lesotho project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Overarching Goal To have competent and confident Nursing and Midwifery personnel who will provide TB/HIV and AIDS services in the selected hospitals and nearby health facilities in order to improve access of these services and reduce their prevalence.	AIM Statement Nursing and Midwifery personnel will be knowledgeable, skilled and competent in the provision of TB/HIV and AIDS. Increase number of clients accessing the TB/HIV and AIDS services and their adherence to treatment from 56% to 75% by July 2017.	Intervention 1. Training of nurses and midwives to become mentors so they keep reinforcing the TB/HIV and AIDS management to fellow colleagues hence an improvement in the knowledge, skills and services regarding TB/HIV and AIDS. 2. Draw the TORs for Mentors. 3. Advocate for recognition of the clinical mentors. 4. Mobilization of the community 5. 75% of TB/HIV clients will access and adhere to treatment.

The Lesotho team noted that, from the baseline data they had learned that the identified mentors had some knowledge gaps on TB/HIV and AIDS management prior to training as evidenced by pre-test results. Post test results indicated that they had gained some knowledge. The increase in knowledge between pre and post-test was 9%. Lesotho shared their input, process, output, and outcome indicators which are summarised in the table below.

Figure 19: Lesotho M&E indicator matrix

Input	Process	Output	Outcome
1. 10 mentors identified and trained 2. MOH mentorship (2016) and TB/HIV and AIDs guidelines (2016) 3. 3 Facilitators 4. One pre-and post test developed	1. Identified 10 clinical mentors from selected health facilities in Leribe district 2. Conducted one training for clinical mentors per selected health facilities. 3. Utilized the MOH mentorship and TB/HIV and AIDS guidelines 4. 3 Facilitators conducted the trainings 5. One Pre test to assess the pre existing knowledge and one post test to assess the knowledge gained	1. 10 mentors trained from health facilities in Leribe district, of which 2 were Nurse Clinicians and 8 Registered nurses and midwives.	1. Knowledge improvement marked based on the pre- and post test result. 2. Project evaluation not yet done.

The way forward for the Lesotho QUAD is to train additional mentors, nurses, midwives and nursing assistants; conduct monitoring and evaluation of client access to TB/HIV and AIDS services in the Leribe district; align the project activities with the MOH activities and budget for sustainability; and conduct summative evaluation to determine the impact of the project.

KENYA QUAD

- Ms Rosemary Mugambi
- Ms Rose Kuria
- Mr Alfred Obengo
- Ms Winnie Shena
- Ms Edna Tallam

The Kenya progress report was presented by Ms Edna Tallam, Registrar, Nursing Council of Kenya. The title of the project is: *An initiative to enhance competencies in nurse-led care and management for HIV exposed infants (HEI) and paediatric HIV.* The two facilities selected were Homa Bay County Referral Hospital and Ruiru Health Centre. The project summary is outlined below.

Figure 20: Kenya project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Overarching Goal **To deliver quality nurse-led HIV care and management to children and adolescents**	**AIM Statement** Increase self confidence score from 53.6 to 75 by June 2017. Increase self competence from 28.3 to 75 by June 2017. **Numerator = Summated score of study population.** **Denominator= Total possible maximum score (100)**	**Your Intervention** **1. Build capacity for 35 nurses.** **2. Establish clinical mentorship program.** **3. Implement a sustainable continuous quality improvement system.**

Kenya shared their baseline data measuring self confidence in the ability to proved PMTCT and paediatric HIV services.

Figure 21: Kenya baseline data

Indicator	All Mean (SE)	Homabay (n=12) Mean (SE)	Riruta (n=7) Mean (SE)
Overall confidence	60.6 (4.2)	68.2 (4.8)	47.5 (5.0)
Pregnant and breastfeeding women	70.7 (3.9)	77.6 (4.6)	59.0 (4.4)
HIV-exposed infants	57.5 (4.7)	66.4 (5.0)	42.3 (6.2)
Children and adolescent living with HIV	53.6 (5.4)	61.1 (6.9)	40.6 (6.8)

Kenya shared their input, process, output, and outcome indicators which are summarised in the table below.

Figure 22: Kenya M&E indicator matrix

Input	Process	Output	Outcome
• # of Training materials • # of Trainers identified • # of Mentors identified • # of Trainees identified • # of mentees identified.	• # of trainings conducted. • # of face to face sessions with mentors • # of CPD done within the facilities. • # feedback sessions given to departments.	• # of trainees trained • # of mentees identified	• Increased competence and confidence scores

For the next action period, Kenya plans to embark on the 3rd objective in the next phase; finalize the ongoing objectives; refine their work plan; commence on the 3rd objective of the continuous quality improvement and assurance; and establish quality improvement activities.

ETHIOPIA QUAD

- Mr Tafesse Worku
- Ms Yezabnesh Kibe Addisu
- Mr Berhane Gebreegziabher
- Ms Gezashign Denekew Kassa

The Ethiopian progress report was presented by Mr Berhane Gebrekidan Gebreegziabher, Senior Academician, Addis Ababa University Department of Nursing and Midwifery. The title of the Ethiopia project is: *Strengthening compassionate and respectful maternity care for HIV positive mothers during antenatal, labour and delivery service in public health facilities of Addis Ababa, Ethiopia*. The project will focus on three HIV high volume sites in Addis Ababa: Tikur Anbessa Hospital, Alert Hospital, and Zewditu Hospital. The project summary is outlined below.

Figure 23: Ethiopia project summary

What are we trying to accomplish?	How will we know if a change is an improvement?	What change will we make that will result in an improvement?
Overarching Goal To improve the quality of maternity and Pediatric Health Services through Compassionate, and Respectful Care approach in the selected three Hospitals of Addis Ababa.	**AIM Statement** • Increase the competence of nurses and midwives on CRC from 50% to 80% at Black Lion, Zewditu and Alert Hospitals, by April 2017. • Improve the service satisfaction of patients attending in the three identified hospitals through the CRC approach from 40% to 70% by June, 2017.	**Your Intervention** • Six days on facility assessment survey which is finished. • Systematic and organized training • Mentoring and supportive supervision q. 2 weeks. • Monitoring and Evaluation q month.

Ethiopia's baseline assessent demonstrated there was inadequate pre-service education for nurses and midwives in HIV care generally and paediatric HIV care specifically. Results of their survey showed 72% full competence and 20% average competence in the provision of PMTCT services and HEI care. The survey also found that 50% and 25% respectively were always and sometimes abusive. Other findings were that nurses and midwives neglect the counselling needs of HIV+ women and children and were disrespectful and unkind to women and children who were HIV+. Kenya shared their input, process, output, and outcome indicators which are summarised in the table below.

Figure 24: Ethiopia M&E indicator matrix

Input	Process	Output	Outcome
•Financial resources • 4 mentors are selected •Finalized training materials and checklists. •Facility assessment survey tool analysis.	•80 participants will be trained •Brainstorming, case studies activities. •Reflection on daily evaluation	Increase on communication skill	Percentile increase from pretest and posttest.
•Pre and post test questions •Checklists for self, team evaluation •Recruitment of 6 mentors • Dev't of TOR for mentors. •Checklist for exit interview. •Prepared document on CRC.	•No of supportive supervision	• Finalized report on the project •No of visit on supportive supervision . •Positive reflection on side of head nurses as evidenced on minute.	Change on service satisfaction from 40% to 70% .

9. SESSION FOUR

Highlights and analysis from project updates

Professor Kenneth Hepburn; Ms Jessica Gross; Mr André Verani; Ms Kethi Mullei


Kenneth Hepburn


Jessica Gross


Andrè Verani


Kethi Mullei

Professor Hepburn provided feedback on the presentations of Mozambique and Ethiopia which focused on: *Promoting compassionate respectful care (CRC)*. The Mozambique project aimed to promote a safe and welcoming environment for adolescents in three community clinics by improving nurse and midwife skill; increasing adolescent centre use and HIV testing; increasing the clinic capacity; and enhancing policy development. The Ethiopia project aimed to promote respectful ante-natal, maternity, and post-natal care for HIV positive women in maternity clinics in Addis Ababa by increasing the competence of nurses and midwives in the provision of CRC and thereby increasing patient satisfaction with CRC at the clinics. Both countries used different approaches: Mozambique used training, structural (equipment and policies) changes, and programming. Ethiopia used training by tailoring a national CRC curriculum. Both countries used pre and post tests to track changes in nursing capacity as an outcome indicator. Both countries had baseline data that they could use to measure impact. Mozambique was able to measure the number of adolescents using the clinics being tested for HIV. Ethiopia was able to meassure nurses' competence and patient satisfaction. Mozambique will use the presence of new policies as an outcome measure and Ethiopia will use observations and interviews to assess both outcome and impact.

Jessica Gross provided feedback on the presentations of Lesotho, Uganda and Rwanda which focused on: *Clinical mentoring.* The focus of Lesotho's project was reinforcing clinical mentorship for nurses and midwives providing TB and HIV services in the Leribe District. They also aimed to increase the number of clients accessing TB and HIV services from 56% to 75%. In Lesotho, the MOH has just developed a preceptorship/mentorship framework for the country. The Lesotho QUAD aligned their project with the Ministry's framework using national TB guidelines (2013) and national HIV guidelines (2016). Pre and post-test demonstrated an improvement in nurse and midwife knowledge, skills and services from 72.5% to 81.5%. Lesotho have three facilitators and ten clinical mentors (two nurse clinicians and eight registered nurses) undergoing training. They intend to train additional mentors to assist with monitoring and evaluation and evaluate client access to services.

The Uganda team aimed to use mentorship to improve paediatric HIV services (ages 2-14 years) at three MildMay facilities. At these facilities, managers, doctors and nurses work together as a team. The nurses have been providing services but recognised gaps in their knowledge and skills, particularly in working with children and adolescents. They are pleased to be receiving clinical mentorship to increase their confidence in HIV service delivery to children. Uganda sought to identify motivated staff already trained to provide HIV services to train as mentors. Pre-test revealed a 65.6% competency and skill level for children and a 44.8% competency and skill level for adolescents. The goal is to improve these scores to 80%. A big challenge for the Uganda QUAD has been the difficulty of organising QUAD meetings which has affected the coordination of the project. Other areas to be assessed are the type of services being provided to children; and measuring the attitude of parents by the number of parents disclosing their HIV status to children and the number of children aware of their HIV status.

The Rwanda project also focused on clinical mentorship to improve paediatric HIV care and services.

In Rwanda there is already a national mentorship program run by the MOH HIV unit. The Rwanda QUAD however identified a gap in that there were only two mentors at district level covering numerous facilities. These mentors had challenges reaching all the facilities in their district and with transport and finances for providing mentorship. The Rwanda project provided training to the heads of the health facilities to mentor the staff within their unit. The Rwanda QUAD partnered with the Rwanda Biomedical Centre (RBC) regarding their strategy. They were confident the approach they adopted would overcome the logistcal challenges being experienced by the existing mentors. The QUAD designed a clinical mentorship program in paediatric HIV care drawing from four existing documents from WHO, ICAP, Zambia, and South Africa. The program included training on task sharing particularly in relation to advanced paediatric HIV services. Prior to the training only two of the ten heads of facilities had been exposed to training in task sharing. Following the training, the reported competence increased from 40% to 85%. Other elements to be evaluated included patient level outcomes and changes in service delivery as a result of the mentorship.

Andrè Verani provided feedback on the presentations of Malawi, Swaziland, and Zambia which focused on: *Retention of HIV patients in care.* Malawi focused on the retention of HIV exposed infants, care and follow-up at Mitundo Hospital; Swaziland on the provision of PMTCT and Option B+ services at Luyengo Clinic; and Zambia on the retention of pregnant women, breastfeeding mothers, and infants on ART and three health facilities.

Mr Verani noted that while retention was a common goal the approaches to achieve it varied. Malawi used expert clients as default tracers in villages. Swaziland used community health workers as default tracers; while Zambia used mentorship of nurses and midwives to improve the services they provide. While all countries used off-site training, they also frequently used on-site mentoring. Malawi contracted mentors with a specific terms of reference. Swaziland trained nurses, midwives and nurse managers; and Zambia piloted a mentorship program which they evaluated for its suitability. The unique contribution of each country also varied. Malawi's use of HIV positive mothers as expert clients to trace defaulters was a unique approach. Swaziland used individual pre-test counselling and provided community health workers with cellular phones and air time for PMTCT and Option B+ default tracing. Zambia used mentor/mentee interaction as the key to nurses' self-evaluation of their knowledge and skill to deliver quality services.

Kethi Mullei provided feedback on the presentations of Kenya and Tanzania which focused on: *Quality assurance and task sharing.* A number of questions were put to each QUAD.

1. *What is the unique contribution of the QUAD's project?*

Kenya: The unique contribution of the quad team is on addressing the disconnect between knowing HIV clinical care and feeling confident in service provision which has also improved supervisor awareness and has sensitised colleagues. Also having trained mentors is an innovative approach to boosting confidence among nurses.

Tanzania: The unique contribution of the QUAD has been to introduce NIMART services to Tanzania which is a tremendous contribution. Also the approach is not to simply target nurses and midwives but make the patient the focal point by involving other clinical cadres involved in the Care and Treatment Centre (CTC).

2. What has the team learned from the first two action periods? What does the data show?

Kenya: In terms of data from the 1st two action periods, the slides in the country report demonstrate improvements in both aspects being measured: self-confidence and competence. The indicators differentiate and provide specificity in what is being measured by service area: PMTCT service and pediatric HIV. Ms Mullei commented that while it is good to have comparison of facility performance against the mean, it is important to have a clear plan for how scores will be checked after intervention. Peer feedback was that the presentation was not clear in parts and they had difficulties understanding the chart of barriers and facilitators and the Y axis is not defined. Ms Mullei suggested unpacking these two issues and not presenting them together. The barriers and challenges have been identified for the team to address in the next action period.

Tanzania: The data suggests that the results are positive. The percentage of HIV positive clients on ART has increased from 45% to 49%. Ms Mullei commented that it would be really important to ensure that indicators pertaining to patients on ART or Live in Care are tracked closely and on shorter time points (monthly/ quarterly). Nurses and midwives now are offering ART, however there is a good observation that the total number of nurses is limited (4) despite this being the number of nurses available at CTC. Can this be explored further? There are challenges in knowing how to use the tool template for monitoring and evaluation as well as indicator development. Ms Mullei suggested that the M&E plan should address mentorship and supportive supervision; these are attainable and the team could readily identify and task nurses trained in NIMART to serve as mentors at additional target facilities, if possible and maximize the use of those trained or identify scope for additional training.

3. Summary and feedback on country report and monitoring and evaluation plan.

Kenya: The goal was to deliver quality nurse-led HIV care and management to children and adolescents. Aim statement: Increase self-confidence score from 53.6 to 75 by June 2017 and increase self-competence from a score of 28.3 to 75 by June 2017. Ms Mullei commented that it is a well stated aim statement but not necessary to include the figures. Desired changes: (1) build capacity for 35 nurses (2) establish clinical mentorship program (3) implement a sustainable continuous quality improvement system. Ms Mullei commented that most indicators are aligned to activities – training. There are a few supporting indicators for inputs, activities and outputs and there is one outcome indicator which demonstrates the 'change' in provider confidence and competence. The tools listed are mostly attendance lists. Ms Muellei said 'tools' are not a critical data source nor should they be used as they are supposed to be a source of guidance not an output. The use of the modular questionnaire to inform change in self-confidence and competence is positive. The output indicators to the second objective to establish a clinical mentorship program among nurses on comprehensive HIV care and management of adolescents and children make sense and are well aligned to the objective. For the indicator, 'rate of compliance', Ms Mullei suggested using the term 'adherence to the guideline'.

Tanzania: The goal was to operationalize the task sharing policy (TSP) to enable nurses and midwives to provide NIMART services to people living with HIV&AIDS by July 2017. Ms Mullei commented that the aim statement does not speak to the goal and there is a slight disconnect or rather an assumption that by implementing the TSP this will allow nurses to deliberately target and enrol new HIV+ patients. Desired changes included: developing job descriptions for nurses and midwives to provide NIMART services according to the expanded roles outlined in the task sharing policy by November 2016; orient CTC staff and hospital management on the TSP; train nurses and midwives on NIMART by December 2016; conduct mentorship by January 2017. Ms Mullei commended the team with their anticipated outcome statements saying they were clear, concise and well aligned to the activities. She said Objective 1: To introduce the project to key stakeholders by 30th September 2016, needs revising to be more specific to speak to the introduction and launch of the TSP.

4. Key highlights to note.

Kenya: Ms Mullei noted there was excellent feedback during Q&A on use of the tool column which is not unique to Kenya, and appears to be a recurring issue. This is likely to point to the need for QUADS to be properly oriented on how to use the tool templates (M&E plan). Plans for follow up to address the issue of quality of services – how can this be examined more thoroughly in the future? Issue on supervision – as part of a sustainability effort – the mentors are expected to prioritise continued supervision going forward and as needed.

Tanzania: Ms Mullei commented that the team from Zimbabwe made a fantastic observation on their experience introducing NIMART which points to the need for countries to support one another's work by sharing valuable lessons. She suggested teams use this platform as much as possible.

10. SESSION FIVE

Pillar meetings: Academics; Chief Nursing Officers; Registrars; Professional Associations and Unions

Meeting of Senior Academics - Facilitator: Ms Mutinta Muleya, Zambia

Questions:

1. *What HIV related competencies are currently covered in the pre-service curriculum for nurses and midwives (eg: NIMART, paediatric HIV care, PMTCT, VMMC)? How could HIV competencies in pre-service education be strengthened in your country?*

   - The theory related to HIV pathology and management is taught including: HIV B+, paediatric care, prevention and treatment; clinical staging of HIV; and testing and treating opportunistic infections. The curricular is heavy on theory however practical experience and learning is lacking.
   - HIV competencies in pre-service education could be strengthened by the inclusion of HIV competencies in the curriculum; the addition of clinical experience and learning and an emphasis on students achieving a specific number of competencies by designing clinical log books; and practical evaluation of the competencies.

2. *Does your country or institution currently use clinical faculty? How could your schools begin creating more positions for clinical faculty to mentor students during their clinical rotations?*

   All countries use either clinical faculty, mentors or preceptors however the ratio of clinical faculty, mentor, or preceptor to student is low. There are too many students making quality supervision difficult. More positions could be created if institutions were aware of the need for clinical mentors so they can employ them and guidelines should be provided of the effective ratio of clinical faculty, mentor or preceptor to student. Additionally, clinical faculty should be trained especially in HIV.

3. *Does your country or institution use clinical skills laboratories? What associated opportunities and challenges have institutions experienced?*

   - All institutions have skills laboratories or practical demonstration rooms. Skills are demonstrated before students go to the clinical area and students have the opportunity to demonstrate their skills to the lecturer and practise on their own. Some of the challenges are that a number of skills laboratories were converted from existing rooms and are not adequate in space. Some are inadequately equipped and there is a lack of simulators. There is also a high number of students and few resources and supplies and poor coordination of activities.

4. *What are the next steps in policy implementation to enable improvements in HIV care for children and pregnant women?*

    - Task sharing policies are being developed and the 2016 HIV guidelines are ready for use. Scopes of practice are being revised and CPD and quality improvement programs are being initiated.

5. *What 1-2 priority elements are needed to strengthen nurse and midwifery capacity to achieve the 90-90-90 goals?*

    - Integrating HIV competencies into the curricular.
    - Increasing in-service competencies through CPD.
    - Capacity building for lecturers in HIV competencies.
    - Increasing the number of clinical mentors who have competencies in HIV.
    - Collaborating with laboratory staff to ensure timely results.

Meeting of Chief Nursing and Midwifery Officers - Facilitator: Ms 'Makholu Lebaka, Lesotho

Questions:

1. *Has your country rolled out Test and Start?*

    - All countries are rolling out Test and Start.

2. *Are there any guidelines in place? If yes, please list them.*

    - All countries have guidelines in place.

3. *What is the view of clients, health providers, and policy makers regarding Test and Start?*

    For clients it saves them time, prolongs their life, and they remain healthy. However, they often do not see the need to start early when they are healthy. They know they will be on ART for a long time and they prefer to wait until they feel sick. They also prefer to be given time to consult with their significant others before they commence ART. Providers often complain it is too much work and counselling is not adequate. They also consider it means more time given to people who are HIV positive and less time to people with other health challenges. All countries considered there is political will to introduce Test and Start.

4. *What interventions could be put in place to promote Test and Start? What hindrances do you anticipate and how can they be mitigated?*

    - Health care workers feel they should be more involved in primary health care rather than in curative care. More health education and health promotion would be an effective intervention. The hindrances include: inadequate supply of tests kits, and ART; as well as cultural and religious issues and myths surrounding HIV.

- These could be mitigated by proper counselling; introducing mobile clinics or health posts to facilitate access; creating awareness by working with the media and community leaders; advocating for more resources (such as money, human resources, transport, infrastructure etc); strengthening the supply chain management; and recognising best performing nurses and midwives.

5. *What are the roles of clinical mentors in your country? What can be done to strengthen clinical mentorship for nurses and midwives?*

   - Clinical mentors provide technical support and they provide CPD. Their role could be strengthened by harmonising a standardised curriculum and role across the region; providing technical and financial support; empowering clinical mentors through regular refresher courses on emerging health challenges and treatment regimes.

6. *What 1-2 priority elements are needed to strengthen nurse and midwifery capacity to achieve the 90-90-90 goals?*

   - Having specific nursing and midwifery indicators in the data base to track nursing and midwifery contributions toward 90-90-90.
   - Empowering nurses and midwives to understand what each '90' means and what is expected of them toward its achievement.
   - Building nursing and midwifery capacity.
   - Documenting and using data to monitor progress toward achieving the goal.
   - Introducing computerized patient management systems.
   - Collaborating and coordinating with other health professions and other stakeholders.
   - Strengthening clinical supportive supervision and mentorship.

7. *What are the next steps in policy implementation to enable improvements in HIV care for children and pregnant women?*

   - Strengthening pre-pregnancy care such as family planning.
   - Strengthening adolescent TB, HIV and AIDS school health programs.
   - Advocating for free comprehensive quality health care services to all pregnant women.
   - Increasing accessibility of health care services to remote and hard to reach areas for pregnant women.
   - Initiating respective and compassionate care programs in the region.
   - Prioritising child and adolescent friendly care.

Meeting of National Nursing and Midwifery Associations - Facilitator: Mr Andrè Gitembagara, Rwanda

Questions:

1. *Does the NNA (NNU) currently offer or promote CPD for nurses and midwives? How could this be strengthened?*

   - Lesotho do provide CPD but their Nursing Council is in the process of accrediting CPD providers.
   - Zambia provides training and it attracts points. They wrote to their Council with a list of topics and the Council responded that they could be one of the providers, however there is need for inspection of premises and curriculum and they are in the process of developing the content.
   - Ethiopia has a CPD framework developed in collaboration with the MOH and other associations and the Ethiopia NNA execute the program for their members, however this is not yet implemented. Ethiopia does not have a Council for nurses however they have health professional's council which accredits for CPD providers, and issues licences.
   - Kenya NNA provides CPD which contributes to the renewal of licences for nurses and midwives. There is an issue with sustainability of the project since most of the CPDs are offered for free.
   - Swaziland as a trade union does not get involved with CPD as they focus on trade unionism: to deal with the country politics; how to analyse the country's budget or economy, negotiations and bargaining. The welfare arm of the union partners with NGOS to support in capacity building the members. The union works to ensure the employer provides the CPD. The work of the union in collaboration with the QUAD, is to evaluate and monitor for quality.
   - Mozambique does not provide CPD. They still do not have a council but this will be established by April when elections are conducted. The work of the association is to advocate with the MOH to do the training.
   - Rwanda is a union with three pillars: labour, professional and welfare. The professional pillar undertakes the CPD. They intend to have the nurses pay for the CPD to ensure sustainability. They have a vision to deduct a certain % from the membership to pay for the members CPD that will increase the CPDs. They have a CPD coordinator in midwifery and they intend to hire a CPD coordinator for nurses.
   - Malawi has been conducting CPD. Long courses are fee paying however short courses are free. The nurses are required to submit a CPD book. It is the initiative of the nurses to search for the CPD courses and the required points are 50 per year.
   - Uganda said that for a long time CPD was being done by other organisations, until the MOH and the Councils and the unions developed a CPD guideline. All health professional councils have been given a mandate to accredit CPD; they have applied for accreditation they still await for the results. The union has two arms: labour and the professional arm. The professional arm is the arm that conducts CPD for nurses and midwives in Uganda. The labour arm also conducts CPD on labour issues and rights labour laws that enable the nurses to defend themselves as they work.
   - Zimbabwe QUAD members agreed to develop CPD guidelines which are used by any health care providers and they will get points. The association/union (registered as both) is one of the CPD providers.
     Tanzania Nursing and Midwifery Council is mandated to provide CPD by law, however the association has worked on the framework to guide CPD provision. They require assistance in the development of modules and evaluation, monitoring to ensure quality of CPD provided.

     In conclusion, the general view was that associations and unions should provide CPD for their members. All the countries are at the initial stage. There is a need to rethink the sustainability of associations and unions offering CPD.

2. *Is the association/union involved in any type of specialty certification? Is this a service the association/union could provide (eg: specialty certification in HIV with NIMART and VMMC skills and competencies)?*

   - Lesotho provides some certification for specific topics in partnership with other providers.
   - Zambia does not provide certification, they just give certificate of attendance.

- Swaziland has partnered with the university to provide certification.
- Rwanda provides certification for PMTCT and paediatric HIV.
- Malawi provides certification for leadership.
- Uganda offers short courses and issues a certificate of attendance.
- Zimbabwe they do not offer certification.
- Tanzania do not offer certification.

3. *What core services does the association/union provide to its members? How could these be strengthened?*

   - Six are professional unions whose core mandate is labour issues however they also provide some professional services. Six are associations whose core services are professional development.

Meeting of Registrars of Nurses and Midwives Councils - Faciltator: Ms Glory Msibi, Swaziland

Questions:

- *How could 'accreditation' for pre-service nurse training institutions in your country be strengthened? Are there any plans for institutions to renew their accreditation status on a routine basis?*

LESOTHO	KENYA	MALAWI	RWANDA	UGANDA	SWAZILAND	TANZANIA	ZAMBIA	ZIMBABWE
Clarification of conflicting mandates: MOU and harmonizing their roles Improve on routine inspections and advocate for approval of the revised ACT for mandate for accreditation	Standards of Accreditation done yearly then renewal in 5years Collaboration in boards and councils	Monitoring and Evaluation done twice per year to check on adherence to standards Working with National Council for higher educations. Plan: Renewal every 2 years upon assessment and ACT is silent	Strengthened Collaborations with Higher Educational Council for self-assessment regularly. Establishment of National Accreditation Authority.	Collaborations through UNEB and MOU with DES To be done every three years following standards: Directorate standards Education.	Enforce Compliance Accreditation guidelines and tools Working Collaboration twice yearly with	Accreditation is done by another regulatory body (NACTE) NMC provide technical assistance during establishment of training. Sporadic assessments under NACTE	Strengthen follow up and adherence to set standards. Improve on periodic assessment Plans to renew accreditation and period not specified	There is need to conduct supportive supervision frequently. Bi annually to monitor compliance. Plans to renew accreditation when they introduce new programme or upgrade existing programmes

- *Are HIV related competencies currently covered in the pre-service curriculum for nurses and midwives (eg: NIMART, paediatric HIV care, PMTCT, VMMC)? How could these HIV competencies be strengthened?*

LESOTHO	KENYA	MALAWI	RWANDA	UGANDA	SWAZILAND	TANZANIA	ZAMBIA	ZIMBABWE
HIV competencies in nurses and midwifery curriculum and examinable **To be included in the CPD**	It's incorporated in preservice which is examinable. Competency based training in CPD pegged to renewal of the licensure	Incorporated in pre-service which is examinable; scope of practice Practical period for HIV competencies is short for NIMART	HIV module exists in the preservice module and it is examinable	Incorporated in preservice curricular but not in the module Have the module on in its own with clinical training and mentorship.	Situational analysis and curriculum desk reviews: developed competencies on HIV: incorporate into the curriculum during reviews awaits Council approval.	It's not covered: only updates for in-service Need to review curriculum	Paediatrics and PMCTC HIV competencies in nurses and midwifery curriculum and examinable VMCC still under discussion. To be included in the CPD	HIV competencies in nurses and midwifery in preservice curriculum

- *Does your council have a human resources information system (HRIS)? If so, what information does it track? How does the council utilise the HRIS to improve nursing regulation?*

LESOTHO	KENYA	MALAWI	RWANDA	UGANDA	SWAZILAND	ZAMBIA	ZIMBABWE
HRIS Available: Track students indexing: examinations; Registration; intent to migrations Share with MOH and Joints boards and council Verifications status by the public	HRIS in the Ministry but not connected to NMC	Weak HRIS and not well utilised	HRIS exists and used to track nurses: professional development and private practice Track disciplinary cases. Generates reports CPD providers	HRIS available Track the nurses, renewals; registration status; deployment of nurses; emigrations	HRIS available HRIS exists and used to track Nurses: professional development and private practice Track disciplinary cases. Generates reports	HRIS available Tracking retention of nurses, students' progress and examination MOH reports	HRIS available and utilised in licensure status: MOH and all boards and council Database shared Track disciplinary cases.

- *What are the next steps in policy implementation to enable improvements in HIV care for children and pregnant women?*

LESOTHO	KENYA	MALAWI	RWANDA	UGANDA	SWAZILAND	ZAMBIA	ZIMBABWE
Adoption of VMCC policy in preservice training **Renewal of licensure through competency based**	MOH to include Mentorship Policy to enable improvements in HIV care	Strengthened CPD in HIV care	Policy Implementation and CPD	Strengthen preceptorship program Strengthen mentorship and supportive supervision	CPD for in-service and review curriculum for pre-service for inclusion of HIV care.	Implement mentorship policy	Enforce free treatment of Children and pregnant in all public Institutions. Improvements in staffing levels for nurses and

Implement task sharing policy; Review Scope of practice and amendments of the ACTS.							Midwives

- *What 1-2 priority elements are needed to strengthen nurse and midwifery capacity to achieve the 90-90-90 goals?*

LESOTHO	KENYA	MALAWI	RWANDA	UGANDA	SWAZILAND	ZAMBIA	ZIMBABWE
Implement VMMC policies and task sharing policy	**Improve competence and confidence levels**	**Mentorship training and follow up**	**CPD, Support supervision and provision of Resources**	**Training and refresher courses for nurses.** **Conduct pre and post-test.**	**Develop guidelines on NIMART** **Mentorship on Initiation of NIMART**	**Technical support in mentorship and leverage on the available resources.**	**Improvements of the staffing levels**

11. SESSION SIX

Dimensions of HIV for young women and adolescent girls

Philomène Cyulinyana, President, Forum of Positive Women

Dr Mary Mwangi, CDC DREAMS Initiative

Mary Mwangi and Philomène Cyulinyana

Ms Philomène Cyulinyana is the President of a Rwandan non-government organisation whose mission is to treat problems related to health at the community level particularly for women living with HIV or AIDS. Ms Cyulinyana informed particpants that she would present in French, however hard copies of her presentation were provided in English for English speakers. Ms Cyurinyana said the focus of her presentation was on gender and the effect gender had on the provision of HIV services to women.

Ms Cyulinyana defined gender as a sociological concept which assigns social relations based on sex, and, concretely, the analysis of laws, social roles, and interactions between men and women. From a public policy perspective, gender analysis aims to promote equality between men and women while taking into consideration differences and socially-constructed hierarchies. As a concept, a gender approach analyses relations of power between women and men which are based on socially-constructed roles based on sex. As an objective, a gender approach promotes equal rights, as well as an equal distribution of resources and responsibilities between women and men. As a methodology, a gender approach develops a comparative analysis of the status of women and of men on economic, social, cultural and political levels.

Ms Cyulinyana said that sexual gender norms influence women's vulnerability to HIV and AIDS as well as its impact. The increased risk for HIV and AIDS are due to numerous biological factors on one side, but also, social, cultural, economic, and legal, such as persistent inequality for women on the social and economic basis in the area of sexual relations and marriage. As a result women and girls often resort to sex work, and forced marriage with older men who are sometimes polygamous. This reality only deepens their susceptibility in the face of HIV and AIDS. Women and girls, including those who are HIV positive, must bear the physical and psychological burden of providing care to those who are living with AIDS. In these unequal relationships, women submit to unwanted sexual relations, which is another risk of HIV infection. They experience sexual violence, sexual exploitation, unplanned births.

Violence toward women and girls may include rape and forced sexual relations, physical agression, emotional violence, humiliation or intimidation, and economic deprivations. Violence during sexual relations can lead to tearing of vaginal tissue which facilitates the entry of HIV into the body. In many contexts, social and cultural values related to female chastity leads to a stronger discrimination of women and girls living with HIV or AIDS than for men. There is the possibility of an increase in sexual and conjugal violence; rejection by families and communities; forced abortion or sterilisation; job layoffs; and the loss of survival income brought about by accusation of women as being the origin of HIV infection.

The risk of HIV infection is frequently influenced by social status. At the personal, individual level, social risks include shame, dishonor, rejection, divorce, and the break of social relations. Fear of being rejected, of not being accepted into the family, or being chased from home, being denied by the family, or rejected by a partner. At the marital level, HIV infection, which is related to the status and role of women, also plays a role in marital separation. These separations take place along with conflicts that break marital bonds, including with in-laws. At the family level, the quality of the relationship with women is an extension of the predominant social status within the family. Therefore, the more a woman is living positively, the more the woman is accepted and bonds can even be strengthened. For women, AIDS can be at the same time fatal, transmissible and bearing stigma. This can lead to the deterioration of the immune system, to a physical decay.

What can be done to change the effect of gender on care for women with, or at risk of, HIV? Ms Cyulinyana said these fall under three board categories:

1. Gender and access to HIV testing and treatment.
   - Expand provision of services on HIV prevention, counseling and testing, and the use of male and female condoms.
   - Strengthen prevention services for people living with HIV or AIDS.
   - Integrate a gender dimension and take into consideration the needs of youth as part of sexual and reproductive health service.
   - Apply comprehensive national laws intended to protect the rights of girls, young women and people living with HIV.
   - Propose to key populations sexual and reproductive health services that are adapted, customized and non stigma-bearing.
   - Link HIV prevention to policies and programs on sexual and reproductive health.

2. Expand socio-economic efforts for girls and young women.
   - Increase economic revenue particularly by working with innovative partners
   - Promote approaches that fight gender inequality and propose a package of services on HIV prevention
   - Reinforce leadership competencies, and participation in decision-making processes

3. Ban child marriage.
   - Ban child marriage through a law, apply the appropriate legislation and collaborate with influential persons in order to modify social norms.

Dr Mary Mwangi shared with participants information about a global partnership to reduce HIV infection in adolescents girls and young women. The DREAMS initiative was launched in 2014 and targets 10 countries in sub-Saharan Africa: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Dr Mwangi explained that 20% of new HIV infections occurred in adolescent girls and young women: 70% of new infections in sub-Saharan Africa are in adolescent girls and young women which amounts to 380,000 new infections each year.

The acronym DREAMS stands for:
D: determined
R: resilient
E:empowered
A: AIDS free
M: mentored
S: safe

Factors that increase the risk of HIV infection in adolescent girls and young women are: insufficient education; poor access to sexual and reproductive health services; poverty; gender inequality; harmful norms; violence; and food insecurity. The DREAMS initiative aims to provide a country determined core package of evidence based interventions that have successfully addressed HIV risk behaviours, HIV transmission, and gender based violence. The primary goal is a 40% reduction in new HIV infections among adolescent girls and young women (aged 15-24) by 2017. The elements of the core package are: adolescent friendly health care; strengthening the community; strengthening the family; and decreasing risk in sex partners.

Dr Mwanti outlined seven priorities for nurse and midwife leaders:

1. Provision of condoms and mixed methods contraception.
   - Demand creation through IEC,
   - Adolescent friendly counselling and services,
   - Provision of contraception,
   - Increase access to long acting methods of contraception.

2. Pre-exposure prophylaxis (PrEP).
   - Health care worker capacity building,
   - Demand creation in clinical settings,
   - Adherence counselling,
   - Adolescent friendly services.

3. Voluntary Male Medical Circumcision.
   - Reaching men 25 years+,
   - Promoting infant circumcision,
   - Engaging women as champions.

4. HIV testing services (HTS) among adolecent girls, young women, and male sex partners.
   - HIV testing services as an entry point to care and treatment,
   - Prioritization of adolescent girls and young women in HIV testing and counselling services,
   - Linkage of HIV positive adolescent girls and young women to care and treatment, PMTCT, VMMC and PrEP for discordant couples, and partner testing and notification.

5. ART test and start.
   - Identifying and starting adolescent girls and young women and male sex partners on ART,
   - Partner and family testing for index clients,
   - Adherence support to achieve viral suppression,
   - Child and adolescent friendly services and support groups,
   - Preventing mother to child transmission in antenatal and PMTCT settings.

6. Comprehensive post-gender based violence services.
   - IEC on gender based violence and services,
   - Capacity building of health care workers,
   - Comprehensive services: HTS, PrEP and adherence, STI, counselling, evidence collection and documentation,
   - Linkage to non clinical services-law enforcement, legal and paralegal support, safe houses, support groups, economic empowerment.

7. Linking adolescent girls and young women to community services.
   - Establish relationships with providers,
   - Referral directories,
   - Effective linkage to services.

Dr Mwangi thanked participants for their attention and encouraged the nurse and midwife leaders present to look closely at the seven priority areas and see what needs to be done in their own countries to improve outcomes for adolescent girls and young women.

12. SESSION SEVEN

Monitoring and evaluation fundamentals
Ms Kethi Mullei

Ms Kethi Mullei said the purpose of her presentation was to introduce participants to the fundamentals of monitoring, evaluation, and learning. Other aspects of the presentation included an overview of results based management (RBM); essential elements addressed by routine monitoring and evaluation; the use of SMART principles in setting goals, objectives, and indicators; the key elements of a Logic Model; types and use of evaluations in monitoring and evaluation; and developing a monitoring and evaluation plan.

Results-based management (RBM), Ms Mullei explained, is a common approach used by managers to improve project or program performance and internal accountability by applying a clear, logical framework and plan on how you intend to measure and achieve desired results using a specific intervention of choice. A results based framework (RBF), often called a log frame, gives explicit guidance on the results expected at different stages of implementation. The log frame includes input, activity, output and outcome stages. It sets time limits for specific activities, outputs, or intermediate outcomes; it outlines potential risks or obstacles; identifies key milestones; documents both direct and indirect indicators; and specifies the data sources to be used, both primary and secondary sources.

Monitoring is a critical component of RBM. Monitoring is a routine, systematic way to track and gather information (data) to check for progress made. Monitoring is recurrent, tracking change over time. Monitoring tracks and captures both qualitative and quantitative information (data) – through primary and secondary sources. Monitoring must be fully integrated into all program areas, and involve all program staff and not be regarded as a separate activity conducted by a single unit. Monitoring checks compliance on how a project or program is performing against set standards. Monitoring reports are shared periodically, as determined by the project (internal) or by the donor (external).

By contrast, Ms Mullei said, evaluation is an activity that makes use of monitoring results and takes into consideration processes, achievable milestones, and experiences routinely collected under monitoring. Evaluation appraises the quality of the data and is typically used to inform strategic planning and decision-making. Evaluation checks program performance based on five aspects of the intervention(s) implemented: relevance, effectiveness, efficiency, impact, and sustainability.

Figure 25: Five aspects of evaluation

Ms Mullei said there were four main types of evaluation: formative, process, outcome, and impact (see figure 26).

Figure 26: Types of evaluation

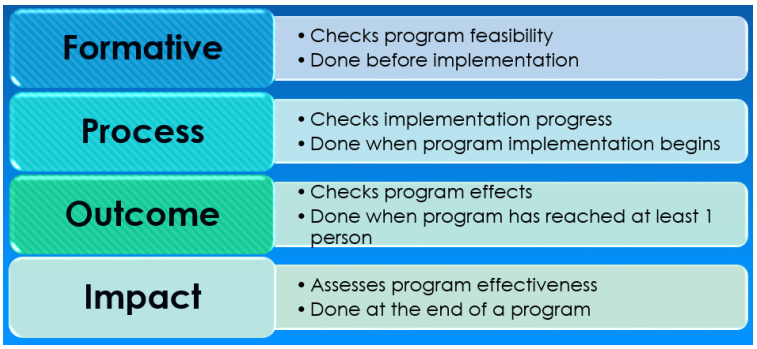


Figure 27: Process evaluation

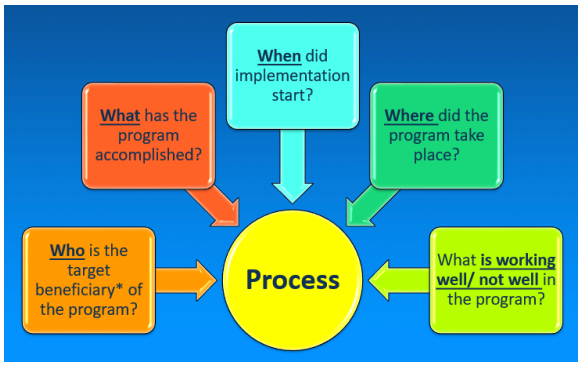
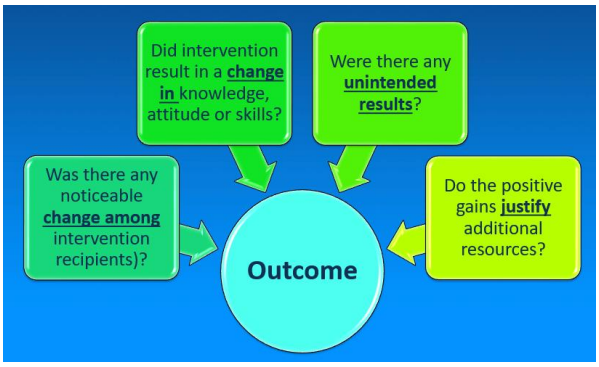


Figure 28: Outcome evaluation



SMART principles can be used in monitoring and evaluation to set goals, set objectives, and develop indicators. The SMART acronym has a variety of meanings: specific, measureable, agreed, realistic, and time-based.

Figure 29: SMART principles

The advantages of embedding monitoring, evaluation, and learning in program management, Ms Mullei said, are that scheduled checks allow for identifying mistakes early for course correction; routine data collection creates a pool of ready-to-use information for strategic planning; good data management boosts institutional memory and instills knowledge management; information collected, once analyzed, provides evidence-base for increased funding support; and routine sharing through learning platforms allows for increased transparency, accountability and improvements through lessons learned.

13. SESSION EIGHT

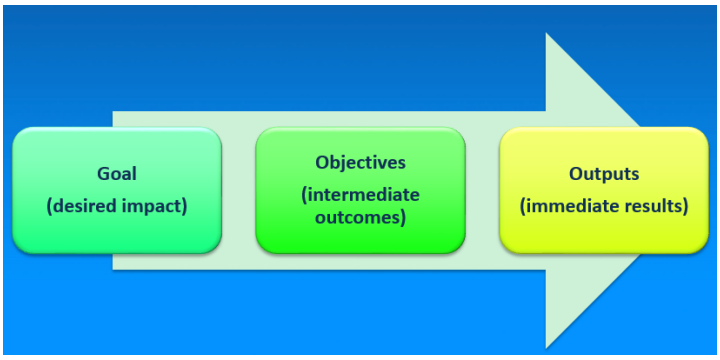
Data measurement and project indicators

Ms Kethi Mullei

Ms Mullei told participants that the purpose of her presentation was to recap on the basic elements of the logic model; review indicator development; and give each country the opportunity to revisit and refine their project's monitoring and evaluation matrix. Ms Mullei explained that, at the end of her presentation, countries would be paired and work together to present their monitoring and evaluation matrix and receive feedback from the other country they were paired with. Through this process, country teams would gain skills in monitoring and evaluation planning, specifically indicator development, based on well-articulated objectives, outcomes, activities, and outputs.

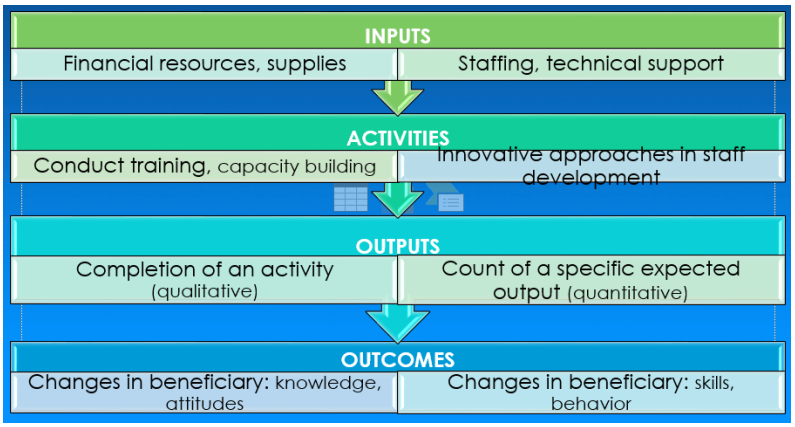
The logic model, Ms Mullei said, is a linear approach to help clarify goal and objectives toward achieving desired short and long-term results.

Figure 30: Elements of the Logic Model



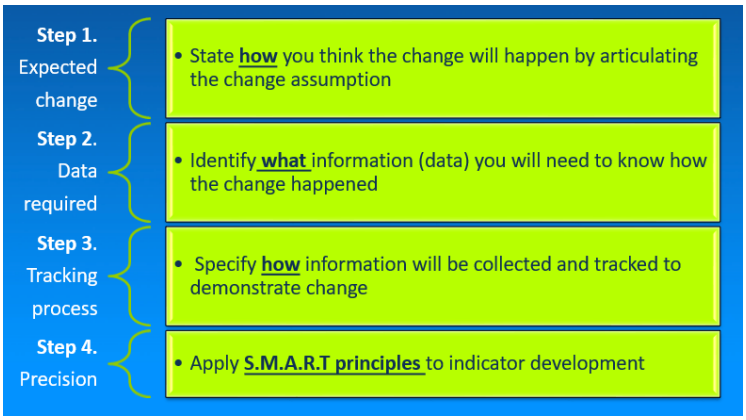
Ms Mullei said objectives (a desired long-term outcome) are the changes that the project would like to make in order to achieve the overarching goal. Outputs (immediate anticipated outcome) are statements articulating the direct results that the project would like to achieve in the short-term which directly contribute to the objective. Activities and the processes and activities conducted throughout the project to achieve the desired outputs and inputs are the resources (human, financial, technical, organisational, or social) used in planned activities.

Figure 31: The Logic Model



An indicator is a specific piece of information that allows you to track the changes you want to achieve.

Figure 32: Developing indicators

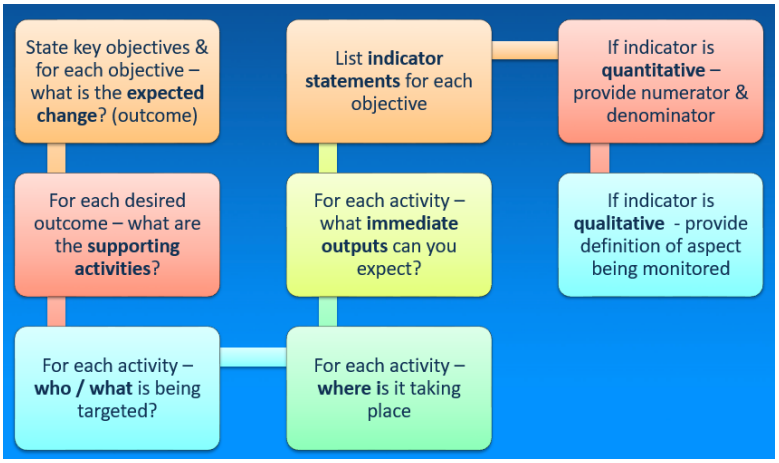


An indicator also has to be valid (as accurate as possible); reliable, in that it can be measured consistently the same way by different people; and comparable – can be used in different settings for standardisation and comparability. There are two types of indicators, Ms Mullei said, quantitative and qualitative.

Quantitative indicators consist of the 'what', 'how many', and 'when'. They are numerical: numbers (count), ratios (percentage), and rates. The first step in developing a quantitative indicator is to determine what is being measured using a precise definition and metric. The second step is to work out how the indicator will be calculated: who or what qualifies to the counted. The third step is to determine the numerator and denoinator: the actual count over the total count.

A qualitative indicator consists of the 'what', 'why', and 'how'. Data is descriptive prose that includes attitudes, perceptions, beliefs, behaviours, and motivations. Quantitative indicators rely on the use of standardized tools: checklists, questionnaires (surveys), registration log books or forms, and patient charts for example. Qualitative indicators rely on the use of: observation checklists, interview guides, discussion guides, and validated reports. Ms Mullei shared with participants a flow chart of the monitoring and evaluation matrix.

Figure 33: Monitoring and evaluation flow chart



Countries were then paired to go through their monitoring and evaluation matrix and receive feedback from their country peers.

Andrè Verani with Mozambique and Ethiopia

Ken Hepburn with Kenya and Zimbabwe

Agnes Waudo with Lesotho and Tanzania

Kethi Mullei with Rwanda and Uganda

Jessica Gross with Malawi, Zambia, and Swaziland

14. SESSION NINE

Refining monitoring and evaluations plans

Country team break-out session

Following the session by Ms Kethi Mullei, countries were given the opportunity to review and refine if necessary their monitoring and evaluation plans, providing a brief report back to colleagues. All countries acknowledged the value of the session and how much they had gained.

ZIMBABWE

The Zimbabwe team added an additional indicator, confirmed others, but made no other changes.

ZAMBIA

The Zambia team, revised their overarching goal, and made some changes to their outcome indicators so they are more realistic, specific, and measurable.

UGANDA
Uganda refined their objectives, numerators and denominators.

TANZANIA
The Tanzania team refined their objectives and outcomes but have not quite finished their review.

SWAZILAND
Swaziland refined their overall aim statement and as a consequence, their monitoring and evaluation matrix to be more explicit. They also made some adjustments to numerators and denominators.

RWANDA
The Rwanda team reviewed their monitoring and evaluation matrix, inputs, outputs, and outcomes. They made no changes to their overall goal statement or outcomes.

MOZAMBIQUE
Mozambique refined their overarching goal so it was not so long and modified their objectives.

MALAWI
The Malawi team made no changes to their overarching goal or objectives, however refined indicators, numerators, and denominators.

LESOTHO
The Lesotho team reviewed their objectives which were confirmed as appropriate but did make some minor changes to their indicator statements.

KENYA
The Kenya team said they had a very interesting discussion and as a result, refined some elements of their monitoring and evaluation matrix, inputs, outputs, and outcomes, but felt they still had more work to do when they return home..

ETHIOPIA
Ethiopia refined their objective to focus more on supportive supervision rather than mentoring which they felt was more reflective of the reality in the project facilities.

15. SESSION TEN

Facility assessment guidelines
Dr Sydney Spangler, Emory University

Dr Spangler explained to participants that her presentation would focus on the end-line facility assessment to be conducted by the QUADS to evaluate their ARC projects at high-volume HIV facilities. Dr Spangler said the presentation would review the purpose, timeline and process for the end-line assessment and provide an opportunity for countries to begin planning and develop strategies for conducting the activity. Dr Spangler emphasised that the end-line assessment should only be done in the facility or facilities where quality improvement projects had been implemented.

The purpose of the end-line assessment was (a) to identify key barriers to the delivery of quality HIV services led by nurses and midwives particularly in relation to PMTCT services, early infant diagnosis care for HIV exposed infants, and paediatric and adolescent HIV care; and (b) assess before-after changes in key nursing and midwifery practice as a result of the implementation of the quality improvement projects. Dr Spangler reminded countries that they would still need facility-level approval to conduct the assessment.

The timelines were critical and countries were reminded they needed to adhere strictly to the timelines. Countries were provided with an End-Line Facility Assessment Worksheet which needed to be completed and returned to Emory University by 1 May 2017 (see attachment 4). The critical timelines were the signing of contracts by 5-8 June; receipt of funds 12-16 June; hiring of consultant if applicable 26 June; completion of data collection 17 July to 4 August; completion of data entry 7-18 August; submission of financial report to Emory 30 August; and submission of raw data to Emory 1 September. Dr Spangler emphasised that countries did not need to analyse the data but just submit the raw data.

Dr Spangler explained there had been some minor changes to the Modules used for the initial base-line assessment as a result of feedback from countries. Module 1 consisted of in-depth interviews with supervisors of nurses and midwives who provide PMTCT and paediatric HIV services. The end-line Module 1 is an abbreviated version of the baseline version. It should be administered in person to 2-3 supervisors and can be administered at the same time as Module 3. It should take no longer than one hour. Module 2 is a questionnaire to be completed by all available nurses at the site/s who provide PMTCT and paediatric HIV services. Module 2 is self-administered but the questionnaires need to be checked for completeness. The questionnaire should take no longer than two hours. Module 3 is the programs and materials audit which, as previously mentioned, can be conducted in the same session as Module 1.

Countries were given time to review the End-Line Facility Assessment Information Sheet, reflect on the major challenges experienced with the baseline assessment, identify potential new challenges in conducting the end-line assessment, and brainstorm potential solutions. Countries were encouraged to use a consultant for the exercise and to seek technical assistance from the ARC faculty.

16. CLOSING REMARKS

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

Ms Iliffe shared with country teams her reflections on the three days of the learning session and said it was quite a challenge to summarise the experiences and learning over the three days of the meeting. The purpose of the learning session, Ms Iliffe said, as outlined in the meeting objectives, was to strengthen the ability of nursing and midwifery leaders to successfully implement, monitor, and evaluate national quality improvement projects. The focus for this learning session has been on monitoring and evaluation.

We were privileged to have with us, Kethi Mullei, who explained monitoring and evaluation concepts and requirements, and shared with us monitoring and evaluation tools. We spent time refining project monitoring and evaluation plans and while differentiating between inputs, outputs, outcomes, indicators, numerators, and denominators is frequently a bit of a struggle, there is no doubt that we are learning, as painful as that learning might be at times, and that this learning is contributing to improved nursing and midwifery care in our countries.

It was really exciting to share the progress being made with your country projects; to hear the constructive comment and affirmation of the work being done. ARC faculty are very aware of the demands on your time and resources when you go back home and truly appreciate your dedication and commitment to the successful completion of your projects.

It is important to remember however that the end of your project is not the end. The end of the project is just the end of the first step. The next step is to take that learning and apply it on a broader scale and scale up what has been achieved to other sites within your countries.

Our learning included presentations from Agnes Waudo about the development of the Task Sharing Policy in Kenya; from Dr Byiringiro Rusisiro on the Rwanda Mentorship Program; and really relevant presentations to our projects from Philomene Cyulinyana and Mary Mwangi on the impacts of HIV on young women and adolescent girls. Such important information and reminders about the unique needs of this special group.

It is always rewarding for the four pillars of nursing and midwifery: administration, education, professional, and regulatory, to spend time together to discuss issues specific to their area of responsibility, and the results of these discussions will be collated and sent to you within the next few weeks.

One of the highlights of the learning session for me was the input from QUAD members in leading ARC learning sessions and I want to particularly commend Andre Gitembagara from Rwanda; Bheki Mamba from Swaziland; Cynthia Chasokela from Zimbabwe; and Makholu Lebaka from Lesotho for taking on this responsibility at this learning session.

Another highlight of this learning session was the site visits to the University of Rwanda Nursing and Midwifery School; the Rwanda Nursing and Midwifery Council; and the Rwanda Nurses and Midwives Union. On behalf of the participants and the ARC faculty I want to thank the Rwanda QUAD for all their effort in organising these really interesting and useful visits.

It is hard to find words to describe the impact of our visit to the Kigali Genocide Memorial and I want to thank the Rwanda QUAD for making the necessary arrangements and providing that opportunity. It was a truly thought provoking, distressing, yet inspiring experience. I appreciated the courage and honesty of Rwanda as a people, to publicly acknowledge the terrible wrongs of the past of a people divided against each other, and to use that history to build a future based on forgiveness and unity. The memorial site is quite beautiful and peaceful, despite the horrors depicted, and caused me to reflect on all the current conflicts in our world and the important role that nurses and midwives can play in being advocates and role models for tolerance, respect, and peace.

I want to acknowledge the ARC faculty and all the work they do preparing for the ARC meetings and supporting you in between meetings with your projects: particularly Ken for his quiet and wise leadership; Muadi for her unfailing energy and enthusiasm; and Agnes, Nancy and Nixon for their excellent organisation and communication to ensure the meeting is successful.

I also want to acknowledge each country team for your input over the past three days; for your patience and your perseverance; for your good humour; for your respect and understanding; and for your very precious friendship. The peer sharing and support has been incredibly valuable. And finally, I would like to again thank the Rwanda QUAD for hosting the ARC learning session. Kigali is a beautiful city and it has been such a pleasure to be here.

There is still a lot of work to be done over the next six months: bringing your projects to a successful conclusion and conducting the end of project facility assessments. It is nice to know we will meet again soon 6-8 July in Lusaka. Until then, take care. Remember that to be able to look after others you need to look after yourselves also. Safe journeys home, all the very best as you move toward the finishing line for your projects, and looking forward to seeing you again in July.

Following the close of the learning session, the Rwanda QUAD organised for traditional dancers to entertain participants who were happy to join the dancers to celebrate the warm hospitality shown them in Rwanda.

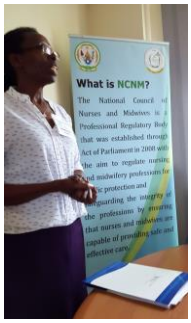





17. SITE VISITS

Organised by the Rwanda QUAD

Participants were divided into three groups to visit either: the National Council of Nurses and Midwives; the Rwanda Nurses and Midwives Union, or the University of Rwanda School of Nursing and Midwifery. The site visits provided an excellent opportunity to compare programs, services, resources, and facilities; and learn from each other.

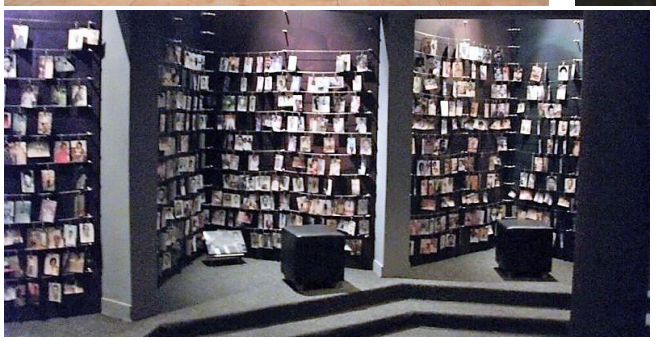



Julie Kimonyo, Registrar Nursing and Midwifery Council; School of Nursing and Midwifery; Participants at Nurses and Midwives Union.

Following the site visits, participants were privileged to have the opportunity to visit the Kigali Genocide Memorial. Set in beautiful and peaceful surroundings, the Memorial is the final resting place for more than 250,000 victims of the genocide against the Tutsi people in Rwanda. It honours, through education and peace-building, the memory of the more than one million Rwandans killed in 1994. Participants learned that the memorial is an important place of remembrance and learning and receives visitors from all around the world. The memorial has five primary objectives:

- To provide a dignified place of burial for victims of the genocide against the Tutsi.
- To inform and educate visitors about the causes, implementation and consequences of the genocide, and other genocides in history.
- To teach visitors about what can be done to prevent future genocides.
- To provide a documentation centre to record evidence of the genocide, testimonies of genocide survivors, and details of genocide victims.
- To provide support for survivors, in particular orphans and widows.

Participants found the visit confronting but also respectful and positive and were glad to have had the opportunity to be reminded of the important role of nurses and midwives in promoting peace and harmony.



APPENDIX 1

Kigali, Rwanda 21-23 March 2017

Strengthening the quality of nursing and midwifery HIV care for women and children across Africa

Meeting Objectives: The main objectives for the Summative Congress are:

1. Provide a regional learning forum to build expertise to sustainably strengthen health system support structures for quality nursing practice in HIV care.
2. Strengthen the ability of nursing and midwifery leaders to successfully implement, monitor and evaluate national quality improvement projects.
3. Convene country teams to strengthen leadership capacity in project management, monitoring and evaluation, and effective communication.
4. Foster collaboration, promote networking, and disseminate tools between nursing and midwifery leaders within each country and across the region.
5. Provide a forum for nursing and midwifery leaders to engage meaningfully with technical advisors in health policy and clinical practice to improve the performance of HIV service delivery.

Tuesday 21 March

0830–0900 **Greetings from ARC Partners**
Moderator: Kenneth Hepburn, Principal Investigator ARC, Emory University
- Agnes Waudo, Director, ARC Secretariat
- Jill Iliffe, Executive Secretary, Commonwealth Nurses and Midwives Federation
- Dr Edward Kataika, Director of Programs, ECSA-HC
- Jessica Gross, Senior Nursing Advisor, CDC Atlanta

9000-0915 **Opening Remarks**
Moderator: Mary Murebwyire, Chairperson, Rwanda Nurses and Midwives Council
- Dr Sabin Nsanzimana, Head of HIV, AIDS, STI and Blood Borne Infection Division, Rwanda Biomedical Centre

0915-0930 **Introduction of Observers, Special Guests, and Technical Advisors**
Moderator: Muadi Mukenge, ARC Project Director, Emory University

0930-0945 **ARC Faculty and Participant Introductions**
Moderator: Alphonce Kalula, Senior Program Officer, ECSACON

0945-1015 **Refreshment break**

1015-1100 **ARC and LARC – Programmatic Updates**
- Kenneth Hepburn, ARC and LARC Principal Investigator, Emory University

1100-1215 **Regional policy brief: Nursing and HIV in sub-Saharan Africa**
Moderator: Andrè Verani, Public Health Lawyer, CDC Atlanta
- Kenya Task Sharing Policy: Agnes Waudo, Director, ARC Secretariat, Nairobi
- HIV Mentorship Training in Rwanda: Dr Mpundu Ribakare, Rwanda Biomedical Centre

1215-1300 **Monitoring and evaluation overview**
Moderator: Kenneth Hepburn, ARC and LARC Principal Investigator, Emory University
Kethi Mullei, Public Health Research Consultant

1300-1320 **Group Photograph**
Moderator: Jill Iliffe, Commonwealth Nurses and Midwives Federation

1320-1420 **LUNCH**

1420-1550 **Project Updates**
Panel 1: Respectful care
Moderator: Agnes Waudo, ARC Secretariat
Discussant: Kenneth Hepburn, Emory University
- Mozambique
- Ethiopia

Panel 2: Improving retention
Moderator: Cynthia Chasokela, CNO Zimbabwe
Discussant: Andrè Verani, CDC Atlanta
- Swaziland
- Malawi
- Zambia

1550-1620 **REFRESHMENT BREAK**

1620-1750 **Pillar meetings (CNOs, Registrars, Educators, NNAs)**
Moderator: Andrè Gitembagara, President, Rwanda Nurses and Midwives Union

1750-1800 **Evaluation**
Moderator: Nancy Ruto, ARC Secretariat

Wednesday 22 March

0830-1030 **Project Updates**
Panel 3: Clinical mentorship
Moderator: Bheki Mamba, President, Swaziland Nursing Association
Discussant: Jessica Gross, CDC Atlanta
- Lesotho
- Uganda
- Rwanda

Panel 4: Quality assurance and task sharing
Moderator: Muadi Mukenge, Emory University
Discussant: Kethi Mullei, Public Health Research Consultant
- Kenya
- Zimbabwe
- Tanzania

1030-1100 **REFRESHMENT BREAK**

1100-1200 **Highlights and analysis from country updates**
Moderator: Alphonce Kalula, ECSACON
Presenters: Kenneth Hepburn, Andrè Verani, Jessica Gross, Kethi Mullei

1200-1300 **Panel: Dimensions of HIV for adolescent girls and young women**
Moderator: Muadi Mukenge, Emory University
- Forum of Positive Women: Ms Philomène Cyulinyana
- DREAMS Initiative: Dr Mary Mwangi, CDC Kenya

1300-1330 **Evaluation**
Moderator: Nancy Ruto, ARC Secretariat

1330-1430 **LUNCH**

1430-1800 **SITE VISITS:** National Council of Nurses and Midwives; University of Rwanda School of Nursing and Midwifery; Rwanda Nurses and Midwives Union
Kigali Genocide Centre

Thursday 23 March

0830-1030 **Workshop: Data measurement and project indicators**
Facilitator: Kethi Mullei, Public Health Research Consultant
Country pairings and exercise

1030-1100 **REFRESHMENT BREAK**

1100-1130 **Country workgroups: Revising and refining monitoring and evaluation plans**
Moderator: Jessica Gross, CDC Atlanta

1130-1300 **Facility Assessment Guidelines and Training**
Moderator: Kenneth Hepburn, Emory University
- Sydney Spangler, Emory University

1300-1400 **LUNCH**

1400-1500 **Rapid report-back on revised monitoring and evaluation plans**
Moderator: Makholu Lebaka, CNO Lesotho

1500-1530 **Closing remarks and presentation of certificates**
Moderator: Kenneth Hepburn, Emory University
- Jill Iliffe, Commonwealth Nurses and Midwives Federation

1530-1600 **Evaluation**
Moderator: Nancy Ruto, ARC Secretariat

African HEALTH PROFESSIONS Regional Collaborative

PARTICIPANTS

Country	Delegate	Position
Ethiopia	Ms Gezashign Denekew KASSA	Nursing Service Coordinator, Ministry of Health
Ethiopia	Mr Berhane Gebrekidan GEBREEGZIABHER	Senior Academician, Addis Ababa University Department of Nursing and Midwifery
Ethiopia	Mr Tafesse Bekele WORKU	President, Ethiopian Nurses Association
Ethiopia	Mr Yezabnesh ADDISU	President, Ethiopian Midwives Association
Kenya	Ms Winnie SHENA	Chairperson, National Nurses Association of Kenya
Kenya	Ms Rose KURIA	Director Nursing Services, Kenya Ministry of Health
Kenya	Ms Edna TALLAM	Registrar, Nursing Council of Kenya
Kenya	Ms Rosemary MUGAMBI	Lecturer, Jomo Kenyatta University of Agriculture and Technology
Kenya	Mr Alfred OBENGO	Chairperson, National Nursing Association of Kenya
Lesotho	Ms Titi Nelly NTHABANE	Representative, Nursing and Midwifery Education Institutions
Lesotho	Mrs Nthabiseng Makholu LEBAKA	Director of Nursing Services, Ministry of Health
Lesotho	Mrs Flavia 'Mamohapi MOETSANA-POKA	Registrar Lesotho Nursing Council
Lesotho	Ms Semakaleng PHAFOLI	President, Lesotho Nurses Association
Malawi	Ms Lucy Guluka GAWA	Representative, Nursing and Midwifery Education Institutions
Malawi	Mr Raymond KANTHITI	Mitundu Community Hospital
Malawi	Mrs Thokozire Tendai LIPATO	Acting Registrar, Nurses and Midwives Council of Malawi
Malawi	Ms Lucy MKUTUMULA	Deputy Director, Nursing Services, Ministry of Health
Mozambique	Dr Olga NOVELA	Chief Nursing Officer
Mozambique	Mr Caetano Anastacio AMELA	Deputy Chief of Nursing
Mozambique	Mrs Norgia MACHAVA	Representative of the Superior Institute of Health Sciences
Mozambique	Ms Maria Olga MATAVEL	President, ANEMO
Rwanda	Ms Mary MUREBWAYIRE	Chief Nursing Officer, Ministry of Health

Rwanda	Mr André GITEMBAGARA	President, Rwanda Nurses and Midwives Association
Rwanda	Ms Julie KIMONYO	Registrar, National Council of Nurses and Midwives
Rwanda	Ms Madeline MUKESHIMANA	Lecturer, School of Nursing and Midwifery
Swaziland	Mrs Gladys Thembisile KHUMALO	Chief Nursing Officer, Ministry of Health
Swaziland	Ms Glory MSIBI	Registrar, Swaziland Nursing Council
Swaziland	Mr Bheki MAMBA	President, Swaziland Nursing Association
Swaziland	Dr Nkosazana Ruth MKHONTA	Lecturer, University of Swaziland
Tanzania	Mrs Lena Mkamiti MFALILA	Registrar Tanzania Nurses and Midwives Council
Tanzania	Mr Samwel Ligmas KOYO	Senior Nurse, Ministry of Health and Social Welfare
Tanzania	Mr Paul Magesa MASHAURI	President, Tanzania National Nurses Association
Tanzania	Mr Ndementria VERMAND	Assistant Director, Nurse Training
Uganda	Ms Catherine Betty ODEKE	Acting Commissioner Health Services – Nursing
Uganda	Ms Janet OBUNI	President, Uganda Nurses and Midwives Union
Uganda	Ms Margaret NYAKUNI	Deputy Executive Secretary, Uganda Nurses and Midwives Examination Board
Uganda	Ms Beatric AMUGE	Assistant Commissioner Health Services – Nursing
Zambia	Ms Emily CHIPAYA	Deputy Director of Nursing, Zambia Ministry of Health
Zambia	Ms Beatrice ZULU	Acting Registrar, General Nursing Council of Zambia
Zambia	Ms Crecious Mutinta MULEYA	Representative of Nursing and Midwifery Education
Zambia	Ms Jennifer MUNSAKA	Representative, Zambia Union of Nurses Organisations
Zambia	Ms Judith CHIPILI	Standard and Compliance Specialist, General Nursing Council of Zambia
Zimbabwe	Ms Mercy CHAKA	Registrar, Nurses' Council of Zimbabwe
Zimbabwe	Ms Abigirl CHIBGHWA	Education representative
Zimbabwe	Mr Simangaliso MAFA	President NNA
Zimbabwe	Dr Cynthia Mery-Le-Bone Zandile CHASOKELA	Director Nursing Services, Ministry of Health and Social Welfare
ARC Faculty	Professor Kenneth HEPBURN	Principal Investigator, ARC and LARC, Emory University
ARC Faculty	Dr Muadi MUKENGE	ARC Project Director, Emory University
ARC Faculty	Ms Jessica GROSS	Senior Nursing Advisor, CDC Atlanta
ARC Faculty	Dr Sydney SPANGLER	Co-Principal Investigator ARC, Emory University

ARC Faculty	Ms Jill ILIFFE	Executive Secretary, Commonwealth Nurses and Midwives Federation
ARC Faculty	Mr Andrè VERANI	Public Health Lawyer, CDC Atlanta
ARC Faculty	Mr Alphonce KALULA	Senior Program Advisory, ECSACON
ARC Faculty	Ms Agnes WAUDO	Country Director, Kenya Health Workforce Project
ARC Faculty	Ms Nancy RUTO	ARC Program Coordinator, Kenya Secretariat
ARC Faculty	Mr Nixon MASINDE	ARC Project Technical Assistant, Kenya Secretariat
Guest	Dr Edward KATAIKA	Deputy Director Programs ECSA-HC
Guest	Ms Kethi MULLEI	Public Health Research Consultant
Guest	Dr Mary MWANGI	CDC, Kenya
Guest	Dr Byiringiro RUSISIRO	Rwanda Biomedical Centre
Guest	Ms Philomène CYULINYANA	President, Forum of Positive Women Rwanda
Guest	Ms Mary BULIKENGERI	Director, Rwanda Women's Network
Guest	Ms Ida KINKINDI	Public Health Specialist, CDC Rwanda
Guest	Ms Patricia MORELAND	Human Resources for Health Program, Rwanda

2017 END-LINE FACILITY ASSESSMENT WORKSHEET

1. Assessment Sites and Contacts – Please provide the name and location of the health facility or facilities you will assess. Only include those that were part of your ARC quality improvement project.

Facility name and location	Contact person at facility			
	Name	**Position**	**Email**	**Phone #**

2. Assessment Team – Please indicate any personnel who will be involved. Who will be the Team Lead for the project? What other members of the Quad team will be involved, and in what roles (e.g., site liaison, data analysis, etc.)? What other support staff or consultants will be involved, and in what roles (e.g., project consultant or personnel who will carry out data collection, data management, and data analysis)?

Team Lead:	
Organization receiving funds:	
Name of person at receiving organization to sign contract:	
Quad members involved and respective roles:	a) b) c) d)
Other personnel and respective roles:	a) b) c)

3. Schedule – Please respect the dates for project conduct and completion, including the following project tasks:

Project task	Date of completion
Sign ARC grant contracts	June 5-8, 2017
Grants received	June 12-16
Review FA modules	June 26-28, 2017
Hiring of consultant (if applicable):	June 26, 2017
Training of data collection personnel:	June 29-30, 2017
Completion of data collection:	July 17-Aug. 4, 2017
Completion of data entry:	August 7-18, 2017
Submit financial report to Emory	August 30, 2017
Submission of data forms to Emory	**Sept. 1, 2017**

***You do not have to submit an analyzed data report as you did in 2016.**

4. Budget – Please estimate the types and amount of anticipated expenditures.

Category	Total
Quad Personnel	
Consultant	
Data Entry Support	
Meetings	
Transportation	
Printing/office supplies	
Participant compensation	
Bank Fees	You must include an amount here
Other	
Total	$5,000 maximum

5. Support – Emory is committed to supporting quads by facilitating a faculty site visit to provide on-site support during the facility assessments in mid-June and mid-August. Faculty visits will correspond with the administration of your facility assessments and faculty can support the data collection, management, and submission process.

This form is due to Emory May 1, 2017.

Please submit to Muadi Mukenge (Muadi.mukenge@emory.edu).