East, Central and Southern Africa College of Nursing (ECSACON)

The 11th Scientific Conference and 5th Quadrennial General meeting of ECSACON

Held Under the Theme

Increasing access to quality nursing and midwifery care: Nurses and Midwives taking the leading role

1st to 5th September, 2014, Rainbow Towers Hotel, Harare, Zimbabwe

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Executive Summary

The **11th** Scientific Conference and 5th Quadrennial Meeting were held at the Rainbow Towers Hotel in Harare, Zimbabwe from 1-5 September, 2014 under the Theme:

Increasing access to quality nursing and midwifery care: Nurses and Midwives taking the leading role.

Sub-themes addressed were:

Improving Maternal, Newborn and Child Health.
Health System's Strengthening
Innovations and excellence in Nursing and Midwifery
Evidence based Primary Health Care Practices and Approaches.

The Conference was attended by **447** delegates from 13 ECSA member states, and partner organizations including the International Council of Nurses (ICN), International Confederation of Midwives (ICM), the World Health organization (WHO), Jhpiego, USAID and others.

The purpose of the Conference was: To explore and share research findings, best practices, (high impact interventions) including experiences on how nursing and midwifery will accelerate achievement of MDG's.

The specific objectives were:

- To share ideas and learn how nursing and midwifery fraternity can facilitate acceleration towards achievement of MDG's.
- To share experiences on strengthening human resources for health for effective health services' delivery through nurses and midwives that forms a pool of frontline workers.
- To disseminate best practices and innovative ideas and increase access to health care delivery.
- To learn about evidence based practices in reproductive health and maternal and child health services' provision through sustainable partnerships.
- To share evidence towards mitigating the impact of alarming communicable and non communicable diseases as well as risky life style behaviours.
- To make recommendations on the way forward in transforming nursing and midwifery to adopt innovative strategies.

Before the commencement of the Scientific Conference the pre-conference meetings, seminars and workshops held including the 25th CNR meeting, Satellite meeting for task force on ECSACON online Continuing Professional Development (CPD) Library; Introducing Antenatal Corticosteroids (ACS) for women in preterm labour and State of the World's Midwifery Report- and using the Report to build a strong National Midwifery workforce.

The Scientific Conference was officially opened by the Guest of Honour, Professor Hope Sadza, Vice Chancellor, Women's University in Africa. **The ECSACON President, Mrs Maleshoane Monethi-Seeiso** welcomed and thanked the Guest of Honour, for gracing the occasion, other special invited guests and all the delegates. She also thanked the ECSACON Vice President for successfully organizing for the holding of the Quadrennial Conference, the

Government of Zimbabwe for the hospitality accorded to the regional and international delegates and the Partners for their continuing support of nursing and midwifery programs and projects in all ECSA countries.

The special invited guests were introduced and they included the Director General of ECSA Health Community, Prof. Yoswa Dambisya, ICM President, Frances Day-Stirk, ICN President, Judith Shamian, President and CEO JHPIEGO, Leslie Mancuso, ECSA College of Health Sciences Senate Representative, Mr Christopher Samkange, WHO Representative from Geneve and Dr Xaba, Vice Chair of the Health Service Board. The presence of other dignitaries that included members of the Diplomatic corps and members of parliament was also acknowledged.

In her address, Professor Sadza commended the delegates on their grand entrance in the Conference hall that was touching and exciting. She noted that ECSACON is a very important body because the health systems are nurse driven in all member states of the ECSA Region It there fore goes without saying that without nurses and midwives the health care system will not function. She encouraged nurses and midwives to do more within the four Faculties of the College and gave some examples of the activities that the Faculties could undertake. She also encouraged nurses and midwives to write textbooks as these are likely to be more relevant to our settings than those written in other countries.

She concluded by encouraging nurses and midwives to stay and develop the nursing and midwifery professions in the ECSA region and thanked the Zimbabwean ECSACON Chapter under the guidance of the Vice President of ECSACON and the Executive committee for successfully organizing this important event. She declared the 11th Scientific Conference officially opened.

Launch of ECSACON Website: Immediately after her address, Professor Hope Sadza, launched the ECSACON website.

The Keynote address on the Conference theme was delivered by Dr Leslie Mancuso, JHPIEGO CEO. Dr Mancuso presented a summary of frightening statistics of disease burden affecting women and children such as, "a woman dies every two minutes due to pregnancy related causes"; 270,000 women die from cervical cancer each year; 3000 women and 1000 children are newly infected with HIV every day. The mission of JHPIEGO is to prevent needless death of women.

Encouraging nurses and midwives to be change agents, she gave an example of four women who have impacted the world positively and improved the health of societies especially women and children. The four women are Hillary Clinton, the former US Secretary of State, Dr Christine Sata, the First Lady of Zambia, Melinda Gates, founder of Bill and Melinda Gates Foundation and Florence Nightingale who needs no introduction among nurses and midwives.

Using Mahatma Gandhi slogan of "Be the change that you want to see in the world" she encouraged nurses and midwives to be confident in who they are and what they are worth.

The Conference presentations and the deliberations that followed explored the main theme and sub-themes through a variety of methods including seven plenary presentations, nine parallel sessions, workshops, poster exhibitions, discussions, short skills building sessions and evening interest group meetings. Throughout the deliberations and discussions delegates made recommendations which are outlined as follows:

Recommendations of the 11th Scientific Conference and 5th Quadrennial General Meeting of ECSACON (1st -5th, September 2014)

Preamble

The 11th Scientific Conference and 5th Quadrennial General Meeting of the East, Central and Southern Africa College of Nursing (ECSACON) were held at the Rainbow Towers Hotel, in Harare, Zimbabwe from 1st to 5th September, 2014, under the theme: "***Increasing access to quality nursing and midwifery care: Nurses and Midwives Taking the Leading Role."*** The four subthemes were: **"***Improving Maternal, New born and Child Health", "Health Systems Strengthening", "Innovations and Excellence in Nursing and Midwifery" and "Evidence Based Primary Health Care Practices /Approaches"*. The deliberations and discussions were shared through plenary presentations, parallel sessions and discussions.

The Conference delegates concurred that nurses and midwives constitute 60% to 80% of health human resources in almost all the ECSA countries and that they are the main professional health care providers found at all levels the national health care delivery systems. This unique position is how nurses and midwives derive their strength and define their key role in improving access to quality health care provision to the majority of the population.

The major gaps towards providing effective health coverage were highlighted by the alarming statistics such as that:

- Maternal mortality rate is as high as 1500 maternal deaths per 100 000 deliveries in some of ECSA countries;
- 85% of ECSA countries have a double digit neonatal mortality rate and only 14% have a single digit neonatal mortality rate;
- 60% of those who have HIV/AIDS are women
- One woman dies of cancer every minute
- Highest unmet family planning need is in the first 12 months post partum

The determination and conviction of the nurses and midwives that they have the capacity to provide quality care was demonstrated through the high standard of presentations covering strategies, proposals, innovations and approaches to address the gaps within the health services. Innovations being undertaken by nurses and midwives are those that bring solutions to where people are rather than bringing people to solutions. They included such areas as:

- Increasing access to quality maternal, newborn and child health services through enhanced public private partnerships;
- The introduction of E-health in the delivery of quality, safe and efficient health care services;
- The use of mobile cell phones technology to support FANC;
- Regional and international institutional collaborations and partnerships in Nursing education;
- Model wards as a means to improve clinical teaching;
- Family Planning and life skills among young people; FP needs during the Post partum period, FP and Partner involvement; FP and increasing awareness, knowledge and choice.

Nurses and Midwives from the ECSA Region have demonstrated that they are ready to be the "change that they want to see" in their countries and region.

In order to support the many initiatives and commitments that nurses and midwives are undertaking and were reported on during the deliberations of this conference, we make the following recommendations to the Ministers of Health in their capacities as representatives of our governments, the ECSACON Executive Committee and Council of National Representatives (CNR), ECSACON Chapters, Nursing Councils, National Nursing and Midwifery Associations, ECSACON Faculties, the ECSACON Secretariat and our Partners:

1. We recommend that the Ministers of Health:

1. Follow up and ensure that the countries are implementing the Standard practice package for expanding access to FP/MNCH services at the community level which the Health Ministers launched during their conference in February, 2014.

2. Support implementation of WHO recommended nurse patient staffing ratios by ensuring that the required posts are established in order to enable nurses and midwives to provide safe high quality care, reduce burn out and sustain motivation.

3. Continue to review the conditions of service for nurses and midwives in the region, taking cognizance of the nurse' and midwives' workload, the new emerging diseases, migration of nurses and midwives to the Diaspora and the additional responsibilities that have been added to the scopes of nursing and midwifery practices. All these have created increased demand for Nursing and midwifery services and call for improved conditions of service.

4. Continue to support implementation of WHA 63.16 of May 2010- WHO Global Code of practice on of Health Personnel which holds governments accountable to improve the conditions of service International Recruitment and to institute retention packages.

2. We recommend that the ECSACON Executive Committee and CNRs:

1. Undertake a survey to assess how member states have utilized ECSACON's major publications -Nursing and Midwifery Regulatory Framework (2001) and Handbook on **Developing** a Nursing and Midwifery Professional Regulatory Framework (2002). The focus of these publications is "defining Nursing and Midwifery competencies", "Developing Nursing and Midwifery standards of practice" and "developing scopes of practice for nursing and midwifery professions". If these documents have been effectively used by countries, they are now due for updating.

2. Set up a committee to work on the development and introduction of ECSACON Degree programmes for nurses and midwives and specify target dates for the completion of various stages of programme development. Degrees are to be offered in Nursing and Midwifery clinical specialty areas and related areas such as Health Human Resource Planning Development and Management.

3. Work in collaboration with the Ministries of Health, Regulatory Councils and ECSACON Secretariat to develop guidelines for establishing a database of nursing and midwifery expertise in the Region.

4. President's Report to include a summary of progress on the implementation of recommendations made during the last Biennial and Quadrennial conference and meetings.

5. At future Biennial and Quadrennial Conferences, Poster Presentations should be allocated time alongside Parallel Sessions to ensure that they are well attended and fully articulated by the presenters.

6. Promote partnerships between countries to share and promote best practices in order to improve the quality of nursing and midwifery education and service in ECSA region.

We recommend that National ECSACON Chapters & National Nurses and Midwives Associations:

1. Through the leadership of the CNR member continue recruitment of nurses and midwives to become active ECSACON members.
2. Strengthen Chapter fundraising activities in order to be able to conduct and sustain in-country and regional ECSACON activities.
3. Strengthen the link and working relationship between ECSACON Country Chapter and the National Nurses' Association since the aims and goals of both organizations are complementary
4. Maintain an inventory of paid up country ECSACON members and send the updated list to the Secretariat in March of each year.
5. Submit Activity reports to the Secretariat 3 months before the Biennial and Quadrennial meetings.

4. We recommend that the Regulatory Councils:

1. Work with the Secretariat to print ECSACON's Code of Ethics into a small booklet that nurses

and midwives are able to carry around.

2. Work with the National Nurses Association to print the country's Nurses' and Midwives' Code of Ethics into a small booklet that nurses and midwives are able to carry around.

3. Device a system through which on initial registration every nurse or midwife would receive a copy of the country's Nurses and Midwives code of ethics.

4. Work with colleges of nursing and midwifery and other experts from clinical practice to develop CPD modules for nurses and midwives. Modules to be used for session presentations that are decentralized to all parts of the country to improve access to CPD especially for those working in rural health facilities and the private sector.

5. Work with Clinical Practice Faculty and Faculty of Education to develop policy guidelines on the expanded role of nurses and midwives in areas such as male medical circumcision and nurse led initiation and management of ART and outline the processes of integrating these activities in nursing and midwifery scopes of practice.

6. Develop and maintain a comprehensive data base of all active nurses and midwives registered by the country Regulatory Body including all their qualifications and current employment/ practice status.

5. To the Faculty of Clinical Practice:

1. Identify strategies for strengthening nursing and midwifery in key areas that include essential newborn care, nutrition and child mortality, postpartum family planning and improving access to modern family FP services.
2. Promote safe working environments for nurses and midwives and ensure adherence to Universal precautions guidelines and staffing ratios based on WHO guidelines.
3. Design and document models of care for the Region and the strategy for implementing evidence based practice.
4. Develop jointly with the faculty of Education E-learning programmes that are linked to nursing and midwifery clinical practice.
5. Follow up on promising clinical practice innovations presented at the Quadrennial Conference and determine the potential for replication in other ECSA countries. Examples include "Use of mobile phones to support FANC", "Establishment of model wards", and "E-health in the delivery of safe, efficient quality care".
6. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

6. To the Faculty of Education:

1. Strengthen the nursing curriculum so that it addresses the issues of self image and perception building in order to prepare nurses and midwives who are confident, able and proud to maintain their nursing identity.

2. Promote self directed and life long learning among nurses and midwives through the development of learning modules on subject areas relevant for both pre-service and CPD programmes.
3. Strengthen communication and collaboration among educational institutions in the ECSA Region on issues of innovations in nursing and midwifery education.
4. Explore how the recently introduced Masters Degree in Midwifery in several ECSA member states can be conducted electronically so that it is accessible to more midwives in the Region.
5. Work together with the Faculty of Clinical Practice and the Regulatory Body to develop teaching materials covering areas of the expanded nursing and midwifery scopes of practice such as medical male circumcision and nurse led initiation and management of ART to be included in the pre-service nursing and midwifery curriculum.
6. Strengthen the teaching of Mental Health in the nursing and midwifery curricula as it has an impact on nurses' and midwives' attitudes.
7. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

7. To the Faculty of Leadership and Management:

1. Develop, support and promote approaches towards continuous quality improvement in nursing and midwifery practice.
2. Develop modules to strengthen the knowledge and skills of nurses and midwives in monitoring and evaluation based on set goals and targets.
3. Develop benchmarks for raising the standard of care based on identified centers of excellence in the Region.
4. Facilitate development of skills and tools for strengthening advocacy capability among nurses and midwives.
5. In collaboration with the Faculty of Clinical Practice, develop career paths that recognize and reward further education, training and experience for nurses in clinical practice.
6. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

8. To the Faculty of Research:

1. Continue efforts to build and strengthen research capacity including skills in the writing of scientific papers for publication by nurses and midwives at country and regional levels through mentoring and peer review support.
2. Identify and share research study findings and best practices from the region that may be replicated in other ECSA member states.
3. Develop research proposals and identify potential Partners for funding research activities within the region.
4. Set targets for research study publications in refereed journals to be achieved by ECSACON members over specified periods and develop a system to monitor progress.

5. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

9. To the ECSACON Secretariat:

1. Ensure that ECSACON website is kept up to date with information and details of recent and upcoming ECSACON events and activities including global trends.
2. Work with ECSACON Chapters to compile a list of all Nursing and Midwifery programmes available in each of the ECSA countries including admission requirements, period of study, application procedures and fees payable and have this information on the ECSACON website.
3. Work with the ECSA Secretariat to ensure that these recommendations are considered at policy forums such as the DJCC and Health Ministers' Conference.
4. Coordinate resource mobilization and support from Partner organizations towards the implementation of the recommendations made at the Quadrennial Conference.
5. Coordinate the implementation of these recommendations through the various faculties and the CNR.
6. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Secretariat.

10. ECSACON Partners and Supporters:

1. Continue to support the development of ECSACON programmes and the implementation of the above recommendations.
2. Keep ECSACON among your network of organizations to work with in the ECSA region.
3. Work with ECSA countries, the Secretariat and ECSACON to identify priority areas for collaboration.

1. Introduction

The 11th Scientific Conference and 5th Quadrennial Meeting were held at the Rainbow Towers Hotel in Harare, Zimbabwe from 1-5 September, 2014 under the Theme: *Increasing access to quality nursing and midwifery care: Nurses and Midwives taking the leading role.*

Before the commencement of the Scientific Conference the pre-conference meetings, seminars and workshops held were:

The Satellite meeting for task force on ECSACON online Continuing Professional Development (CPD) Library, (August 30th am), 25th CNR meeting (August 30th pm), Introducing Antenatal Corticosteroids (ACS) for women in preterm labour; Landscape analysis of other tools available to support nursing and midwifery Associations (ECEB, MACAT, Global competencies and standards); Practical application of the Family Planning Training Resource Package (August 31st am); and State of the World's Midwifery Report-Using the Report to build a National Midwifery workforce. August 31st pm)

The Scientific Conference was attended by 447 delegates from 13 ECSA member states, and partner organizations including the International Council of Nurses (ICN), International Confederation of Midwives (ICM), the World Health organization (WHO), Jhpiego, USAID, European Union (EU) and others. Tanzania had the largest delegation of 58 participants surpassed only by the host country.

The deliberations were conducted through a variety of methods including plenary presentations, parallel sessions, workshops, exhibitions, discussions, poster sessions, short skills building sessions and evening interest group meetings.

The opening conference session was chaired by Mrs Maleshoane Monethi Seeiso, ECSACON President and the Rapporteurs were Catherine Ngoma from Zambia and Gustav Moyo from Tanzania.

Mrs Maleshoane Monethi Seeiso ECSACON- President called the meeting to order at 9.30 am. A Roll call of countries present was conducted by Mrs Khumbulani Mbuya, the Zimbabwe CNR member. Countries present were Angola, Botswana, Democratic Republic of the Congo, Kenya, Lesotho, Malawi, Mauritius, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

Mrs Mbuya welcomed all the delegates including all the special invited guests and Partners, and encouraged them to enjoy their stay in Zimbabwe, participate actively in the conference deliberations and plan to take a few days after the conference to visit Zimbabwe tourist sites such as the Victoria Falls.

Sheilah Matinhure, Manager HRH&CB, ECSA Health Community, outlined the Conference Objectives, themes and expected outputs including the methods of conducting the conference.

The main objectives of the Conference were:
To explore and share research findings, best practices, (high impact interventions) as well as experiences on how nursing and midwifery will accelerate achievement of MDG's.
The specific objectives were:

1. To share ideas and learn how nursing and midwifery fraternity can facilitate acceleration towards achievement of MDG's.
2. To share experiences on strengthening human resources for health for effective health services delivery through nurses and midwives that form a pool of frontline workers.
3. To disseminate best practices and innovative ideas and increase access to health care delivery.
4. To learn about evidence based practices in reproductive health and maternal and child health services' provision through sustainable partnerships.
5. To share evidence towards mitigating the impact of alarming communicable and non communicable diseases as well as risky life style behaviours.
6. To make recommendations on the way forward in transforming nursing and midwifery to adopt innovative strategies.

The Sub- themes of the Scientific Conference were:

Improving Maternal, Newborn and Child Health.
Health System's Strengthening
Innovations and excellence in Nursing and Midwifery
Evidence based Primary Health Care Practices and Approaches.

Mr Alphonce Kalula, ECSACON Senior Programme Officer greeted and welcomed the delegates and expressed appreciation for the high motivation of health workers in general and nurses and midwives in particular as their work frequently expose them to risk of infection, the example being that of the Nurse who was the first health care provider to die from Ebola. The conference delegates were requested to stand for a minute of silence to remember this nurse and other health professionals who were infected by deadly diseases in the line of duty.

Other administrative issues included safety precautions such as encouraging delegates to avoid moving around alone at night or in secluded places.

2. The Official Opening Ceremony: Venue: Rainbow Towers Hotel, Harare

Director of Ceremonies: Dr Mukonoweshuro.

The official opening ceremony commenced at 10.30am with country delegates presenting themselves country by country in ECSACON attire.
The Director of Ceremonies welcomed the delegates and gave a brief background of the foundations of professional nursing including pioneers of the profession. Florence Nightingale is the most known and the lamp that she carried at night when she visited the sick soldiers has remained as a symbol and a source of inspiration for the nursing profession. Hence the lamp lighting ceremony continues to be a symbol of love, hope and dedication that shines even during the most difficult times of nursing duties.

The lighting of the Florence Nightingale lamp was carried out by two Senior Nurses. Singing of the National Anthem was led by student nurses from Parirenyatwa Central Hospital School of Nursing.

Words of encouragement and prayer were given by Dr R. F. Wutaunashe. Parirenyatwa School of Nursing student nurses' choir welcomed the delegates in song.

The special invited guests were introduced and they included the Director General of ECSA Health Community, Prof. Yoswa Dambisya, ICM President, Frances Day-Stirk, ICN President, Judith Shamian, President and CEO, JHPIEGO Leslie Mancuso, ECSA College of Health Sciences Senate Representative, Mr Christopher Samkange, WHO Representative from Geneva and Dr Xaba, Vice Chair of the Health Service Board. The presence of other dignitaries that included members of the Diplomatic corps and members of parliament was also acknowledged

The ECSACON President, Mrs Maleshoane Monethi-Seeiso welcomed the delegates, thanked them for having come in large numbers and expressed the hope that they would participate actively and benefit greatly from exchange of experiences and other conference deliberations. She thanked the Guest of Honour for gracing the occasion, the ECSACON Vice President who is also the Zimbabwe Director of Nursing Services for successfully organizing for the holding of the Quadrennial Conference and the Government of Zimbabwe for the hospitality accorded to the Regional and international delegates. She also thanked the Partners for their continuing support of nursing and midwifery programs and projects in all ECSA countries.

The ECSACON President highlighted that ECSACON derives its strength through its unique attributes of linking National Nursing Councils, National Nurses' Associations and Ministries of Health together. Additionally, nurses and midwives are found at all levels of the health care delivery system and this is one of the attributes that gives them strength.

In his remarks Mr C. Samkange representing College of Health Sciences and wearing the three hats in which he represents the Chairman, the Senate and the Health Board explained that the College of Health Sciences was an umbrella body uniting ECSACON, College of Surgeons, College of Pathologists, and College of Anaethetics. He highlighted that the future of the Region lies in its human resources and that the uniting feature in the colleges is "creating well disciplined professionals who will ensure best quality outcomes for patients". He acknowledged the contributions of ECSACON President towards the establishment of the ECSA College. ECSACON was encouraged to look beyond the current achievements and review the model that is being used by the College of Health Sciences to develop centers of excellence. The three questions that health professional organizations should be constantly reviewing are: What are we doing? What do we need to do? And can we do it better? He thanked the Partners for their support.

Remarks by ECSA-HC Director General Prof. Yoswa Dambisya

He thanked the Guest of Honour and the Keynote Speaker for accepting the invitations to address the Conference. He noted that the Theme of the Conference highlights the roles and responsibilities of nurses and midwives and the sub-themes show how the deliberations will focus on midwifery and nursing care.

He informed the delegates that ECSA was celebrating 40 years of existence. ECSACON, born in 1990, is the first born to the existing ECSA Colleges. He commented on the challenges faced by health care systems throughout the world for example, the current Ebola outbreak, hence the need for robust nursing and midwifery services all the time. He noted that the challenge in achieving the MDG's lies in having adequate health personnel and thanked ECSACON for efforts made by nurses and midwives of providing health care services in ECSA countries. "It is true that nurses are chosen by God, giving the example; "if you save one life you are a hero but if you save thousands of lives you are a nurse, so please continue being nurses- we do not need heroes".

He concluded by thanking the Partners for their support, ECSACON and the delegates for holding a successful conference and the Ministry of Health and Child Care and the local Organizing committee.

Guest of Honour: Professor Hope Sadza, Vice Chancellor, Women University in Africa

The Guest of Honour, Professor Hope Sadza, Vice Chancellor, Women's University in Africa commended the delegates on the grand entrance in the Conference hall that was touching and exciting. She welcomed the regional and international delegates to Zimbabwe and expressed the hope that they will have a pleasant stay and take home fond memories and knowledge about Harare.

She noted that ECSACON is a very important body as in all member states in the Region the health systems are nurse driven. It there fore goes without saying that without nurses and midwives the health care system will not function. It is very encouraging to note that the primary goal of ECSACON is to improve the quality of health of the communities especially at such a time when member states are experiencing a heavy disease burden and high maternal, newborn and child mortalities.

She encouraged nurses and midwives to do more within the four faculties and gave some examples of the activities that the Faculties could undertake. The Faculty of Education could lead in harmonizing the education and training of nurses and midwives in the Region, the Research Faculty could focus on research findings that add value to the health systems while the Leadership and Management Faculty could focus on strengthening networking among member states. She expressed the hope that through presentations and discussions the gathering will share best practices and that out of these discussions will come recommendations that will influence country policies and strategies to improve health care delivery services.

Dr Sadza also encouraged nurses and midwives to write textbooks as these are likely to be more relevant to our settings than those written in other countries. She noted that nursing and midwifery professions have been affected negatively by disease burden and brain drain. She concluded by encouraging nurses and midwives to stay and develop the nursing and midwifery professions in the ECSA region and thanked the Zimbabwean ECSACON Chapter under the guidance of the Vice President of ECSACON and the ECSACON Executive for organizing this important event. Gratitude was also extended to the various sponsors for this conference and all the delegates.

She declared the 11th Scientific Conference officially opened.

Launch of ECSACON Website: The ECSACON website is supported by Africa Health Professions Regulatory Collaborative (ARC) was launched by the Guest of Honour, Professor Hope Sadza, Vice Chancellor of Women University in Africa. The website is www.ecsacon.org.
A Vote of thanks was given by Ms C. Chasokela, Director of Nursing Services and Vice President, ECSACON, followed by removal of the Lamp by the same two senior nurses.
Meeting adjourned for lunch.

3. Plenary Sessions

3.1 Plenary Session 1. Increasing Access to Quality Nursing and Midwifery Care: Nurses And Midwives Taking the Leading Role

Keynote address: by Dr Leslie Mancuso, JHPIEGO CEO.

JHPIEGO is an international NGO affiliated to John Hopkins University in Maryland, USA. In the last 40 years JHPIEGO has worked in 150 countries including most of ECSA countries. Dr Mancuso presented a summary of frightening statistics of disease burden affecting women and children such as "a woman dies every two minutes due to pregnancy related causes"; 270,000 women die from cervical cancer each year; 3000 women and 1000 children are newly infected with HIV every day. The mission of JHPIEGO is to prevent needless death of women. Their focus area MCH, malaria prevention, HIV/AIDS, prevention of Cancer of the cervix, infection prevention, FP, and health innovations. They use a multifaceted approach to strengthen health systems, support integration of services and human resource development to promote sustainability of services.
Encouraging nurses and midwives to be change agents, she gave an example of four women who have impacted the world positively and improved the health of societies especially women and children. The four women are Hillary Clinton, the former US Secretary of State. Dr Christine Sata, the First Lady of Zambia, Melinda Gates founder of Bill and Melinda Gates Foundation and Florence Nightingale who needs no introduction among nurses and midwives.

Using Mahatma Gandhi slogan of "Be the change that you want to see in the world" she encouraged nurses and midwives to be confident in who they are and what they are worth.

3.2 Plenary Session Two: Sub-theme: Improving Maternal, Newborn and Child Health

There were four presentations in this session as follows: A key note address by the ICM President Frances Day –Stirk, and presentations by Mary Lynn Gaffield, WHO Scientist, Monica Dragoman and two presentations by Peter Johnson.

Keynote Address: ICM President, Frances Day-Stirk

The ICM President gave an overview of the current state of maternal, neonatal and child health**.** The State of the world Midwifery Report highlighted these challenges from the 73 countries profiled in 2014 report. The 73 countries account for 99% of all maternal deaths, 91% of all still births and 93% of all newborn deaths.

In 2013, 299,000 women died from childbirth complications and 2,8 million newborns are still born each year.
Four key actions that will ensure more effective health coverage are: Availability, Accessibility, Acceptability and Quality.
Educated and well trained midwives have greater impact of positive outcomes.

The recommended 10 point Action plan is as follows:
1. All women of child bearing age including adolescents should have universal access to midwifery care when needed.
2. Governments to provide and be held accountable for a supportive policy environment
3. Governments and health systems to provide and be held accountable for creating a fully enabling environment.
4. Data collection and analysis are fully embedded in the service delivery and development.
5. Midwifery care is prioritized in national health budgets and all women are given universal financial protection.
6. Midwifery care is delivered in collaborative practice with health care professionals, associates and lay health workers.
7. First level midwifery care is close to the woman and her family with seamless transfer to the next level.
8. The midwifery workforce is supported through quality education, regulation and effective human and other resource management.
9. All health care professionals provide and are enabled to deliver respectful quality care.
10. Professional Associations provide leadership to their members to facilitate quality care provision.

After 2015 the MDG's will be replaced by Sustainable Development Goals.

Programming strategies for post partum family planning: A new resource to support health system strengthening by Mary Lyn Gaffield, WHO Scientist, Department of Reproductive Health.

Introduction
Unmet need for family planning is very high among women following childbirth- 65% of women who are 0-12 months postpartum want to avoid a pregnancy in the next 12 months, but are not using contraception. Programmes need to consider an extended postpartum period – the first 12 months after childbirth.
Postpartum family planning (PPFP) defined as the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth. WHO has developed two products to address this need.
Statement for Collective Action-Highlights importance that family planning programmes reach postpartum women and defines the issue, offers broad strategies to address unmet family planning needs for the women.
Programme Strategies for Postpartum Family Planning: A new resource for FP programmes managers and policy makers to implement the Statement.

Introducing new WHO guidelines, resources and technical updates to strengthen family planning and safe abortion by Monica Dragoman.

MEC – Provides guidance on who can use specific methods, based on medical or other conditions and The Medical Eligibility Criteria addresses who can use contraceptive methods, for example, can women with hypertension use the pill or can women with diabetes use Depo-Provera? The fourth edition of the MEC covers 17 contraceptive methods and 94 medical conditions and or characteristics. Recommendations are provided for these conditions or characteristics, as well as numerous sub-conditions of these conditions or characteristics. First published 1996, updated 2000, 2004 and 2009.
SPR – Provides guidance on how to use methods; for example, when can IUD use be initiated? First published in 2002, updated in 2005 and 2008.

Other resources available include the documents outlined below:

- Living with HIV and using Anti-retroviral therapy
- A Training resource package for family planning
- Clinical handbook for safe abortion.

Low dose High Frequency Learning Materials: The Case of Helping Mothers Survive by Peter Johnson and Cherrie Evans

The goal of the new approach to training is to produce evidence based education and training solutions that improve the health systems. This presentation introduces the concept of bringing solutions to where the people are instead of the previous practices of bringing people to solutions.
The most important goal of educating and training nurses and midwives is to ensure that they have the required competencies for their responsibilities. Today Stakeholders want training programs that are effective and demonstrate a clear link between the training and the identified gaps, that are efficient, that is less costly and requiring shorter time away from service area, and sustainable to ensure that they can be continued without external funding.
Effectiveness, efficiency and sustainability are the three new pillars promoted by the new in-service training framework developed by JHPIEGO in collaboration with Partners and sponsored by USAID. Cross cutting strategies are: Systems Approach, Standards driven, and bringing solutions to the people.
Implementation technique involves increased interaction and use of questions and feedback. New modules being developed in collaboration with UNFPA and WHO use the case based question and feedback as the primary technique of teaching and learning. Less lectures, less presentations, more simulation, practice and feedback ending with 80% practice and 20% presentation.
Frequency: It has been demonstrated through research that low dose high frequency if preferable to one off interventions and therefore the recommended approach is a move away from one long training to shorter more frequent exposures
Setting: Work place settings have proved to be more important for skill development.
Media: There is a move away from print based to greater use of multimedia, graphics and video. In areas of poor connectivity mobile phones and pre-loaded tablets make the use of multi-media possible.

Introducing Maternal and Child Health Survival Project by Peter Johnson

Programme Overview: This is a 500 million dollar USAID funded flagship programme whose goal is to end preventable maternal mortality and child death. This is to be achieved through accelerating the rapid expansion of innovative high impact approaches in 24 priority countries. ECSA priority countries are Kenya, Malawi, Namibia, South Sudan, Tanzania, Zambia and Zimbabwe.

Partners in the programme include JHPIEGO, Save the Children Federation, John Snow Inc., ICF International, Path, PSI, Results for Development Institute, and Core Group.

Cross Cutting/Integrated Themes are:
Better care on the day of birth; Strengthening integrated ANC and PNC services; Global leadership- Engaging Global Partners to inform, advocate, and advance key Maternal Health Strategies and Initiatives; Updating the WHO Managing Complications of Pregnancy and Childbirth (MCPC) and Improving availability and access to key maternal health commodities and strengthening service delivery and metrics and measurement for improved quality care.

3.3 Plenary Session Three: Innovations and Excellence in Nursing and Midwifery

There were four presentations in this session as follows; A keynote address by Judith Shamian, other presentations by Jill Ilfe of ARC, Janel Smith from ICAP and Lyn Middleton from NEPI

Key note address: Judith Shamian, President, International Council of Nurses

Innovation is thinking in a creative manner frequently referred to as thinking outside the box. It involves having a broader view of situations or plans, being curious and having the courage to try new approaches and methods. Anything perceived to be new by those doing it is regarded as an innovation.
In nursing and midwifery practice innovations involve identifying and implementing new evidence based approaches in the provision of nursing and midwifery services. Well planned innovations can bring about economic and health benefits. Research studies have demonstrated that recovery of hospitalized patients was shortened when some of the traditional procedures were modified and when nurses with higher qualifications were providing the care.
Barriers to introduction of innovations include fear of failure lack of knowledge, internal organizational bureaucracy and group behavior.

Essential elements for promoting innovations include knowledge, research and experience, quality standards and frameworks for educating nurses and midwives which include the preparation of professionals to consider innovation as an integral part of their work, systems to maintain essential nursing and midwifery competencies, professional expectations to lead and innovate and strong professional associations and holding seats at the decision making tables. It was noted that the post of Nurse Advisor to the Regional Director has not been filled following the retirement of the last incumbent. This is regrettable since it means there will be a void in addressing nursing and midwifery issues.

Environments that support innovation include Managers who engage their staff and demonstrate interest in their work. Shortage of highly qualified staff and the education -service gap is also an important barrier to innovation.

Coordinating a multi-country pre-service nursing education strengthening initiative: ICAP Columbia University Coordinating Centre for Nursing Education Partnership Initiative. **By Lyn Middleton, NEPI**

Context: The African continent carries 25% of the world's disease burden and yet the continent's share of the world's health work force is only 1.3%. Nurses and midwives are critical to achieving global HIV goals and other health targets and yet nurses and midwives often have limited voice in many countries and work in difficult contexts. HRSA's Global Nurse Capacity building Programme is a Partnership programme implemented in 10 Sub-Saharan countries by ICAP, Columbia University. Currently it has ongoing programmes in D.R.C, Ethiopia, Lesotho, Malawi, South Africa and Zambia. **Its objectives are to:**

1. Improve the quantity, quality, and relevance of nurses and midwives to address essential population-based health care needs, including HIV and other life threatening conditions.
2. Identify, evaluate, and disseminate innovative models and practices that are generalizable for national scale-up of nursing and midwifery education and health workforce development.
3. Build local and regional partnerships to provide technical and capacity building support for nursing and midwifery policy and regulatory development, curricula reform, faculty education, continuing professional development, retention, and leadership.

Lessons Learned :

Success hinges on the full coordinated involvement of all stakeholders, including donors, and strategic leadership from the Ministry of Health and Ministry of Education

- Evidence (national plans, reports, literature) and available resources must inform project design and implementation strategies
- Capacity building in project management and monitoring and evaluation increases the likelihood of results being delivered on time.
- Leveraging country and regional resources for technical assistance increases ownership and strengthens capacity.
- Managing partner and donor expectations involves clear, on-going communication.
- Opportunities for cross-country knowledge sharing and dissemination allow countries to learn from one another and speed up the processes of implementation

Updates on Africa Health Professional Regulatory Collaborative (ARC) by Jill IIfe

The ARC Initiative

This is a 4 year initiative funded through PEPFA focusing on East, Central and Southern Africa and targeting nursing and midwifery leaders using a south-to-south collaboration approach. The collaborating partners include Center for Disease Prevention and Control, Atlanta Georgia USA, Emory University, Atlanta Georgia USA, East, Central and Southern Africa Health Community, Commonwealth Nurses and Midwives Federation and Commonwealth Secretariat .

The collaboration objectives are to:

i) Sustain the scale-up of HIV services through strengthened nursing and midwifery regulatory frameworks.
ii) Align accreditation, licensing, continuing education, scopes of practice among other key regulatory functions with global guidelines and regional standards
iii) Review legislation and regulation to strengthen the alignment of policy and practice
iv) Strengthen the capacity and collaboration of national organisations to perform key regulatory functions and mobilize resources
v) Foster a sustained regional network of nursing and midwifery regulatory leaders to facilitate the exchange of best practices.

ARC works with countries through Ministries of Health, National Nurses Associations, Nursing Councils and Health Professional training Institutions.
The 14 ECSA countries have been working with this organization and 11 countries submitted funding proposals between 2011-2013 and 5 were funded.

The Option B+ approach to antiretroviral treatment to prevent mother to child transmission of HIV- An E learning module for pre-service nursing and midwifery students by Janel Smith.- ICAP

Option B+ is a new approach to prevent mother to child transmission of HIV and includes the initiation of lifelong antiretroviral treatment for all pregnant and breast feeding women infected with HIV. It was recommended by WHO in 2013 as a new guideline to accelerate and improve global efforts to prevent mother to child transmission.
The training is accessed on line through a stable learning platform developed specifically for users with limited Internet bandwidth. The course may be incorporated into pre-service nursing and midwifery curricula, in-service training programme or accessed individually for continuing professional development.
It is a competency based curriculum including six sessions covering the topics as follows:
PMTCT Basics, HIV testing for pregnant women, ART for pregnant and breast feeding women, Care for the HIV exposed infant, early infant diagnosis of HIV and Retention and linkage to lifelong care.
The programme uses interactive teaching methods such as narratives, case studies. Evaluation tools pre and post multiple choice examinations.

Day 2 Tuesday, September 2nd 2014.

3.4 Plenary Session 4: Increasing acceleration access to modern family planning services to meet FP 2020 targets: The Role of Nurses and Midwives.

There were three presentations in this session as follows: A keynote address by Grace Miheso and other presentations by Simbarashe Shayanewako and Jonesmus Wambua et al.

Key note address: Seasonality of Safe Motherhood: Grace Miheso, USAID/East Africa

Seasonality is a concept meaning there is a time and a season for everything. There is a seasonality to safe motherhood. The ideal age for child bearing is 19-34 years of age. Before 19 is the time to be a child.
In the same manner that the farmer lets the soil rest, pregnancies should be spaced. Short birth intervals affect three people negatively- the mother, the older child and the new born.
Nurses and midwives should advocate for the prevention of child marriages, they should also encourage adolescents not to be sexually active too early.
Three years between births is the most ideal spacing time. Breast feeding acts as a contraceptive.

Student Nurses' Life Skills and Family Planning Program in Zimbabwe by Cynthia Chasokela, Regina Kanyemba and Simbarashe Shayanewako
The project on Family Planning and Life Skills was initiated by student nurses in response to a very high pregnancy rate among student nurses. This was detrimental to the students and the training programme in that students who fall pregnant have to discontinue the training and this also reduces the planned for expected annual output. In 2009 21student nurses fell pregnant, there were 5 abortions with one being septic in one school of nursing.
The Ministry of Health and Child Care through the office of the Director of Nursing Services invited the students to consider participating in an educational programme in Family Planning. The proposal was welcomed by the students and a youth friendly Family Planning clinic was established specifically for student nurses. The project has been very successful and in 2014 there have been no pregnancies among student nurses. This project which was initially established in 2 schools of nursing will now be extended to other schools.
The plea from young people is that since they constitute almost 50% of the population in developing countries. There is an urgent need to increase youth participation in the development of national policies and empowerment and partnership in the implementation of programmes.
As part of preparing the young people for leadership roles they should be encouraged and supported to initiate and conduct projects. The future belongs to young people and therefore the nations should invest in them.

How to get enough practice: Overcoming clinical caseload and equipment obstacles for training in long acting reversible contraceptives (LARC's): Experience from Kenya
Authors: Jonesmus Wamba, Emmah Kariuki, Milka Akala and Paul Nyachae.
Accelerating Scale up implants (ASI) Project.

The Aim and objectives of the project were to create an enabling environment for LARC's through advocacy for Family Planning, Capacity building in FP, reducing supply chain disruptions and increasing service delivery, quality and availability.
Background to this project is that at the London summit FP2020 committed to provide access to FP services information and supplies to an additional 120 million women and girls. Local collaborating partners in Kenya include JHPIEGO, Bayer, MSD, AFP, Clinton Foundation, CHAI and APHIA.

LARC training programme is a six days competency based training for FP providers and participants come from different geographical parts of the country.
Overcoming clinical challenges involves identifying volume sites before training, mobilizing additional equipment from neighbouring facilities and using multiple clinical sites and ensuring provision of adequate supplies.
Overcoming clinical challenges was mitigated through focused client mobilization, negotiating for free services during practice sessions, promoting PIFP in other clinical areas and providing post test training.

Program Results:

Knowledge evaluation based on pre and post test performance showed that from the 4 training centers the post training test scores were 10% higher than the pre-training test scores.
There was an overall increase in the numbers of service providers trained as TOT's and others as Mentors and over 200 facilities were reached.
Challenges include low client demand for IUCD's shortages of some commodities affecting range of available services, inadequate number of mentors and poor male involvement in FP.

Lessons Learned.

-Continued post training support is required to achieve proficiency especially with IUCD.
-Availability of equipment and FP supplies facilitates acquisition of competencies.
-Collaboration and joint planning is useful in identifying eligible potential trainees, needy sites and matching skills with distribution.

3.5 Plenary Session Five: Health Systems Strengthening

There were two presentations in this session both by Dr C. Samkange

Strengthening Human Resources for Health through ECSA Colleges of Health Sciences by Dr Christopher Samkange

The Role of ECSA Colleges in Strengthening Human Resources

Local training has several advantages compared to sending local candidates overseas. Sending people overseas is expensive and some candidates never return on completion of their studies.
ECSA now has 5 colleges namely:
ECSACON established in 1990,
COSESCA established in 2000
COPESCA established in 2000
CANECSA established in 2011

The College of Health Sciences at ECSA –HC encompasses all the health disciplines. The training programmes should be competence based and contextualized according to the stages of development and the environment. The professionals should be prepared to work in this environment especially in relation to cultural competence referral systems how to conduct research and to improve the health delivery system. Colleges should there fore increase access, provide equity and promote professional development.

Teaching hospitals provide an opportunity for improving clinical practice, for example, a district hospital as a training institution is an advantage because such a district hospital can be transformed into a College the activities of which will upgrade the quality of care provided.

Colleges enable the system to avoid creating super specialists and provide opportunities for acquisition of basic competencies that are required from every physician.
Universities and colleges complement each other, therefore both are necessary. To improve the system there is need to review the requirements for an institution to be considered as a Training institution and to stream line the training that is required for the professionals who run the colleges.
Qualification through a College rather than through a University pathway is now the preferred route for Post Graduate studies.

The Role of Surgical Camps in Promoting South to South Cooperation by Dr Christopher Samkange

The exercise is based on bringing volunteers with specialized professional skills to the selected country within the ECSA Region for the purposes of undertaking specified surgical procedures within a specified period.
The exercise has several advantages such as:

- Providing the opportunity for participants to see procedures done differently.
- Reducing the costs for the patient and the country because it is based on voluntarism.
- Reduces the burden of referral as the specialists move to the lowest level of care.

Once the surgical procedures have been completed the critical part is the nursing care. One of the main aims of the surgical camps is to provide quality care. Since professionals of various levels participate, the exercise promotes interest among junior staff members to engage in post graduate studies.
An invitation to the surgical camp in Malawi commencing 5thOctober, 2014 was extended to all Colleges.

3.6. Plenary Session Six: Panel Discussions 1, 2 and 3

Working together to support Nursing and Midwifery workforce development: From global to local context

Panel Discussion 1: Moderator: Leslie Mancuso
Judith Shamian, President, International Council of Nurses (ICN) ;
Frances Day-Stirk, President, International Confederation of Midwives (ICM);
Maleshoane Monethi-Seeiso, President, East, Central and Southern Africa College of Nursing (ECSACON).

The International Confederation of Midwives has a membership of 101 countries with which it works to support nursing and midwifery workforce. The organization works collaboratively with ICN and other professional associations. It also works closely with UN agencies including WHO, UN Population F and UNFPA and NGO's such as JHPIEGO and the private sector such as Johnson and Johnson.
ICM has a tool called Member Association Assessment tool.

The ICM President is looking forward to discussing with ECSACON how the partnership and collaboration between ICM and ECSACON can be strengthened.

The International Council of Nurses represents approximately 19 million nurses throughout the world. The organization has connections with global organizations that include WHO, World

Bank and other UN agencies, NGO's and the private sector. It also has connections with 5 other global health professional associations that include Medical Association and Pharmacy Association.

The ICN has 3 Pillars through which it carries out its mandate. The three pillars are Regulatory Pillar, Socio-economic Pillar and Professional Pillar that focuses on education and practice.

ECSACON is a professional organization of nurses and midwives and is made up of 14 countries in the East, Central and Southern Africa (ECSA) region. Its membership is organized into four faculties namely Clinical Practice, Education, Leadership and Management and Research.

Collaborating Partners are UN agencies such as WHO, UNICEF, Governments such as USAID, NGO's such as JHPIEGO.

Discussion issues:
-Establishing standards/ guidelines for nurses and midwives to be able to quantify their work.
-ECSACON needs to do more than collaboration. Since it is a College and not an Association, it should offer recognizable qualifications.
-Appreciation for the collaboration between ECSACON and ICN and now ICM was noted.
-The image of the nurse and nursing/midwife and midwifery-We are encouraged to get out of the "nursing bubble" and talk about economic value, clinical outcome and social value.
-Nurses and Midwives need to be valued and recognized in tangible ways and as nurses and midwives, we should be our own advocates.
-In conclusion, nurses and midwives need to use the available resources to improve knowledge and skills.

Working Together from Research to Evidence –Based Practice- The example of Medical Male Circumcision (MMC) for HIV prevention in Zimbabwe

Panel Discussion 2: Moderator Peter Johnson , Jhpiego
Presenters: J. Ncube, C. Samuelson, C. Samkange, X. Tshimanga Sinothemba, C. Chasokela, And R. Baggaley
The presentation outlines the process that WHO undertakes to develop evidence-based recommendations to inform practice.
A. In this project the first strategy was to address the HR shortage and expand access to MMC for HIV preventions through the introduction of innovative MC methods rather than sticking to the three conventional surgical methods.
B. The second issue was to develop guidance on the use of MC methods and highlight the value of interdisciplinary approaches and global – regional – local networks.

Interdisciplinary/professional groups are used to develop all WHO guidelines and recommendations and decisions are made on who to include in the groups.
Two main groups were convened to inform the guidance on use of MC devices:

The Technical Advisory Group (TAG), on Innovations in Male Circumcision provides expert advice to WHO as an established, ongoing group and

Guideline Development Groups (GDG) which are temporary and provide inputs into recommendations and programmes, service and clinical considerations; recommendations that influence decisions taken by Ministries and resulting practices in countries.

The voices of those invited to be on these groups decide which outcomes and evidence are to be considered, and they voice the 'values and preferences' of the group they represent. For the MC device methods guidance these groups decided it was priority outcomes to consider such as safety and provider acceptability.

Representation:

The TAG composition was specifically defined prior to its creation based on knowledge needed, and includes experts such as biomedical engineers and urological surgeons including Dr Samkange, but not necessarily nurses.

The temporary GDG composition was based on perceived needs to obtain key inputs and represented certain stakeholders. For the MC devices use guidance included some TAG members, service providers, implementing agencies and programme managers, of whom some had nursing background, and specifically included the Zimbabwe Director of Nursing Services.

Lessons Learned:

1. **Value of multiple perspectives**, leading to rich discussions and better recommendations. Learning new terminologies – like mechanical forces, prequalification and risk matrices permitted detailed understanding and more confidence in speaking about the specific intervention to take into practice.
2. **Value of global-regional- national networks**.
   The research was conveyed to regional and national teams and donors, focusing and systematizing research undertaken across countries. The results of the research in Rwanda, Uganda and Zimbabwe was then used by the TAG and guideline development groups. This bi-directional networking led to relevant research being conducted and programme considerations that reflected realities on the ground; faster response including evidence-based recommendations and prequalification decisions was possible as findings were shared confidentially prior to publication.

Key points and questions to consider

1. **What is the ideal professional composition to put** forward the most relevant guidance and streamline the uptake of the guidance?
2. **Was nursing adequately represented in the above reported study?** WHO needs to provide a specific policy statement focused on nursing practice and use of MC devices. Would the study team have developed that statement already if more nurses had been engaged in the discussions which are relevant to their practice and their predominance as service providers.?

Guidelines are now being updated and any inputs from interested parties, are welcomed. Nursing participation in any WHO guideline and strategy development groups, and for senior nurses in delegations to WHA, is essential to add in the nursing perspectives. Nurses and midwives are encouraged to participate in the working groups.

Networking between global, regional and local levels is a win-win situation to get to better research and evidence for policy and practice decision making; and to take the evidence-based recommendation to practice.

The presentation ends with the question: What needs to be done by WHO and by nursing to streamline the process of getting the evidence-based recommendations on high impact interventions into nursing practice?

Medical Male Circumcision- Perspectives from the VMMC Programme'
Key Talking Points by Sinokuthemba Xaba

Voluntary Medical Male Circumcision (VMMC) offers a great opportunity to turn the tide of the HIV epidemic. MMC targets for prevention of HIV targets healthy boys and men. The four main types of surgical procedures used include forceps guided method, dorsal slit, device led circumcision and the sleeve method.

The procedures indicated above are safe when undertaken by doctors as well as Registered General Nurses and Primary Care Nurses who have been trained in these procedures.

Psychologists, Statisticians, Counselors and Community mobilizers were part of the teams when the study was undertaken.

Key implications of the study are that the services are required in areas where the nurses are the only heath care providers available. The study findings are that nurses of various categories can safely perform Medical Male circumcision when they have been trained to do the procedures. A supportive regulatory environment is the key. Nurses also need back up services to deal with those cases which they may not be able to manage. An enabling legal environment is also essential to ensure that nurses are protected.

Key challenges include adding new responsibilities to cadres that are already overstretched, high staff attrition and competition for limited resources.

Panel Discussion 3: Essential Care for Every Baby –by Mumbi Bupi Mwamba and Facilitated by Laerdal Global Health in collaboration with JHPIEGO and other GDA Partners.

Neonatal care remains a major challenge in many African countries mainly due to lack of appropriately qualified neonatal nurses and other critical material resources.

Neonatal mortality rates in ECSA member countries are unacceptably high ranging from low 9/1000 lives in Mauritius and Seychelles to a high 39/1000 in Zimbabwe and 46/1000 in Lesotho. Eighty five percent of ECSA member states have a double digit neonatal mortality rate and only 14% have a single digit mortality rate.

Essential newborn care interventions to mitigate this very alarming neonatal mortality include interventions before conception, during the antenatal period, during labour and delivery and the first 1-2 hours of life and interventions from 1-2 hours after delivery to 4 weeks.

Long term plans to reduce neonatal mortality include ensuring adequate numbers of approximately qualified personnel to improve staffing in neonatal units.

Main recommendations are a development of a systematic data driven decision making process and a participatory rights based policy process, improved access to health care for newborn sand monitoring coverage and measuring costs and effects.

Day 3 Wednesday, September 3rd 2014

3.7 Plenary Session Seven- Evidence Based Primary Health Care

There were two presentations in this session as follows: A keynote address by Annette Mwasa and a presentation by Elizabeth Oywer.

Keynote Address: Optimizing Community Health Nursing in the context of Primary Health Care: Contextualizing Universal Health Coverage (UHC)

The presentation was made by Ms Cynthia Chasokela on behalf of Annette Mwansa, Technical Officer- Nursing W.H.O. who was not able to attend.

The contribution of Community Health Nursing within the national health services in the context of Primary Health care is viewed as the most appropriate strategy to achieve Universal Health Coverage. The presentation is organized under the five subheadings as follows:
I) Universal Health Coverage; ii) Community Health Nursing ;iii) Context ; iv)WHO Multi-country Study; and v) Opportunities.

Universal Health Coverage is a service delivery approach designed to reduce the gap between use and need, by improving equity in resource distribution, and enhancing people's knowledge of rights. This approach includes improving quality of the services offered, promoting universal financial protection and improving efficiency to enable greater attainment of all the intended outcomes. This approach is very relevant to Community Health Nursing.

Community Health Nursing is defined as:

"A field of nursing that combines the skills of nursing, public health and some phases of social assistance and functions as part of the total public health programme for the promotion of health, improvement of the conditions in the social and environment and rehabilitation of illness and disability"

WHO Multi-country Study

A multi country was conducted between 2010 and 2012, to determine the existing scope of practice of Community Health Nursing in selected countries experiencing a critical shortage of human resources for health. Eighteen countries from WHO four regions participated in the study. The study participants were :
Directorates of Nursing (13); Nursing Regulatory bodies (10); Nursing/midwifery Training institutions (44); Nurses/Midwifery Associations (11); Practicing Community Health Nurses (428) and Health Systems and Services.
All countries in the study had Primary Health Care (PHC) as strategy for health care service delivery and all had institutions responsible for policy, training, regulation, accreditation and monitoring and evaluation of nursing services.

In 86% (13/15) of the countries, CHN was recognized profession and had a clear mechanism for monitoring workforce performance. Only 9 (50%) of the countries had specific retention packages (incentives) for nurses working in hardship areas.

CHN offered as a post-basic qualification in 7 (38%) countries, in 8(44%) an entry level exam is a requirement for admission to the training programme. Nine (60%) of the regulatory bodies regulated the scope of CHN.

Commonest tasks performed by the CHNs were:
Maternal and child health (30%); General health care provision (23%); Administration (16%) ,Health education (10%)

Time and length of Training

Seventy six percent (76%) received formal training in Community Health Nursing and for 51% of them; the training was more than 24 months. Only 15% indicated their training involved training with other health professionals (primarily medical doctors and other nurses). In 91%, the practicum period was at least 12 months duration

The study identified gaps and shortcomings related to training and utilization that need to be addressed and are outlined below:
The educational preparation of Community Health Nurses, though varied between countries surveyed, needs to be strengthened. Strengthen key roles including planning of health activities, coordination and planning with other partners
CHNs practice in a variety of settings; therefore, appropriate policies based on professional needs assessments are critical.
Health care training has traditionally tended to be largely biomedical with emphasis on diagnosis and treatment of acute problems with not enough emphasis on prevention and health promotion.
Nurses are the main professional component of the "Frontline staff" in most health systems and their contribution is recognized as essential for universal health coverage.
Conditions of service must be conducive enough to retain CHNs in practice.

The Status of Nursing in Kenya with Specific Reference to Mental Health Nursing
Presented by Elizabeth Owyre

The presentation is covered under the four headings of:
a) Background, b) Supply and Regulation, c) Deployment and Distribution, d) Way Forward.

Background

Nursing in Kenya is governed by 4 Bodies:
Nursing Unit – policy maker and main employer for nurses
Associations – welfare and political arm of the profession
Nursing Council (NCK) – the legal or competent authority
Nurse Training Institutions – educating the future workforce
These 4 pillars work together to advance nursing in Kenya.
Data existed in paper form in different agencies, was incomplete, numbers of qualified, deployed or needing training unknown

Kenya Health Workforce Project

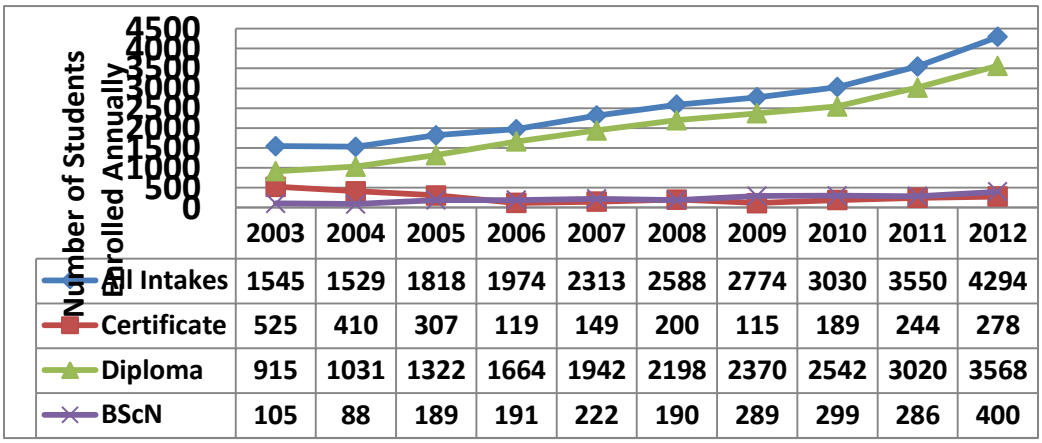
Objective 1: To design and establish reliable information system to capture a minimal data set for analysis to inform nursing workforce training and deployment.
Objective 2: To build capacity among Kenyan leaders in the development of health workforce management, research, policy and leadership.

Supply and Regulation

Data to Inform HRH Regulation
Student nurses are currently in training

Indexed, registered and re-licensed
Applied for private practice license
Applied to migrate out of Kenya
Trained by age, gender, cadre, province, county
Advancing in their careers with additional training

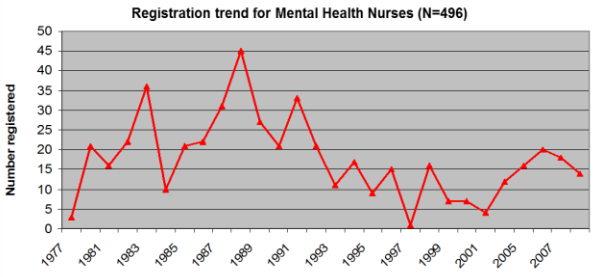
Trends in Nurse Training Annual Enrollment, 2003-2012



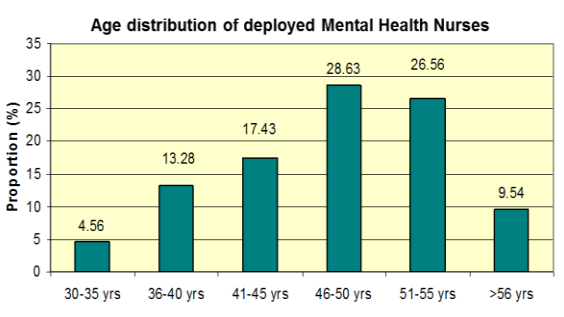
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
All Intakes	1545	1529	1818	1974	2313	2588	2774	3030	3550	4294
Certificate	525	410	307	119	149	200	115	189	244	278
Diploma	915	1031	1322	1664	1942	2198	2370	2542	3020	3568
BScN	105	88	189	191	222	190	289	299	286	400

Registration

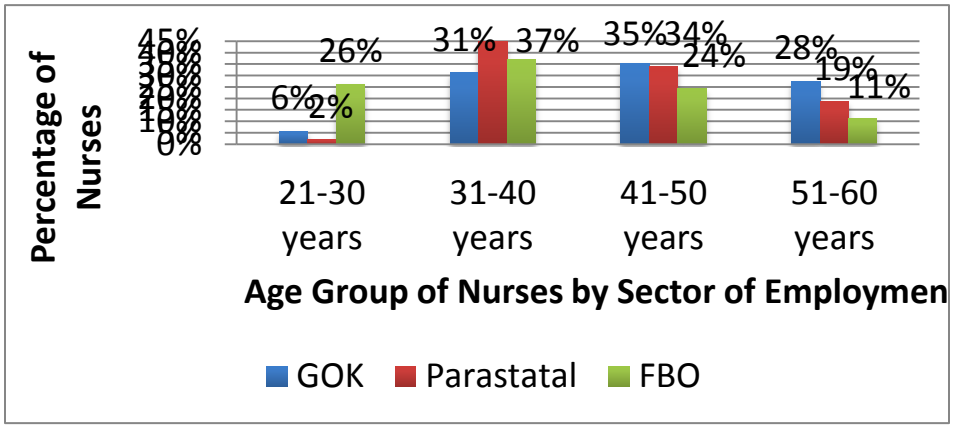
No of mental health nurses registered per year ranges between 0 and 45.
The lowest number registered was recorded in 1998 [N=0]
The highest number registered was recorded in 1988 [N=45]
Since 1992, the number of registered has not gone beyond 20.
Kenya has capacity to produce 100 registrants per year
Results: Mental Health Nurses



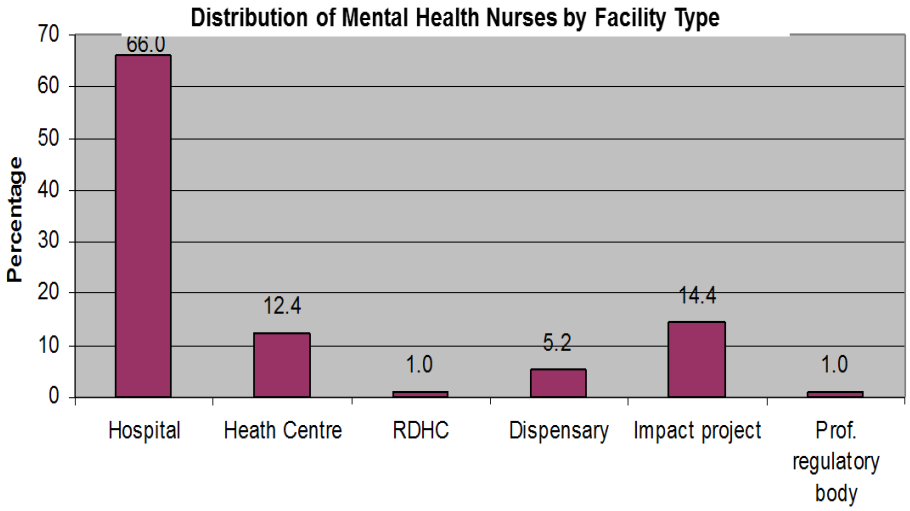
Results: Mental Health Nurses -Age distribution



Nursing Workforce Policy; Data to Inform HRH Regulation



Deployment and distribution of nurses, Skill mix at the facility level;
Nursing workforce capacity – present and future: Career advancement, promotions
Workforce exits, attrition by cause.



Public Sector Attrition -By Cause 2008-2012:

Retirement (37%); Death (28%); Dismissal (19%); Resignation (10%); Transfer of service (6%)
(Data: Comes from NCK on licensure verifications to work abroad)

Way Forward

Development and Investment:
Marketing – Mental health nursing as a future career choice
New Curriculum change –focus on pre-service training
Scholarships- Attract applicants to mental health
Replacements – of those retiring within the next 5 or so years
Access to Primary Care – 68% deployed at Level 4-6 facilities
Distribution by Skills – inform deployment to facilities and wards
Database-inform evidence
"An investment in knowledge pays the best returns"
- Benjamin Franklin

4. Parallel Sessions 1 to 6: Tuesday, 2nd September, 2014

There were several parallel sessions during which sub-themes were explored. Sub-themes covered three areas as follows:
Session 1: Promoting Maternal and child health
Session 2: Control of Communicable and Non-communicable diseases
Session 3: Health Systems Strengthening
Highlights from these sessions are presented in chronological order in sub-sections.

4.1 Parallel **Session 1: Promoting Maternal and child health**

There were six presentations by Peter Kirabi et al, Prof. Christa Van der Walt et al, Scholastica Pauline Bakibinga et al, Mduduzi Shongwe, Nomathemba Nxumalo et al, and Scholastica Chibehe, et al.

Dr. Peter Kirabira et al from the Institute of Health Policy and Management, International Health Sciences University, Kampala, presented a paper titled: **Partner Consent on Women's Choice of Using Family planning not required: Findings from Slums of Kampala, Uganda.**

Dr Kirabira noted that family planning (FP) remains one of the most important pillars of safe motherhood, hence needed for population regulation in urban settings with high population growth. The purpose of the study was to assess the utilization of FP services in Namuwongo slums and determine the factors influencing FP-choices.

A cross-sectional baseline-survey in 4 slum zones of Bukasa parish clustered along the railway line within a distance of 5km was conducted, sampled 824 out of 3,158 households, held 12-FGDs and 12-Key Informants interviews. Did quantitative analysis with STATA and manually analyzed the qualitative data.

Results of the study were as follows: FP-utilization rate was 46%, (49%-injection, 16%-pills, 7%-male condoms and only 2%-IUCDs). At bivariate analysis, widowed women, women who ever discussed FP-choice with husband, ever used FP, used FP pills, Used FP-Injection and paid for FP were more likely to use FP. The higher the FP-cost from 1,000- 5,000/=to 5,000-10,000/t=, to, over10,000/= the less likely to use FP. Women who sought the FP from a pharmacy/drug-shop were twice more likely to use FP than from a public health facility.

On multivariate analysis, those with monthly income of 250,000- 500,000/= (aOR=3.7 95%C I 1.2-11.38) were 4-times more likely to use FP compared to < 2,500/= income. Those who didn't discuss FP-choice with partner were 3-times more likely to use FP compared to those who actually discussed with their partners (aOR2.995%CI1.68-5.03) while cost of FP above 1,000/= was associated with less current FP use compared to cost under 1,000/=.

The study conclusion was that in a young slum population with youthful household heads, over a dollar monthly income of mothers not discussing FP-choice with the partner influenced FP-use. FP- cost above 1,000/= was a barrier to FP use. The recommendation was that free FP-commodities be provided and women be empowered through engaging men in FP- involvement ,allowing their wives make independent FP-choices, with men playing only a supportive roll.

Prof. Christa Van der Walt et al presented a paper entitled: Maternal-child Health Nurse Leadership Academy: An intervention to address the quality of maternal-child nursing and midwifery in Africa.

In partnership with Johnson & Johnson and Sigma Theta Tau International (STTI), the Honor Society of Nursing, the Africa Maternal and Child Health Nurse Leadership Academy (MCHNLA) develops the leadership skills of nurses and midwives who work in a variety of health care settings. The MCHNLA, adapted from the North American model, prepares participating nurses and midwives for effective inter-professional team leadership as they strive to improve the quality of health care for childbearing women and children up to 5 years old.

The objective of the presentation was to share information on the process followed in the implementation of the MCHNLA in the South Africa pilot, the outcomes achieved; and the challenges and lessons learned.

The MCHNLA South Africa Pilot (SAP) was implemented in the North West Province of South Africa after extensive adaptation of the North-American MCHNLA. Implementation took place in 2012-2013, after which the pilot was independently evaluated. The objectives of the evaluation were to (a) document the evidence of changes in mentee and mentors' leadership-related knowledge, skills and behaviors, as well as evidence of organizational and/or patient impact from mentee projects; (b) summarize mentees' and mentors' feedback on the workshops and on the MCHNLA as a whole; and (c) identify aspects of SAP evaluation instruments and data collection processes that could be improved for the next SAP cohort.

The conclusion and implications of the programme were that MCHNLA was successfully adapted for implementation in Africa. Many lessons were learned but overall the aim of the MCHNLA SAP was reached which was to see if and how the MCHNLA can be implemented in Africa. The success of the MCHNLA SAP led to the launch of the first Africa MCHNLA 2014-2015. Twelve mentor-mentee pairs from Malawi, Uganda, Swaziland and South Africa are included in this cohort.

Pauline Bakibinga1, et al presented the study titled: Increasing access to quality maternal, newborn and child health services through enhanced public-private partnerships: preliminary results from an intervention study in two urban informal settlements in Nairobi, Kenya.
The rapid urbanization in Kenya has resulted in a population of over 58% of urban residents living in slum like conditions. In the wake of this rapid urban growth, the formal health care delivery system has not kept pace with the growing needs of the population. Research done in the slums of Nairobi has shown that less than 1% of health facilities serving these settlements were public.

More than a decade of research in the slums of Nairobi, Kenya shows that these areas exhibit poor child, neonatal and maternal health indicators including high levels of maternal mortality (709/100,000), high neonatal, infant and under-five mortality. The African Population and Health Research Center rolled Out a 3 year project, "Partnership for Maternal, Neonatal and Child Health (PAMANECH)" in Viwandanai and Korogocho informal settlements of Nairobi, Kenya with the aim of strengthening public-private partnerships for the improvement of health care services and out comes for mothers, neonates and young children through various strategies: service delivery, leadership and governance health work force and the health information system. The objectives of the study was to determine the effect of strengthened public-private partnerships on the quality, accessibility, and affordability of maternal health services

This was an intervention study with pre and post-intervention phases to assess the impact on the MNCH services and population health outcomes. Data were collected at baseline and is continuously being collected, from multiple sources, examining trends and trying to find explanations for the findings.

The study is currently in progress and data analysis of preliminary findings is currently on-going. The findings will show effectiveness, if any, of the intervention and possibly provide a model of

public-private engagement for adoption by the local and central governments for under-served populations like slums, in Kenya and other sub-Saharan African countries.

Mduduzi Shongwe from the Department of Nursing Science, Faculty of Health Sciences, Swaziland Christian University, Swaziland presented the study titled: **The Experiences of HIV-Positive Mothers, Breastfeeding Exclusively at a Regional Hospital in Swaziland**

In Swaziland, 41.1% of pregnant women live with HIV, while only 32% of Swazi mothers (including HIV negative mothers) currently practice exclusive breastfeeding among infants under six months of age. The Rate of exclusive breastfeeding decreases with an increase in the infant's age, as only 17% of infants aged four to five months are reported to be exclusively breastfed. However, little is known about HIV-positive mothers' perspectives and experiences of exclusive breast feeding in Swaziland.
The objective of the study was to describe the experiences of HIV-positive mothers breastfeeding exclusively at a regional hospital in Swaziland.

An explorative, descriptive qualitative study design was employed where seven exclusive breastfeeding, HIV-positive mothers were purposively selected to participate during two visits to the study site. Responses to semi-structured and in-depth interviews were analyzed in order to generate themes.

Five major themes that emerged were: (i) benefits of breast milk to the mother and the baby (ii) social support; (iii) the role of health care workers in promoting exclusive breastfeeding. (iv) psychological factors; and (v) challenges faced by breastfeeding mothers. Despite pressure from relatives and in–laws, for some of the participants continued to breastfeed exclusively for the first six months of the baby's life, stating that breastfeeding benefited themselves and their infants. Continuous teaching and counseling offered by nurses during the mothers' child-welfare clinic visits motivated them to continue breastfeeding exclusively.

Recommendations are that, there is a need to develop and implement feasible interventions to improve support for HIV-positive mothers, in order to scale up exclusive breastfeeding practices in the country. In addition, counseling on exclusive breastfeeding should also include the in-laws as they play a pivotal role in child feeding. This study contributes to the body of knowledge on infant feeding and provides insights to health care professionals and stakeholders working with breastfeeding women.

Nomathemba Nxumalo et al, from the Department of Community Health Nursing , University of Swaziland, Faculty of health Sciences presented the study entitled: **Challenges Faced by Pregnant Women Taking ARV Prophylaxis at Mbabane Public Health Unit: a Health Facility in the Hhohho Region.**

Swaziland's HIV prevalence rate of 26% (31% women and 20% men) among people aged 15-49 years (NERCHA, 2009), and 42% amongst antenatal women (Swaziland Sentinel Surveillance Report, 2010), is reported to be the highest compared to other countries in the region. The introduction of PMTCT Programme in Swaziland in 2003 helped reduce mother to child transmission of HIV and statistics showed a success of 77% by the end of 2010 (HlV Estimates and Projections 2010). In 2011, UNAIDS (2012) reported a total of 10,641(87.5%) HIV positive

pregnant women were provided with antiretroviral prophylaxis to reduce the probability of MTCT.

The purpose of the study was to explore and describe the challenges faced by pregnant women taking ARV prophylaxis at Mbabane Public Health Unit which is a health facility in the Hhohho region of Swaziland.

The study sample was composed of a total of 34 HIV positive pregnant women on ARV prophylaxis with ages ranging from 18-40 years, mean age 27±7.431. Of these 47.1% had primary school level education; 41.2% were single and 47.1% were unemployed living in the rural area (52.9%) with their partners (52.9%). A minority (32.4%) had an average monthly income of more than 2000 Emalangeni.
The study utilized a quantitative cross-sectional survey design, and the 34 participants were recruited by non-probability convenience sampling. A structured questionnaire administered face to face was used to gather data. Analysis was done using SPSS software version17.0 to generate description using bi-variate analysis with one way ANOVA.

A majority (88%) of the respondents had disclosed their status to their partners, 55.9% had disclosed to someone else, while 41% had not. Reasons for non-disclosure included fear of rejection or fear of in-laws or employer knowing status.

Among socio-demographic variables, source of income($p=0.047$) and mode of transport used to travel to the health facility were significantly($p=.020$) associated with challenges faced by the participants. Significant correlation between the age and average monthly income($r=0.417, p=0.041$), first diagnosis and health status($r=0.929$, $p=0.001$), duration on ARV prophylaxis and health status ($r=0.397$, $p=0,001$), travel expenses and challenges($r=0.537$, $p=0.000$) were observed.

The results of the study showed that HIV positive pregnant women face many challenges including stigma and discrimination, poverty, unemployment and low levels of education which limits their decision making capacity with regards to their health care. Recommendations to be addressed by practice and research were made in order to improve the quality of life of women taking ARV prophylaxis

Scholastica Chibehe et al, presented a paper entitled: **Standard based Management and recognition process improving Quality of Maternal and New Born Care in Tanzania**
At 454 per 100,000 live births, maternal mortality in Tanzania is unacceptably high, despite showing some improvement compared to what it was in the 1990's. Approximately half of deliveries take place in health care facilities, making quality of health care services an important factor in saving lives of mothers. The USAID-funded MAISHA program provides technical support to the Ministry of Health and Social Welfare (MOHSW) to improve the quality of maternal and new born health care across the country.

MAISHA supports a quality improvement process to improve maternal and newborn health care, assisting facility-based teams to use MOHSW-approved standards to identify gaps in service delivery and take steps to improve. When facilities score 70% of the Focused Antenatal Care (FANC) and Basic Emergency Obstetric and New Born Care (BEmONC) standards they are recognized by the MOHSW.

Summary findings were that out of 53 health facilities from 19 regions that requested for external verification, 49 health facilities (92%) both FANC and BEmONC scored above 70% and received recognition from the MOHSW. A total of 44 health facilities scored above 71% in FANC and 38 in BEmONC.

The conclusion was that effective implementation of evidence-based MNH standards resulted in improving the quality of care in FANC and BEmONC. The recognition status promotes motivation, and ownership hence improves quality of care.

4.2 Parallel Session 2- Control of Communicable and Non -Communicable Diseases

There were five presentations in this session by Sakhile Masuku, Florence Mulenga, William Baratedi, Lillian Dodzo and K.S. Dithole

Sakhile Masuku et al from the Department of Community Health Nursing Sciences Faculty of Health Sciences University of Swaziland presented a paper titled "**Child malnutrition and mortality in Swaziland: situation analysis of the immediate, underlying and basic causes"**

Malnutrition is a major confounding factor for child morbidity and mortality in developing countries. In Swaziland, about31% of the under-five children are stunted in growth, where as 1% and 6% are wasted and underweight respectively. Hhohho region has the highest prevalence of underweight children (8.2%) relative to other regions such as Shiselweni (7.3%), Lubombo (6.7%) and Manzini (6.4%).

The prevalence of infant and under-five children mortality rate (per 1,000 live births) are 85 and 102 deaths, respectively. Lubombo region has the highest cases of under-five mortality rate (deaths per 1,000 live births) of 115 when compared to rates in other regions, namely; Manzini (112), Shiselweni (100) and Hhohho (96). Despite the several child healthcare programmes, the problem of high child malnutrition places a significant hindrance towards the attainment of the Millennium Development Goals (MDG) 4 on reduction of child mortality.

Potential determinants of childhood malnutrition and mortality in Swaziland can be categorized into three levels, namely: (a) immediate causes (inadequate dietary intake of protein, energy and micronutrients; diseases such as pneumonia, diarrhoeal diseases and HIV/AIDS, (b) underlying causes (inadequate access to food due to poverty and decline in food production; inadequate care of children and women, insufficient health services and unhealthy environment), and (c) basic causes (inadequate mother's education and nutrition knowledge, insufficient human resources in child health care; inadequate policies on child nutrition and healthcare; inequitable distribution of household and national socioeconomic resources).
is paper presents an in-depth analysis of the causal factors of childhood malnutrition and mortality in Swaziland and further explores opportunities that could be adopted to address the malnutrition and mortality problem. It also aims to reinforce that in order to ensure effectiveness and sustainability of intervention programmes, there is need for multi-dimensional strategies and collaboration between all the stakeholders concerned with child nutrition, health and socio-economic development. However, the interventions must recognize the existing socio-economic differentials between the rural and urban areas, and the administrative regions.

Florence Mulenga, **Communications Support for Health Project**, Chemonics International, Zambia presented a paper titled "**The Role of Nutrition in the Reduction of Child Mortality"**

The Communications Support for Health (CSH) is a USAID funded project which aims to strengthen the capacity of the Government of the Republic of Zambia (GRZ) to implement effective health communications activities. The vision of the CSH project is to have an empowered Zambian population that is able to make informed health decisions and healthy lifestyle choices. In 2013, the Zambian Government (GRZ) with support from UK-AID launched the First 1000 Most Critical Days Programme, which includes critical evidence-based services as well as behavior change communication. CSH is a partner on this project to support behavior change communication component.

Child stunting (low height-for-ages) is one of the most serious but least addressed health problems in the world. In Zambia, although rates of stunting have shown some improvement over the past five years, they are still high (in rural area almost half of all children are stunted) and a major factor in preventing maternal and child mortality.

The Zambia 2007 DHS house hold survey indicated that:

- Poor maternal diet in consumption of animal-source foods, fruits and vegetables
- Of 90% of children breastfed, only 61% are exclusively breastfed until 6 months.
- Sixty three percent (63%) of children do not receive an adequate diversity of foods in their diet and almost half (45%) do not eat enough meals for their age.
- Only 59% of the population has access to improved water sources and only 49% use improved sanitation facilities.

The goal of the campaign was to contribute to the GRZ goal of reducing young child stunting in Zambia from 45% to 30% by 2015. Consultative meetings with key partners, formative research and a literature review of existing research were conducted in 2012 before the final strategy for the campaign was developed in early 2013.

The audiences for the meetings were pregnant women of any age and mothers (or other care givers) of children under two. Secondary target audiences include fathers/male partners and grandmothers, facility and community based health workers including Safe Motherhood Action Groups (SMAGs) and traditional leaders.

The campaign products included Mass Media in the form of 13series of a radio drama programme dubbed, “Bushes that grow” and translated into Zambian local languages and Radio discussion guide for use with mothers’ groups.

Interpersonal products included Child reminder card, child feeding bowl, child feeding placemat and child feeding menu game.

The results were: 13radio drama series translated into seven local languages,16500, growth reminder cards distributed in 5 provinces, 440 menu games distributed to community health workers, 9,200 menu placemats distributed to mothers, 180 community nutrition promoters trained in community counseling and use of products (8 districts of four rural Provinces.)

The conclusions were that the Project uses simple and interactive approaches and tools for use by community health workers to influence behavior change. The programme is anchored on Government national campaign and so lessons learned can be easily rolled out countrywide. Nutrition is one of the key priority areas for Government hence acceptability, support and sustainability is a reality for the reduction of maternal and child mortality towards attainment of the 2015MDG’s 4 and 5.

William Baratedi presented the study titled: The lived experiences of HIV sero-discordant couples in Botswana

Background: The phenomenon of HIV Discordance has been in existence for a long time along with HIV. However, very limited attention has been given to it. This has resulted in increase sero –conversion by negative partners. Studies in some African countries have identified a sizable number of discordant couples, (Walque 2007). Reports by the ‘’Tebelo-pele Counseling and Testing centre” revealed that discordance in Botswana is around 17%. The understanding of their experience would help clinician to devise strategies for empowering behavioral change and reduce infections.

The Objectives of the study objectives were to; identify HIV discordant couples living in Botswana, explore their knowledge and understanding of the situation, explore the psychological, social and sexual experiences of the HIV discordant couples.

Methodology: A qualitative phenomenological approach using face to face in-depth interviews. Participants were selected through purposive sampling method from three cities in Botswana. The Inclusion criteria included couples aged 21 years and above; with no known mental illness; have been discordant for at least six months and living in Botswana

The Sample and study findings: The study sample consisted of forty-six (N=46) participants, from three sites across the country. The findings revealed three forms of discordance named at the time when the couples got into relationship, that is: **discordant unaware,** (that is, when the couple did not know their status) **discordant aware** (that is, the situation when the couple knew that another partner is infected), and **discordantly discordant,** (that is, a situation where there is discordance upon another. In this situation couples go into the relation differing opinions. One partner who is infected hides his/her status from another partner). There are intense psychological, sexual and social stresses experienced by couples. HIV discordant goes through three phases of initial shock, conflict and resolution; there is also a degree of sexual risks.

Conclusion and Recommendation: HIV sero-discordant couples battle with psychological, social and sexual hardships in their relationships. To assist them cope with their situation, the researcher recommends the OPEN DESK MODEL to be integrated in the health care services to cater for HIV discordant couples.

Lillian Dodzo from the School of Midwifery in Harare, Zimbabwe presented a study title: **The increase in abdominal septic suture lines post caesarian section among post natal mothers aged 18-35 years of age at a Central Hospital in Harare, Zimbabwe.**

Health care associated infections can be transmitted through the respiratory route however contact transmission is the most common in health institutions. This includes hands, instruments and equipment hence the emphasis on proper hand washing. Infection Prevention Control (IPC) is promoted through application of policies and all nurses and midwives have an important role of promoting adherence of all staff members.

The problem statement of the study was that the incidence of septic suture lines among post partum mothers had been increasing between 2011 and 2013. Such infections were contributing to the currently unacceptably high maternal morbidity and mortality.

The objectives of the study were to establish factors contributing to the increase of septic suture lines among post partum women and assess the practices on IPC measures among health care providers in the maternity unit.

The study used a descriptive design and a convenient sampling method comprising of midwives, doctors, post natal mothers and ancillary staff constituted a sample size of 108. Data collection methods included focus group discussions, face to face interviews, nursing audits, observation on procedures and a review of patients' records.

The study findings indicated that the measure problems were associated with failure by the staff to follow specified guidelines and procedures. These included:
Poor adherence to IPC measures and guidelines by nurses/midwives and doctors.
-Poor spacing of patients' beds
-Improper use of gloves.
-Uncontrolled movement of equipment in and out of theatre
-Poor documentation of procedures
-All infected cases were operated at night although by different doctors
-Absence of Focal IPC person in the departments
-Mothers not given health education on hand washing and wound care
-Pre-existing infections among patients
-Poor documentation on discharge plan of mothers

Implications and recommendations were:
Re-activating the teaching on IPC sessions and promoting strict adherence to standard operating procedures and guidelines for pre-operative and post operative care and improving patients' knowledge of IPC.
The study conclusion was that increases in septic suture lines post caesarian section among mothers 18-35 years of age was due to lack of knowledge and malpractices.`

4.3 Parallel Session 3 – Health Systems Strengthening

There were five presentations in this session by Lenias Hwende, Dolorence Alaki Wakida, Rapinyana Ogah, Ukende Shala, Cynthia Chaibva and Doris Naitore

Lenias Hwenda presented the paper titled: Medicines for Africa- Going Beyond Philanthropy

As background to the presentation the author pointed out that over the next decade, the Africa region's growing health care demands will require approximately $30 billion in new investment. The constraints facing governments towards meeting this demand raises the necessity of governments to engage partners who can contribute to necessary solutions. The private sector already makes a significant contribution to health care across the region. The level of participation by the Sector is influenced by the capabilities of the public sector and the government's view of its role in health development. Constructive engagement coupled with the appropriate checks and balances to ensure accountability could create shared value towards solving pressing medicines challenge facing countries by leveraging the strengths of partners.

The aim of the was to build partnerships between governments, the local and global private sector to collaborate on sustainable solutions to meeting growing demand in medicines in African countries.
Preliminary work to create partnerships between African governments and the medical and technology industry, which synergize the strengths of partners to solve poor access to medicines focused on assessing feasibility of such partnerships. A consultative process with stakeholders to determine potential interest in the partnership amongst partners led to a meeting convened between the African Group Ambassadors and representatives of the industry in July 2013.

The conclusion was that the meeting established the interest of both partners to engage in areas of shared value. Progress has been made towards forming a consortium of like-minded private sector partners interested in the agenda of improving access to medicines in African countries. Ongoing projects include a platform for innovation and access to medicines in African countries being developed in collaboration with the WHO, with the support of the International Finance Corporation.

Mrs Dolorence Alaki Wakida, Principal of the Public Health Nursing School, Kampala-Uganda presented a paper titled: **The Extent to which Factors within the Work Environment of Health Institutions in Uganda Affect the Performance of their staff and therefore, the performance of these Institutions**

The study set out to establish the extent to which factors within the work environment of health institutions in Uganda had affected the performance of these institutions. It was guided by four objectives which included: ascertaining the factors within the work environment that facilitated performance; how effective the identified performance management practices used to manage performance; how effective the identified performance management practices were in enhancing performance and what health workers required in their work environment in order to contribute to better performance.

The Study was undertaken in Mulago National Referral and Teaching Hospital in Kampala using a self-administered questionnaire to the employees, an interview guide; Focus group Discussions and consumers of health services were also interviewed. The data collected was analyzed using the Statistical Package for Social Scientists (SPSS). The hypotheses of the study were verified using the Pearson Product Moment Correlation based on certain conditions that described the data.

The study findings were that a number of management practices were used in measuring performance. However, though these practices were identified as important, the results from their measurements were not made known to the health workers by their supervisors and had therefore affected the employees' recognition of the value enshrined in these practices. The idea of involving employees in decision-making was neglected yet it was important as it promotes sharing of ideas, consultation and general cooperation that would eventually motivate workers and therefore improve performance.

The study results indicated that there was a relationship between factors within the work environment and performance and that employees needed to obtain results generated from continuous assessment. The element of performance management practices has a strong correlation with worker and organizational performance.

Ukende Shalla et al from Tanzania presented a paper titled **"Tracking Human Resources for Health from Pre- service Nurse Midwifery Programmes in Tanzania."**

The graduating midwives had been trained in BEmONC and Interpersonal communications and there fore the sponsors wanted to find out where the graduands were placed after completing the programme.
In 2009 data collection forms sent to all schools requesting student: names, addresses phone numbers emails, anticipated places of employment. A total of 1440 students graduating in 2009 from 53 numbers of schools provided contact information. The follow up survey administered in 2010 asked 18 quantitative and qualitative questions, including 1) Participants' current workplace; 2) Primary responsibilities at work and 3) Incentives for working in rural settings, among others.
The survey was administered using phones, 3 fulltime phone operators were employed for two months.
The study results were that out of the 984 graduates interviewed one year after graduation 95.3% were employed in a health facility. Reasons for unemployment were,: 1) Returning to school; 2) unable to find a job and 3) caring for a sick relative.
Lessons learned were that50% of the nurses returned to their original stations after completing the midwifery course and that the majorityare employed within a year after completing the Midwifery course.

Dr. Mabel, K. M.Magowe[1] et al from the University of Botswana, School of Nursing presented the study entitled: **Expected Roles of Nurses and Midwives by Key Informants in Botswana.**

The paper presented the results of a qualitative study that explored the perceived tasks and roles of nurses and midwives, by key informants, in Botswana, in order to contribute to the development of a culturally relevant Sub- Saharan nursing and midwifery practice model.
The method used was a cross sectional qualitative descriptive study, which was part of regional study involving Sub-Saharan African countries. Respondents were patients, community leaders, and nurse-leaders, selected from different settings in Botswana by purposive sampling based on eligibility criteria, who participated in focus group discussions. Permission was received from the local institutional review boards. Participants signed a written consent form, completed a 16-item demographic questionnaire and engaged in focus group discussions. Qualitative data were textually analyzed to generate themes and subthemes, supported by excerpts from participants' responses.

Respondents stated that nurses and midwives were the backbone of the health care system in Botswana, operating at different levels of the system, with dependent, interdependent and independent roles. They expected nurses to be respective, welcoming, and respectful, compassionate to patients and be knowledgeable about their work. They identified that nurses have caring, leadership, supervision, mentoring and managerial roles. Tasks expected from nurses included basic nursing, and other roles beyond that would be normally expected of other health workers, because *"the nurse is often the sole health care provider out there".*

Implications of the findings are that nurses are often the only personnel in remote areas and therefore, expected to perform more duties than those specified in their scope of practice and

training curricula. Hence curricula and regulation should be reviewed so that nurses take additional roles independently and be remunerated accordingly.

Ukende Shalla, et al presented a paper titled Tracking Human Resources for Health from Pre-Service Nurse Midwifery Programs in Tanzania: Where do they go?
The purpose of the study was to follow up nurse-midwifery graduates who had benefited from the strengthened FANC curriculum including training of tutors on BEmONC and Interpersonal communication. These tutors have transferred knowledge and skills to students. Jhpiego as the sponsor of the programmes that the tutors had undertaken wanted to know the eventual placement of the tutors following completion of the programme.

The study objectives were:
1. To identify where graduates are posted after graduating from colleges and
2. To find out the percentage of graduates working in maternal and newborn health departments.

The findings were that of the 984 graduates interviewed, 95.3% reported being employed in a health facility one year after graduation. Reasons for unemployment were returning to school, unable to find a job, and caring for self or sick family member. Sixty five percent worked in a government-run facility, 70.1% in hospitals and 91.8% were in service delivery.
Lesson learned were that:

50 percent of graduates return to their previous working station after graduation
26 percent were employed after one month after graduation
17 percent were employed between 1-5 months after graduation
6 percent were employed between 6-12 months after graduation

Dr Cynthia Chaibva et al from National University of Science and Technology, Faculty of Medicine presented a paper entitled**: Needs Assessment: A process towards nursing programmes at the National University of Science and Technology (NUST)**

Nursing education has a professional and ethical obligation to meet the needs of its learners, clients and society and should be held accountable for the outcomes of the educational interventions. Logical and systematic approaches to curriculum development can help identify the desired programmes and subsequently design need driven curricula. The institutions of higher learning recognize the critical role they should play in facilitating the attainment of the MDGs through capacitating the various cadres in the health sector as a means of addressing the skilled human resource crisis.

The purpose of the needs assessment study was to determine the training needs of stakeholders in the health sector in order to initiate desired nursing programmes and provide capacity development through designing need driven curricula. The Faculty of Medicine within the institution had in previous years confined the training to medical doctors only.

One hundred and thirty three (133) purposefully selected stakeholders completed self-reporting questionnaires. Ninety one percent (91.7%) supported the introduction of the nursing programmes at the National University of Science and Technology (NUST). Dissemination and streamlining of the results through participatory workshops and consultations confirmed the need

for nursing programmes. Specialization in midwifery, leadership and management, mental health and public health were cited as priority programmes at both undergraduate and postgraduate levels.

The conclusion was that there was strong evidence that NUST should consider the process of initiating nursing programmes as the institution exists to contribute positively towards the advancement of humanity through the provision of knowledge-based solutions to scientific, social and health challenges.

D. Naitore et al presented a paper titled: **Kenya General Nursing Assessment of Tasks and Competency in HIV Care and Treatment.**
As background the authors pointed out that Kenya has significant shortages of health workers and consequently nurses are assuming an expanded role in HIV care. However, the current nurses' scope of practice in Kenya does not mirror these expanded roles. Similarly, the current Kenya nurse training curricula have not been revised to reflect the expanded roles of nurses. The quality of HIV care offered by nurses may be compromised if nurses perform task shift without proper training. The objective of this assessment was therefore, to identify discrepancies between nursing education and competence in HIV care.

This was a cross- sectional survey of nurses providing HIV care services was conducted in four public health facilities in Kenya using a modified WHO HIV nurse tasks assessment tool. The frequency of performed tasks Related to HIV care, their training and self-perceived competency were analyzed. Tasks performed by <40% of nurses and deemed an important/expected nursing task was classified as a gap. Training and competency gaps were also identified when >5% of nurses performing the se tasks reported not having received training in the task or if nurses did not feel competent to perform the task.

From the results, one hundred and sixty-eight (168) nurses were surveyed. Major gaps in training were identified in the clinical management of HIV, including the management of opportunistic infections and ordering and interpretation laboratory tests; provision of isoniazid preventive therapy was also a gap. In the management of antiretroviral therapy (ART), gaps were identified in the management of adverse drug events and treatment failure. Additionally, widespread training and competency gaps were identified in the clinical management of HIV in people who use drugs. No major gaps were identified in the management of HIV in pregnant women.
The study conclusion was that the findings characterize the broad scope of work Kenyan nurses perform in offering HIV care and identified key gaps in training and competency amongst nurses offering HIV care. The findings provide essential information to inform national policy and revision of the nurse training curriculum.

4. Wednesday 3rd September, 2014 Parallel Sessions Continued

Parallel Sessions covered three sub-themes as follows:
Sessions 1 and 4: Promoting maternal and child health
Sessions 2 and 5: Innovations and excellence in nursing and midwifery
Sessions 3 and 6: Strengthening nursing and midwifery education

4.4 Parallel Session 1- Promoting Maternal and Child Health

There were eight presentations in this Session by Scholastica Chibehe et al, Rose Mnzava et al, Sheillah Matinhure et al, Dr Fatma Suleiman and Dorcas Jidayi et al, Lillian Nuwabaine, Mavis Nxumalo, Rose Katumba and Stembile Mugore

Rose Mnzava et al presented the study titled Adaptation of Focused Antenatal Care Model: Improving Quality of ANC Services in Tanzania.

As background to the study the author pointed out that antenatal care (ANC) is a widely used strategy to improve the health of pregnant women and to encourage skilled care during childbirth. The Ministry of Health of the United Republic of Tanzania developed a national adaptation plan based on the new model of the World Health Organization. Jhpiego through MAISHA program in collaboration with the Ministry of Health achieved building Focused Antenatal Care capacity of frontline health care workers and supervisors including Pre-service education curriculum by ensuring the model is included in to the national curricula. ANC Quality Improvement tool among other guidelines was integrated to a six day Focused ANC training to empower providers and supervisors with knowledge and skills and to conduct self, internal and external assessments for quality care.

All health facilities providing RCH clinic are providing Focused Antenatal Care. In 2010 and 2012 Quality of care study on ANC conducted showed remarkable improvement on ANC services provided from MAISHA supported health facilities and included counseling on IPTp, preventative services; FE/FO, screening for pre eclampsia and danger signs.

Fifty (50) health facilities requested external verification after they had reached 70% and 35 (70%) health facilities received national recognition guided by the National Recognition Guidelines for Health Care Quality Improvement in June 2013.

Recommendations:

-Increase number of qualified health personnel for ANC and other maternal health services to promote efficiency and better outcomes for the services being delivered to mothers during ANC, delivery, and postnatal period.

-Improve supportive supervision, coaching and mentoring to support high quality provision of care.

-Strengthen linkages between health care facilities with community to improve quality of care.

Ms Sheillah Matinhure[1] et al presented a paper titled: **Improving Health Coverage: Lesotho Nurses and Midwives Taking the Lead**

The presenter highlighted that Lesotho is a very mountainous country with a population of 1.8 million, a maternal mortality ratio (MMR) of 1155 per 100,000 live births and HIV prevalence of 23.2%. A total of 46 clinics are extremely hard to reach, 9 of which are only accessible on horse back or by aero plane. According to WHO, Lesotho has fewer than the recommended density of 2.3 health workers per 1000 population. Contributory factors include weak HRH recruitment processes, low hiring rate of quality staff and unattractive salary packages. Of the total health workforce, only 20% of the formal health work force worked at primary care level. This situation resulted in poor delivery of services at Health Centre level. Currently, Lesotho is revitalizing Primary Health Care and also attempting to meet the MDG targets. The HRH crisis was hampering these efforts. HRAA decided to work with the Ministry of Health to embark on an

intensive advocacy campaign for creation of posts and recruitment and retention of nurses for the 46 health centers in hard to reach areas.

Methodology

In 2012, HRAA embarked on activities to engender political commitment, policy-maker engagement and partners' support. High level meetings attended by the Principal Secretaries of relevant sector Ministries were convened. These resulted in the expansion of nurses' establishment for hard to reach facilities by creation of 183 posts, securing a retention package of both financial and non financial incentives from donors and obtaining government commitment to take over the retention package for sustainability. In order to accelerate recruitment, HRAA conducted media campaigns advertising vacant posts and encouraging all unemployed nurses to apply.

Results of the advocacy activities

The results of the activities were that in February 2014, HRAA used the Human Resource Information System tool to assess the impact of the advocacy efforts in accelerated recruitment process. Since the sights of focus were hard to reach areas, the HRIS team had to use the airplanes provided by the Lesotho Flying Doctors (Figure5). Currently, 74% of health centers have a full staff complement of 5 (one clinical nursing officer, 2 nursing sisters and 2 nursing assistants). All the created posts had been filled. This greatly improved access to health care services and contributed to the new focus of revitalizing Primary Health Care.

Lessons Learnt

Recruitment, placement and retention of nurses in hard to reach areas is possible if: High level commitment is cultivated. Advocacy efforts are sustained to encourage nurses to continue to apply for the available posts. Innovative recruitment strategies are implemented, retention package improved, mobilization & motivation of nurses is sustained, Partnerships are engendered and, the Public demand for improved services is achievable.

Dorcas Jidayi et al presented a paper titled: Empowering midwives on the management of Eclampsia: The case of Tanzania

Beginning in 2010, Comprehensive Community Based Rehabilitation in Tanzania's (CCBRTM) Maternal and Newborn Health programme embarked on a project to build capacity and improve quality at hospitals and health centres in Dar es Salaam. It partnered with the Regional Health Management Team (RHMT) to target sixteen public health facilities in Dar es Salaam.

The objectives of the project were to improve the quality of maternal and new born care at sixteen sites, focusing on improving Basic Emergency Obstetric and Newborn Care (BEmONC) skills among health staff. Of particular importance was the management of eclampsia as it was the number one cause of death in 2013 in the Dares Salaam region.

Using the national register (MTUHA), data was collected from three quarters in 2013on the causes of maternal death, specifically focusing on eclampsia. This data was shared with the hospital management and maternal department supervisors. Consequently, common module and methodology of teaching was created at the beginning of 2014 and implemented in April 2014. Preceptors were selected for training on the management of eclampsia, and they were tasked with coaching and mentoring the midwives and doctors at their respective sites.

Results

Sbmr scores showing increases/decreases in eclampsia management

Discussion, Conclusions, Recommendations

It is too early to say whether the training program has led to an increase in diagnosis and effective treatment of eclampsia. On-the-job training and coaching did help raise competency of the health staff. It is important to ensure that members of health staff are competent in best practices for care. Continuing professional development is an imperative for ensuring that health staff receive up-to-date training. The midwives were receptive to these trainings because they were empowered to manage eclampsia more effectively.

Lilian Nuwabaine, Intern BSN Nurse, Makerere University presented a paper titled: **Factors influencing willingness to use Intrauterine Contraceptive Device among Women of Reproductive age in Rwengwe Sub County, Buhweju District, Uganda**

As background to the presentation, the author pointed out that general contraceptive prevalence rate of Uganda has remained low (30%) and currently, only 26% of women are using modern methods of family planning (UDHS, 2011). Despite the fact that the intrauterine contraceptive device (IUCD) is very safe and highly effective (WHO, 2010; Katz *et al.,* 2012), it is used by only 0.4% of Ugandan women (UDHS, 2011). Therefore, due to low utilization of IUCDs, this study sought to understand the factors influencing women's willingness to use IUCDs.

The objectives of the research was to assess factors influencing the willingness to use IUCDs specifically the individual factors and social factors among women of reproductive age in order to increase their willingness to use IUCDs through increase of family planning programs.
A cross sectional study using quantitative method of data collection was employed to obtain information from women of reproductive age in Rwengwe Sub County, Buhweju district. The study respondents were selected using convenient sampling method. Written informed consent was obtained and participants interviewed using a questionnaire and the study was voluntary.

Results in this study indicated that majority of the participants 195 (59.1%) were not willing to use an IUCD. Also, general CPR for family planning in this study was 46.2% and the one for modern methods of family planning was 25.9%. However, IUCD was used by only 1.7% of the participants hence indicating an unmet need of use of long term methods of family planning. Statistically significant individual factors influencing willingness to use IUCD at multivariate analysis were; education level, occupation, it prevents pregnancy once inserted; has side effects of menstrual irregularities; heavy menstrual bleeding and only the following social factors were found to be statistically significant at multivariate analysis.

The study conclusion was that irrespective of the mass education programs on the long term methods of family planning like an IUCD, few women were willing to use it. According to this study, the following factors were found to be influencing willingness to use IUCD; educational level, occupation, side effects of menstrual irregularities and heavy menstrual bleeding.

Mavis P. Nxumalo from Swaziland presented a paper titled: **Community Dialogue in the Causes of Maternal Death.**

This paper aimed at summarizing a six weeks technical Support in developing Millennium Development Goal 5 Accelerated Framework (MAF) Country Plan of Action since August 2013. This assignment was preceded by a community dialogue for better understanding of the opinion of communities on the causes of maternal and neonatal mortality rate in Swaziland.

Methodology adopted **in** addressing Community Dialogue was conducted in eight hard to reach rural communities that were randomly selected in the four regions. Focus group discussions were held with women and men of childbearing ages.

The findings from the dialogue revealed that the causes of maternal mortality were observed to be beyond the client and out side the sphere of the Ministry of Health. It also confirmed that most mothers still deliver at home whist some deliver on their way to health facility. Other causes cited ranged from family structure, myths and misconceptions, poverty, socio-economic/socio-cultural issues, absence of waiting huts, road infrastructure and communication net-work.

The results of the community dialogue revealed that the issues were outside the mandate of the MOH and hence the need to link the key issues with the responsible sector so that they have a buy in and participate in the development of the Country Plan of Action for MAF. Identified Ministries that had a stake in MNCH included almost all Govt. Ministries Sectors, Civic Societies, NGOs and the Private sector.

In conclusion, the assessment was an eye opener as it opened doors for working together with other Ministries for the country to yield great impact in reducing maternal and neonatal mortality rates in Swaziland as the CARMMA slogan says, *"**No Woman Should Die While Giving a Life."***

Mrs Rose Katumba from the office of the Director of Nursing Services Ministry of Health and Child Care, Zimbabwe, presented a paper titled**: Public Awareness on the Maternal and Neonatal Mortality Prevention Strategies.**

Introducing the presentation Mrs Katumba pointed out that maternal and neonatal mortality rates in Africa, Zimbabwe included are unacceptably high despite most of the causes of death being avoidable. Midwives provide essential care for women and newborns aimed at meeting the Millennium Development Goals 4 and 5. The Nursing and Midwifery Department within the Ministry of Health and Child Care took an undertaking at the 2013 Harare Agricultural Show to create public awareness on maternal and neonatal mortality.

The objectives of the undertaking were to create awareness on the causes and prevention of maternal and neonatal deaths, to stimulate discussions on ways of preventing further maternal deaths and to explain the role of the Midwife in the provision of maternal and child health services.

Posters on pregnancy and Midwifery activities displayed in a cubicle were used to stimulate discussions with the public who visited the cubicle. The guests were then requested to give comments in the guest book. The comments were analyzed thematically.

One hundred and forty three (143) people visited the Nursing stand and forty three (43) gave comments.

The public appreciated the information given commenting that 'such awareness should go beyond exhibition'. Men asked a lot of questions to clarify maternity problems that affected their relatives while females gave their birthing and hospital experiences which were mainly negative, for example, delay in attending to women in labour. Some positive contributions were given by men to create awareness at small group church meetings and through drama.

The Public recommended midwives to give detailed information at clinics and hospitals, more nurses to be added to clinics, to select and train nurses who are passionate about the profession, nurses attitudes to improve and not to use cell phones when on duty.
The conclusion reached was that public awareness and engagement should be intensified and midwives should display a positive and competent image.

4.5 Parallel Session 2-Innovations and excellence in Nursing and Midwifery

There were 9 presentations in this session made by Linnet Mulinya, Odongo Odiyo, Gertrude Chipungu, Safina Kisu Musene, Dr Lakshmi Rajeswaran, Sarah Burje, Evelyn Chilemba, Ivan Mwebaza and Paul Mageza

Linnet Mulinya, Senior Nursing Officer and MPH Student at Moi University School of Medicine Nairobi Kenya presented a paper titled: **The role of E-health in the delivery of quality, safe and efficient health care services in Kenya: Review of published literature on e/m-Health in Kenya**
Health systems in Kenya continue to face considerable challenges in providing high-quality affordable and universally accessible care. This review looked at the extent to which e-health strategies and policies were implemented in Kenya including identifying specific areas where e-health has been used to enhance issues of quality, equity, effectiveness and efficiency in the delivery of health services and also the gaps and challenges in the implementation of e-health policies & strategies with the aim of making key recommendations to policy and decision makers.

The four objectives of the review were:
1. Assess the comprehensiveness and inclusiveness of the e-health policies, guidelines and strategies to support implementation of e-health in Kenya
2. Determine the capacity and extent of preparedness of the Ministry of Health in Kenya in implementation of the e-strategy & Policies
3. To determine the factors that enhances effectiveness of e-health strategy on quality of health service delivery in Kenya.
The review was conducted between December 2013 and March 2014 and focused on published and unpublished literature in journals, bulletins and articles. It involved use of internet engines such as Pubmed, Google and Hinari.

The findings of the review were that the Ministry of Health, Kenya is among the few Ministries in the Region with an e-health strategy which has largely remained unimplemented. Implementation of e/m-health activities in Kenya is fragmented. Most of the e/m health interventions have focused on health information systems, health promotion, disease surveillance and human resources for health with little focus on e-learning which is still lagging behind.

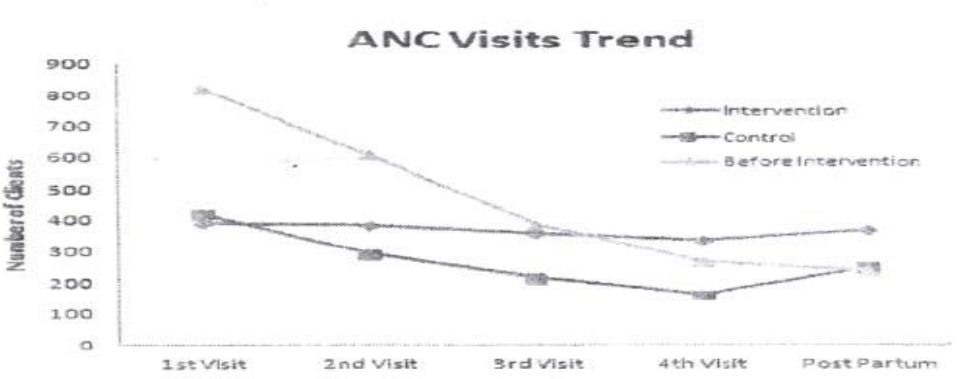
The conclusion and implications are that progress has been made in Kenya on the e-health front but there still remain several challenges that include coverage, training, curricula, awareness, legislation partnerships and infrastructure among others.

Odongo Odiyo presented the study entitled: "The use of mobile cell phone technology in supporting FANC in Kenya".

Many communities in the developing world own mobile phones, whose use has been shown to improve quality of health care. Involvement of male partners in healthcare is an important approach in the improvement of pregnancy outcome. Such involvement facilitates the release of resources that are then used to support the care of the pregnant women. It also enhances their interest in the care of their partners during pregnancy and childbirth.

The purpose of the study was to determine whether the use of mobile phone would improve MNCH services; and facilitate the participation of male partners to improve the MNCH.

In the intervention group mothers and their male partners were recruited along the lines of ownership of the mobile phone, and willingness of the male partner to participate in the care of woman through pregnancy, child birth and post partum period. Short messages were sent to the couples through mobile phones reminding them of the subsequent visit. Coded messages were also regularly sent to educate them on progress and expectations of pregnancy. Intervention took place in 5 EmONC facilities. 5 other facilities acted as controls. 391 women were recruited for the intervention sites and 420 in the first control. Follow-up was done for 15 months. Both quantitative and qualitative methods were used to collect data. Data and content analysis used SPSS software.
The findings were that before the intervention, only 33% of women in the control group attended the 4th antenatal visit, compared with 86% in the intervention group; and only 29% of mothers attended the post natal care compared to 95% in the intervention group. The study further demonstrated that those mothers who attended the 4th antenatal visit had 94% chance of skilled facility delivery.



The conclusion and programme implications are that Mobile phone use in pregnancy and childbirth facilitates constructive male partner involvement significantly, improves the FANC visits, skilled facility delivery and post natal care.

Safinah Kisu Museene from Jinja School of Nursing and Midwifery presented a paper entitled: Preceptors' clinical teaching practices at a Regional Referral Hospital in Uganda.

Health service provision in Uganda comprises public and private sectors with a central and decentralized approach under the district and health sub districts, (Ministry of Health, 2010a). There are thirteen regional referral hospitals, two national referral hospitals and several other

referral and district hospitals under the government of Uganda and private sector (Ministry of Health, 2010a). Four out of the 38 fully accredited nursing training institutions in Uganda, acquire their clinical competencies from preceptors working at Jinja regional referral hospital. The study was conducted to describe the preceptors' clinical teaching practices of pre-registration nursing students at Jinja regional Referral hospital in Uganda.

The Objectives of the study were:
Describe the current nursing preceptors' clinical teaching practices at Jinja regional referral hospital
Describe current pre-registration nursing students' satisfaction in terms of clinical teaching by preceptors at Jinja regional Referral hospital
The study methods used were a cross sectional survey of the current preceptor clinical teaching practices and nursing students' perception of the nursing preceptors' clinical teaching practices was done

The results of the study were that Nursing as a practice is an outcome of clinical teaching and learning which is facilitated by preceptors. During the process of providing clinical services to patients, nurses precept nursing students (service and education). It is important to initiate a program for nursing preceptors which will equip them with knowledge and skills to conduct clinical teaching. A program that will be friendly to their work requirements.
The conclusion and implications are that Nursing and Midwives Council of Uganda can build on the findings to ensure that deliberate move of preparing preceptors for clinical teaching is implemented.

Gertrude Chipungu, et al from the Department of Nursing, Mzuzu University, Malawi presented a paper entitled: Model Wards as a Means to Improve Clinical Teaching/Learning of Nursing and Midwifery Students in Malawi.

Pre-service nursing students spend between 50-60% of their time in clinical settings developing the requisite knowledge, skills and attitudes for competent nursing practice. The quality of the clinical learning environment is a significant bottleneck to increasing the production of sufficient numbers of nurses to competently address health challenges in Malawi. Clinical wards frequently lacked essential clinical supplies and resources for training, were overloaded with students and had insufficient numbers of registered nurses to supervise clinical learning and act as role models for students.

In partnership with the Department of Nursing at Mzuzu University and the Ministry of Health, ICAP Columbia University Coordinating Center for the PEPFAR-funded Nursing Education Partnership Initiative developed model teaching wards at four of the country's teaching hospitals to strengthen the clinical learning and teaching environment.

A model ward development team, lead by Mzuzu University, developed a multi-level approach for establishing model teaching wards. This approach involved extensive engagement with stakeholders; gap analysis of the ward learning environment and resources; development of professional practice guidelines for clinical practice; preceptorship training for the clinical nurses on the wards; procurement of clinical supplies and equipment for the wards; and the establishment of a clinical placement coordination forum with clinical services and faculty.

Lessons learned

Students' acquisition of clinical competencies and professional behavior is closely tied to the quality of the clinical teaching environment. Strengthening the capacity of clinical wards to provide quality clinical education requires intensive collaboration between the clinical nurses, hospital management and education faculty at each stage of development.

Conclusion

Anecdotal reports from students, clinical services and faculty suggest these model wards have improved the quality of teaching, learning and most importantly, patient care. A systematic evaluation will contribute robust evidence for this innovation, informing best practices in clinical teaching in Malawi.

Dr Lakshmi Rajeswaran, Sarah Burje, Evelyn Chilemba, Ivan Mwebaza and Paul Mageza

Dr. Lakshmi Rajeswaran, Lecturer in Nursing, presented a paper titled: **The Influence of Culture on Health**

Nursing is a profession that the society has vested with a very challenging role of maintaining the health of individuals, families and communities. Caring within nursing is a complex process that involves not only the knowledge but also the intellectual and analytical ability of the nurse to relate relevant and culturally appropriate knowledge in the delivery of health care. Providing quality care cannot be possible without considering the context of the client as a whole person and the associated factors such as culture, beliefs and traditions.

Description of the topic

Caring exists in all cultures but how it is carried, out and interpreted should be culturally applicable and relevant. Since nurses interact with clients and families from various cultural backgrounds, it is important that nurses understand their cultural values and beliefs in order to provide holistic care. Recent trends migration and globalization have a tremendous influence on nursing care.

Nurses are in a period of great mobility and exchange, and they interact with people from all over the world. This poses the greatest challenge to nursing profession that demands nurses to expand their role in trans-cultural nursing. Accommodating trans-cultural issues in nursing care is an innovative method of contributing to the enhancement of excellence in nursing care. This creates awareness among nurses to improve the quality of health care.

Conclusion

This concept paper highlights the cultural issues that may arise in delivering care with special focus on the third world countries. Integrating Trans-cultural Nursing concepts into nursing and midwifery curriculum will contribute to achieve culturally congruent holistic care.

Elizabeth Oywer and Sarah Burje, from Nursing Council of Kenya, presented a paper titled: **Review of Nursing Council of Kenya Regulatory Tools to achieve Quality and Safety**

The presenter outlined the main purpose of regulations as quality and safety. These can be achieved if the students and practitioners alike have regulatory tools against which their practice can be benchmarked and safety to patients is guaranteed. Nursing Council reviewed its regulatory tools including the standards of nursing education and practice document. The tools are aligned to the Kenya Constitution and the amended Nurses Act (2012)

The objectives of the exercise were:
-To ensure nursing education programs are appropriate and adequate in preparing nurses to join the profession and
-To foster continuing improvements in nursing education and practice.

The National Nurses Association of Kenya (NNAK), responding to a call from ICN to develop standards, put in place a committee to work on the same. This project never took off. A time came when the Council needed to start officially accrediting institutions for training nurses. This had to be done using objective measurement. NNAK therefore, approached partners to develop the standards. Consultative meetings took place. Extensive literature review was also undertaken to learn what has been done elsewhere. A workshop was held with stakeholders, then finalization done by NNAK and NCK.

Results/Lessons Learnt
Standards of education and practice were developed which can be used first of all to accredit nurse training Institutions and secondly to guide practice. These standards include: Curriculum resources and facilities; Continuing Professional Development (CPD); provision of care including emergency treatment; occupational safety and private practice
Documented standards are essential for safe practice: Effective regulators need to revise their tools regularly and align them to changes in nursing and health in general.

Evelyn Chilemba, Lecturer, Kamuzu College of Nursing, Lilongwe Malawi presented a paper titled: **Preferred learning styles among graduate nurses in Malawi.**

The growing concerns among stakeholders in Malawi that graduate nurses are not well prepared for practice, points to possible deficiencies in the undergraduate nursing education processes. Learning for optimal performance in practice requires learners to use diverse learning styles in an effort to advance deep learning. Learning styles are crucial for learning engagement if student-centred learning is to be promoted among learners. Lack of diversity in use of learning styles is a factor that might imbed deep-learning for the development of cognitive abilities.

The objective of the study was to determine learning styles employed by the graduate nurses during the BSN programme.
A two-phased cross sectional sequential explanatory mixed research design was used to investigate the learning processes of graduate nurses. Sample size of 235 graduate nurses who qualified from Kamuzu College of Nursing, were invited participate. Data was collected using the Grasha-Reichmann Learning Style Scales. MS Excel was used to quantify the items of learning styles which were later entered on the statistical package SPSS Version16.0 and descriptive statistics were computed.

The study findings were that the most dominant and preferred learning style among graduate nurses' is the Competitive Learning Style ((x= 3.98; SD=0.52), followed by Avoidant Learning Style ((x=3.88; SD=0.68t); these are teacher-centred learning styles. There was also lack of diversity in the use of learning styles resulting in learner dependence and minimal learning involvement among the learners. Least preferred learning style was the Independent Learning Style (x= 2.84; SD=0.80).

The recommendation is the need to promote diverse learning styles are advocated for in the BSN programme by designing curricular benchmarks that integrates Socratic and facilitative teaching methods to promote diversity of learning styles among graduate nurses.

Ivan Mwebaza et al from the Department of Medical Microbiology, College of Health Sciences, Makerere University, Kampala, Uganda presented a paper titled: **Nurses' Knowledge, Practices, and Barriers in Care of Patients with Pressure Ulcers in a Ugandan Teaching Hospital**

Pressure ulcers have been identified as one of the major burdens of long hospitalization all over the world. There are several reasons why their proper prevention and management should be one of the nursing care priorities. The most common reason is that disease conditions which are associated with pressure ulcers are on increase. This means such patients are more likely to get pressure ulcers and their consequences are sepsis, tissue destruction and increasing in hospital costs. Nurses are usually at the fore front of preventing pressure ulcers in clients who are under their care.

The purpose of this study was to determine the nurses' knowledge and practices regarding risk factors, prevention and management of pressure ulcers at a teaching hospital in Uganda.

The objectives of the study were:

- To determine the nurses knowledge about the risk factors, prevention strategies and management of pressure ulcers.
- To determine the Nurses practices towards prevention and management of pressure ulcers during their routine care of patients.
- To identify the barriers that hinder nurses to put in practice their skills and knowledge towards the prevention and management of pressure ulcers.

The study employed a descriptive cross-sectional design. Fifty-six Ugandan registered practicing nurses were sampled. A composite self-administered questionnaire and an observation check list were utilized.

Study findings were that the nurses had limited knowledge about critical parameters of pressure ulcers. Prevention practices were observed to be unreliable, uncoordinated and related to a significant shortage of staff and logistics for pressure ulcer prevention. Lack of education and poor access to literature about pressure ulcers were also cited as barriers to proper management of pressure ulcers.

The study conclusion is that translation of nurses' knowledge into practice is possible if barriers like staff shortage, pressure relieving devices provision, and risk assessment tools are addressed at Mulago.

Programme implications: The nurse training schools and universities need to examine their curricula to address issues related to pressure ulcers prevention and treatment. Hospitals also need to devote more resources to prevent and manage pressure ulcers. Professional bodies should also provide continuous nursing education and continuous medical education to staff about pressure ulcers.

Paul Magesa from School of Nurse Teachers Muhimbili, Ministry of Health and Social Welfare presented a paper titled: **Factors affecting mental health nursing practice in Tanzania**.

Introduction

Introducing his presentation the author stated that recently, hospital management teams have experienced and received reports that are highly suggestive of elements of inadequate mental

health care. Adverse events such as patient killing one another in the psychiatric wards are one among incidences that indicate the degree or severity of deterioration of the quality of mental health practice. Limited infrastructure makes patients cared for in a non-therapeutic milieu; non-conducive working environment for nurses, including high work load, creating more demands from patients and their significant others. These factors compromise the quality of care provided and this affects the motivational factors for nurses working in mental health care. Understanding factors affecting mental health practice will be vital in correcting this anomaly.

The objective of the study was to determine factors affecting mental health nursing practice in Tanzania.
The study method was a descriptive qualitative design at Mirembe National Hospital for Mental Health and Muhimbili National Hospital. Twenty seven nurses participated in providing information through focused group discussions and in depth interviews. Sixteen of the nurses were from Muhimbili and 11 nurses were from Mirembe National Hospital. In addition, 10 Charge Nurses and Managers were involved in filling up the institutional quality assessment tool. Sessions were audio recorded, transcribed, analyzed and translated.

The study findings were as follows:
-Un-conducive working environment was the main factor
- Low motivation among nursing staff,
-Lack of on job training for a longtime,
- Limited infrastructure in mental health facilities,
- High workload, unguaranteed safety at work place, and nursing leadership in mental health units affected performance.

- Other factors included shortage of qualified nurses trained in mental health
- limited treatment modalities, poor environments for hospitalized patients,
- inadequate funding of mental health services and absence of community mental health nursing.
- Also it was found that the quality of care was below standard.

Conclusion and Recommendations

There is an urgent need for the government to provide adequate budget for financing mental health services that could enable hospital managements to improve the working environment, motivate nurses and increase their interest in their work. It is also important to have effective community mental health nursing and training for nurses working in mental health settings. Mental health nursing requires well-trained and competent nurses.

4.6 Parallel Session 3: Strengthening Nursing and Midwifery Education

There were 9 presentations made during this session by Rose Ndlovu, T. Bvumbwe, Mpho Shelile, David Ngilangwa, Stella Kamphinda, Nthabiseng Molise, Priscar Mkonda, Edward Makondo and Jules Bashi.

Rose Ndlovu and CMZ Chasokela, Director of Nursing Services, et al presented a paper titled: The Curriculum Review of the Zimbabwe Midwifery Diploma.

Zimbabwe Ministry of Health and Child Care seeks to accelerate attainment of the MDGs 4, 5 and 6 by reducing maternal, newborn and child morbidity and mortality through a competent midwifery workforce among its key interventions. Such competency requires that the curriculum be relevant and responsive to the changing needs of society and in keeping with modern trends and practices.

Rationale for the curriculum review was:

-To systematically incorporate new areas of responsibility, approaches, strategies and treatments such as, Zimbabwe Maternal and Neonatal Roadmap guidelines, PMTCT, Nurse prescribed ART, Post abortion care, Revised protocols for Childhood immunizations ,T.B, Malaria in pregnancy, Newer methods/trends in FP. etc.

-To ensure alignment with societal needs, regional and international standards and ICM Competency guidelines.

The Approach, Steps and Processes

The review was conducted in a participatory and interactive manner beginning with a Situation Analysis that included a desk review of documents and literature followed by a sensitization and stakeholders' consultation workshop and solicitation of inputs. Other activities to promote inclusiveness were site visits to Midwifery schools and clinical practice areas for continuing consultations. Focus group discussions were held with practicing midwives of various grades including recent graduates. The deliberations included re-affirmation of the Vision, Mission , Philosophy ,Values and expected exit competencies.

Compilation of the Curriculum

Expected exit competencies were guided by ICM Essential Competencies for Basic Midwifery Practice Document outlining the 7 competencies including the required knowledge, skills and or abilities. Up to date references were compiled and other teaching aids requirements to support the teaching and learning activities.

Recommendations and the way forward were that:

- Classroom educators to maintain clinical competence by being in the clinical area regularly as specified in the job descriptions.
- Practice setting based Clinical Instructors to have regular opportunities to update theory especially in new areas
- Strengthen teaching approaches that promote self directed learning, integration of theory and practice and accommodation of different learning styles.
- Educators knowledge and skills in the use of IT to be updated on a continuing basis.
- Availability of equipment and supplies to be looked into- Competency assessments are difficult where there is shortage of requirements
- Staffing- All units to have Midwifery qualified staff-These make appropriate Role models and Mentors
- Efforts be made to ensure recommended student teacher ratios in the clinical areas.

A three day workshop with stakeholders (Matrons, Tutors, Clinical supervisors and some junior midwives} was held and the draft curriculum was shared. Further refinements were made before finalizing document.

T. Bvumbwe presented a paper entitled: Bridging the theory practice gap: Insights from clinical preceptors at Mzuzu University, Malawi.

Clinical experience is essential for nursing education and professional socialization. Malawi has an average ratio of 1 clinical preceptor to 40 students, compared to the Council-approved ratio of 1:10 for the clinical settings. The shortages of well-prepared clinical teachers undermine the quality of clinical teaching and learning experiences and student acquisition of clinical competencies. Mzuzu University offers a six-week university certificate course in clinical preceptor ship to prepare experienced registered nurses to teach, supervise and support students and serve as a clinical role model for pre-service students in developing competence and confidence.

Description of the project

Course evaluations were conducted for the first two cohorts to ensure the course's fidelity with overall objectives and to inform planning for the 2014 course. Preceptors discussed their experiences with the learning process, the knowledge and skills they gained, and the changes they anticipate in their performance as preceptors, which will bridge the theory-practice gap. Level one of Kirkpatrick's approach to evaluating training and education was applied to measure learning satisfaction. The course coordinator summarized the discussion and obtained verbal permission from participants to use their in put in disseminating information about the course.

The findings were that participants viewed the course content and structure favorably and made suggestions for how Preceptor-ship theory could be further integrated into their supervised practice. They felt the course increased their knowledge and skills and fostered a positive attitude towards teaching and students.

The conclusion was that clinical preceptor course was received favorably. There is a need to measure learning outcomes and job performance amongst the preceptors in, order to determine the effectiveness of the program.

Title: Mpho Shelile presented a paper entitled: Strengthening Clinical Environment in Nursing and Midwifery Education: The Nursing Education Partnership Initiative (NEPI) Clinical Simulation Program in Lesotho.

Lesotho has the third highest HIV prevalence in the world at 23%, and a maternal mortality ratio twice the global average at 620 per 10000 live births. The nursing shortages are acute with 0.49 nurse-midwives (NM) per 1000 population. Increasing the number of qualified NM providing clinical care especially in rural areas may reduce HIV-and pregnancy-related morbidity and mortality. Limited clinical placement sites and opportunities for supervised clinical practice have constrained the productive capacities of pre-service institutions.

In partnership with the Ministry of Health, ICAP-Columbia University Coordinating Center for the PEPFAR- funded NEPI developed a clinical simulation program in Lesotho to enhance acquisition of clinical competencies by NM and bridge the theory and practice gap.

Clinical simulation in Lesotho was designed to provide students with a learning environment in which mistakes can be made and learning takes place without the risk of harming the patient. A systematic approach included review of curricula; building of scenarios/case studies for the required skills; defining minimum criteria for learners to move to the clinical setting.

Lessons learned

Clinical simulation allows all students to gain experience in critical competencies that might be difficult for them to develop in real life due to limited clinical practicum settings. It promotes the integration of evidence to practice, increases student confidence, and improves problem solving and clinical reasoning.

The study conclusion was that Clinical simulation will increase the capacity of NM entering the work force to provide competent care. Many institutions are investing significantly in this method. The NEPI advocates for the need to apply a systematic and evidence based approach for effective implementation of this intervention in low resource settings.

Stella Kamphinda et al presented a paper titled: Standards for Nursing and Midwifery Education in Malawi: Promoting Quality in Nursing and Midwifery Education

The need for standards in nursing and midwifery education has risen globally as a result of the complexities in health service delivery systems, increasing numbers of health professionals at different levels, variations in the type and duration of education programmes and the need to ensure more equitable access to quality health care. In 2006, the World Health Assembly (WHA) called for the development of global and national standards for the initial education of nurses and midwives to ensure a minimum quality of nursing and midwifery education.

ICAP-Columbia University -Coordinating Center for the PEPFAR-funded Nursing Education Partnership Initiative (NEPI) in collaboration with the Nurses and Midwives Council of Malawi (NMCM) and the Ministry of Health developed nursing and midwifery education standards to serve as a benchmark for moving educational institutions towards a common competency based education in unison with global requirements to ensure the provision of quality nursing and midwifery services in Malawi.

Description of the Project

Standards for nursing and midwifery education programmes were prescribed for ten categories including mission, philosophy and objectives, educational programme, academic faculty, educational resources, governance and administration, student selection, admission and support, assessment of students, programme evaluation, quality assurance and research and evidence. Each of the standards categories has indicators that guide in bench marking achievement.

Lessons learned were that the development and application of the standards among training institutions has allowed for immediate intervention and capacity building, ensured education is relevant to the needs of the population, improved quality assurance and performance mechanisms and facilitated ongoing development of nursing and midwifery education through continuous dialogue and feedback.

In conclusion, establishment of standards to promote quality in nursing and midwifery education in Malawi will serve as leverage in the production of sufficient numbers of well trained, clinically competent graduates, building a high quality nursing and midwifery workforce for strengthened health systems.

Nthabiseng Molise presented a paper titled: **The Nursing Education Partnership Initiative: Lesotho's experience of transforming midwifery education from a content based to a competency base curriculum.**

Lesotho has a population of 1.8 million. Mountainous terrain poses challenge to access facilities and hospitals; thus the importance of ensuring competent nurse midwives to practice independently.
Midwifery education compulsory based on terrain and status of maternal mortality ratio– 1,155/100, 000 LB.
Translating theory into practice was a considerable challenge for midwifery education in Lesotho with attention given to addressing the theory practice gap. Many newly graduated midwives entered clinical settings unable to translate classroom learning into "real life" clinical practice. The one year post basic diploma in midwifery curriculum was transformed to prepare nurse midwives to provide relevant competency based midwifery care aimed at contributing to improved maternal and child health.

The Lesotho Ministry of Health in partnership with ICAP Colombia University Coordinating Centre for the NEPI in Lesotho supported the Nursing schools to transform the content based curriculum for one year post basic diploma in Midwifery to one that was competency based in order to enable graduate midwives to attain clinical competencies to offer effective life saving midwifery services.
Lesotho followed a multi-phased participatory approach to the development of midwifery competency based curriculum. An assessment was undertaken to determine the level of readiness and the abilities of faculty to implement the approach. Subsequently the competencies outlined by the International Confederation of Midwives and guidelines for curriculum developments from the World Health Organization were adapted. The CBC and study guides were developed underpinned by learning principles of constructivism, authenticity, of clinical competencies, scaffolding and constructive alignment. Assessments of competencies were aligned with academic and professional regulatory standards. Innovative methods including clinical simulation and clinical residency programmes in hard to reach areas were implemented to strengthen acquisition of clinical competencies.

Lessons learned were that to change to CBC faculty had to change from lecture centred to student centered approach with the student assuming the lead in the learning process. Faculty training in CBC and the introduction of clinical residency programme supported this shift.
In conclusion CBC will prepare nurse midwives to competently address health challenges facing women during pregnancy, childbirth and the post partum period in Lesotho.

Priscar Sakala Mukonka et al from the School of Midwifery University Teaching Hospital in Lusaka presented the paper entitled "The **Role of Institutional Collaboration in Improving Nurse Education Experience of Lusaka Scholl of Nursing in Zambia."**

Lusaka School of Nursing is the biggest Nurse education institution in Zambia and the institution now offers seven programmes as follows: -Operating theatre school, midwifery, nurse-midwifery, critical care nursing, clinical instructor Nursing, HIV nurse practitioner, Paediatrics and child health nursing.
It is part of the Malawi Zambia Finland co-operation (MaZaFi). The cooperation has six partners namely Helsinki Metropolia and Karelia Universities of Applied Sciences in Finland, Kamuzu College of Nursing and Malawi College of Health Sciences and Lusaka School of Nursing and Livingstone School of Nursing and Midwifery in Zambia. The project is sponsored by the Finish Ministry of Foreign Affairs through the Center for International mobility (CIMO) and it is

managed by Helsinki Metropolia University of Applied Sciences through an international coordinator.

The main goal of the project is to produce a competent practitioner who will provide quality to the clients in accordance with the needs of the country. This has been achieved through promotion of nurse midwifery education in partner institutions.
The school (Teachers and students) has hosted and also attended network meetings, intensive courses and Exchange programmes at home and also in Partner countries. The school is also organizing in collaboration with the Partners an international conference on care of cancer patients to be held in March 2015. Evidence based practice and Clinical Tutoring have been the broad themes of the intensive courses.

The results of the collaborations have been improved knowledge for both teachers and students I Evidence Based Practice, Teachers, students and Clinical staff are conducting Action Research to improve practice. Journal clubs are being conducted once a month. There is improvement in reading culture by Clinical staff. Better care for the cancer patients as a result of the international conference which the school will host in March 2015 through the collaboration.
The programme implication and conclusion is that evidence based Nursing Education has improved the quality of care rendered to patients in Zambia.

Dr Edward Makondo, Deputy Director Nurse Training and Administration Ministry of Health and Child Care presented a paper entitled: **An evaluation of the programme for the Diploma in Nursing Administration in Zimbabwe.**
The purpose of the study was to identify the strengths and weaknesses in the programme and make the necessary changes. Stufflebeam's Evaluation Model was the design used for the study.
Questionnaires were sent to 228 nurses who completed the programme and 165 nurses responded. All six Nurse Tutors, al1 6 guest lecturers involved in the teaching of the programme and 34 Matrons who supervised nurses who completed the program were interviewed. Descriptive statistics were used to analyze the data.
Components indicated as being highly relevant and to be retained included management of health services. Unit budgetary control measures in hospital cost benefit analysis in health care, labour Relations, health sector reforms, patient/clients rights, health care personnel rights and strategic planning.

Recommendations made included computer literacy for all candidates enrolled in the programme; the Sociology course to include issues on gender .Resources required to strengthen the teaching to include a purpose built school, six full time Nurse Educators, up to date textbooks and journals, a vehicle and fax facility.
The Nurse Tutors and the majority of matrons expressed satisfaction with the general performance of the nurses who completed the course. Recommendations were made were that graduands should work under supervision of experienced nurse managers for a period of at least three months to consolidate what they learnt in the programme.

Kramo Yao, and Jule Bashi et al presented a paper titled: **Reforming nursing and midwifery education in Cote d'ivoire: Introducing the License-Master-Doctorate" System at INFAS**
The West African Health Organization (WAHO) an ECOWAS health agency is guiding implementation of the 'License-Master-Doctorate (LMD) reform in nursing and midwifery

education in the sub-region to enable diploma equivalence at the interactional level. The national nursing school (INFAS) in Cote d'ivoire is revising its 'License' educational program and conducting a project at its Korhogo satellite campus.

Background

Strengthen INFAS Korhogo in production and maintenance of a skilled nurse/midwife workforce by improving pre-service education quality and sharing innovative models.

Description of the Project

ICAP Columbia University's PEPFAR-funded Global Nursing Capacity Building Program is supporting the transition to a LMD system. During academic year 2013-2014, a national Technical Working Group is implementing the project through: a) preparation of an annual work plan, staff recruitment, and a baseline assessment; b) implementation with revision of academic and clinical education tools, training teachers (INFAS faculty) and clinical mentors (at health facilities for students' internship) in new teaching techniques and mentorship, revising the clinical mentors' guide and students' training portfolio, equipping clinical skills laboratories; c) evaluation of how mentorship affects nurses'/midwives' knowledge/skills, quantity/quality/impact of support provided for pre-service training and policies/practice for improving retention of students/faculty/nurses/midwives.

Lessons Learned are that as of March 2014, the training portfolio was revised into a single document for the 'License' training duration. This model enables teacher/clinical mentor/student to have on going follow-up of acquired clinical skills. Training sessions on LMD teaching and mentoring techniques were realized for 11 teachers and 100 clinical mentors. Close and harmonious collaboration between INFAS and health facilities is crucial for a successful competency-based training system. Documentation access and student self-education were improved by a permanent internet connection.

Program Implications of this project paves the way for the expansion of the innovative LMD system for nurses/midwives to all INFAS institutions and other regional structures, making INFAS a regional pioneer.

5. Poster Presentations

Poster Title and Description	Name and country of Presenter
1.The role of male involvement in reducing maternal mortality	Agnes Mpota
2. The impact of using a modified Ministry of Health Traditional Birth Attendant training curriculum on the infection prevention, knowledge, practice and attitude of traditional birth attendants in Chongwe District of Zambia.	Dorothy Chanda
3.Intent to stay in the nursing profession and associate factors among nurses working in referral hospitals, Amhara Regional State, Ethiopia	Eshetu Haileselassie
4.The Role of National Council for Higher Education in Ensuring	DolorenceAlaki Wakida

Quality of Nursing and Midwifery Training...	
5. Improving Quality Nursing and Midwifery Care through facility visits: Lessons from Botswana...	Opelo Mercy Rankopo
6. Realizing Nursing Process through reflection..	Anne Kabimba Wawire
7. Improving nursing and midwifery care delivery through transforming professional conduct...	Hannah Mmamokgatla Kau-Kigo
8. Nursing education and practice: a global collaborative project for Botswana...	L.Raieswaran and K. Dithole
9. The role of spirituality in coping with HIV/AIDS in Gaborone Botswana...	Ogar Rapinyana
10. Addressing the gaps in Nursing and Midwifery Care Documentation..	David Wambua
11. Quality of TB/HIV care as perceived by patients in the municipal clinics in Bulawayo …	Sithokozile Hove Zimbabwe
12. The role of Nutrition in the reduction of Child Mortality….	Florence Mulenga Swaziland
13. The role of Midwives in the Management and Care of Women diagnosed with Post Partum Mental Disorders admitted at MTRH, Eldoret	Ann Kabinda Wawire. Kenya
14. Barriers to Antiretroviral Therapy for adolescents living with HIV Infections and AIDS reporting at Chitungwidza Central Hospital Opportunist infections Clinic.	Mr Pisirai Ndarukwa Zimbabwe

6. Recommendations of the 11th Scientific Conference and 5th Quadrennial General Meeting of ECSACON (1st -5th, September 2014)

Preamble

The 11th Scientific Conference and 5th Quadrennial General Meeting of the East, Central and Southern African College of Nursing (ECSACON) was held at the Rainbow Towers Hotel, in Harare, Zimbabwe from 1st to 5th September , 2014, under the theme: "***Increasing access to quality nursing and midwifery care: Nurses and Midwives Taking the Leading Role."*** The four subthemes were: **"***Improving Maternal, New born and Child Health", "Health Systems Strengthening", "Innovations and Excellence in Nursing and Midwifery" and "Evidence Based Primary Health Care Practices /Approaches"*. The deliberations and discussions were shared through plenary presentations, parallel sessions and discussions.

The Conference concurred that nurses and midwives constitute 60 to 80% of health human resources in almost all the ECSA countries and that they are the main category of professional health care providers found at all levels the national health care delivery systems. This unique position is where nurses and midwives derive their strength and defines their key role in improving access to quality health care provision to the majority of the population.

The major gaps towards providing effective health coverage were highlighted by the alarming statistics such as that:

- Maternal mortality rate is as high as 1500 maternal deaths per 100 000 deliveries,
- 85% of ECSA countries have a double digit neonatal mortality rare and only 14% have a single digit neonatal mortality rate
- 60% of those who have HIV/AIDS are women
- I woman every minute dies of cancer
- Highest unmet Family Planning is in the first 12 months post partum

The determination and conviction of the nurses and midwives was demonstrated through the high standard of presentations covering strategies, proposals, innovations and approaches to address the gaps within the health services. Innovations being undertaken by nurses and midwives are those that bring solutions to where people are rather than bringing people to solutions. They included such areas as:

- Increasing access to quality maternal, newborn and child health services through enhanced public private partnerships
- The role of E-health in the delivery of quality, safe and efficient health care services
- The use of mobile cell phone technology in supporting FANC
- Regional and international institutional collaborations and partnerships in Nursing education
- Model wards as a means to improve clinical teaching

- Family Planning and life skills among young people; FP needs Post partum, FP and Partner involvement. FP and increasing awareness, knowledge, choice.

Nurses and Midwives from the ECSA Region have demonstrated that they are ready to be the "change that they want to see" in their countries and region.

In order to support the many initiatives and commitments that nurses and midwives are undertaking and reported on during the deliberations of this conference, we make the following recommendations to the Ministers of Health in their capacities as representatives of our governments, the ECSACON Executive Committee and Council of National Representatives (CNR), ECSACON Chapters, Nursing Councils, National Nursing and Midwifery Associations, ECSACON Faculties, the ECSACON Secretariat and our Partners:

We recommend that:

1. the Ministers of Health,

1. Follow up and ensure that the countries are implementing the Standard practice package for expanding access to FP/MNCH services at the community level which the Health Ministers launched during their conference in February, 2014.

2. Support implementation of WHO recommended nurse patient staffing ratios by ensuring that the required posts are established in order to enable nurses and midwives to provide safe high quality care, reduce burn out and sustain motivation.

3. Continue to review the conditions of service for nurses and midwives in the region, taking cognizance of the nurse' and midwives' workload, the new emerging diseases, migration of nurses and midwives to the Diaspora and the additional responsibilities that have been added to the scopes of nursing and midwifery practice. All these have created increased demand for nursing and midwifery services and call for improved conditions of service.

4. Continue to support implementation of WHA 63.16 of May 2010- WHO Global Code of Practice on International Recruitment of Health Personnel which holds governments accountable to improve the conditions of service and to institute retention packages.

2. ECSACON Executive Committee and CNRs:

1. Undertake a survey to assess how member states have utilized ECSACON's two major Publications -Nursing and Midwifery Regulatory Framework (2001) and Handbook on Developing a Nursing and Midwifery Professional Regulatory Framework (2002). The focus of these publications is "defining Nursing and Midwifery competencies", "Developing Nursing and Midwifery standards of practice" and "developing scopes of practice for nursing and midwifery professions". If these documents have been effectively used by countries, they are now due for updating.

2. Set up a committee to work on the development and introduction of ECSACON Degree programmes for nurses and midwives and specify target dates for the completion of various stages of programme development. Degrees are to be offered in Nursing and Midwifery clinical specialty areas and related areas such as Health Human Resource Planning Development and Management.

3. Work in collaboration with the Ministries of Health, Regulatory Councils and ECSACON Secretariat to develop guidelines for establishing a database of nursing and midwifery expertise in the Region.

4. President's Report to include a summary of progress on the implementation of commendations made during the last Biennial and Quadrennial meetings.

5. At future Biennial and Quadrennial Conference, Poster Presentations should be allocated time alongside Parallel Sessions to ensure that they are well attended and fully articulated by the presenters.

6. Promote partnerships between countries to share and promote best practice in order to improve the quality of nursing and midwifery education and service in ECSA region.

3. National ECSACON Chapters & National Nurses and Midwives Associations:

1. Through the leadership of the CNR member continue recruitment of nurses and midwives to become active ECSACON members.
2. Strengthen Chapter fundraising activities in order to be able to conduct and sustain in-country and regional ECSACON activities.
3. Strengthen the link and working relationship between ECSACON Country Chapter and the National Nurses' Association since the aims and goals of both organizations are complementary
4. Maintain an inventory of paid up country ECSACON members and send the updated list to the Secretariat in March of each year.
5. Submit Activity reports to the Secretariat 3 months before the Biennial and Quadrennial meetings.

4. Regulatory Councils:

1. Work with the Secretariat to print ECSACON's Code of Ethics into a small booklet that nurses and midwives are able to carry around.

2. Work with the National Nurses Association to print the country's Nurses' and Midwives' Code of Ethics into a small booklet that nurses and midwives are able to carry around.

3. Device a system through which on initial registration every nurse or midwife would receive a copy of the country's Nurses and Midwives code of ethics.

4. Work with colleges of nursing and midwifery and other experts from clinical practice to develop CPD modules for nurses and midwives. Modules to be used for session presentations that are decentralized to all parts of the country to improve access to CPD especially for those working in rural health facilities and the private sector.

5. Work with Clinical Practice Faculty and Faculty of Education to develop policy guidelines on the expanded role of nurses and midwives in areas such as male medical circumcision and nurse led initiation and management of ART and outline the processes of integrating these activities in nursing and midwifery scopes of practice.

6. Develop and maintain a comprehensive data base of all active nurses and midwives registered by the country Regulatory Body including all their qualifications and current employment/ practice status.

5. Faculty of Clinical Practice:

7. Identify strategies for strengthening nursing and midwifery in key areas that include essential newborn care, nutrition and child mortality, postpartum family planning and improving access to modern family FP services.
8. Promote safe working environments for nurses and midwives and ensure adherence to Universal precautions guidelines and staffing ratios based on WHO guidelines.
9. Design and document models of care for the Region and the strategy for implementing evidence based practice.
10. Develop jointly with the faculty of Education E-learning programmes that are linked to nursing and midwifery clinical practice.
11. Follow up on promising clinical practice innovations presented at the Quadrennial Conference and determine the potential for replication in other ECSA countries Examples include "Use of mobile phones to support FANC", "Establishment of model wards", and "E-health in the delivery of safe, efficient quality care".
12. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

6. Faculty of Education:

8. Strengthen the nursing curriculum so that it addresses the issues of self image and perception building in order to prepare nurses and midwives who are confident, able and proud to maintain their nursing identity.
9. Promote self directed and life long learning among nurses and midwives through the development of learning modules on subject areas relevant for both pre-service and CPD programmes.
10. Strengthen communication and collaboration among educational institutions in the ECSA Region on issues of innovations in nursing and midwifery education.
11. Explore how the recently introduced Masters Degree in Midwifery in several ECSA member states can be conducted electronically so that it is accessible to more midwives in the Region.
12. Work together with the Faculty of Clinical Practice and the Regulatory Body to develop teaching material covering areas of the expanded nursing and midwifery scopes of practice

such as medical male circumcision and nurse led initiation and management of ART to be included in the pre-service nursing and midwifery curriculum.

13. Strengthen the teaching of Mental Health in the nursing and midwifery curricula as it has an impact on nurses' and midwives' attitudes.

14. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

7. Faculty of Leadership and Management:

7. Develop, support and promote approaches towards continuous quality improvement in nursing and midwifery practice.
8. Develop modules to strengthen the knowledge and skills of nurses and midwives in monitoring and evaluation based on set goals and targets.
9. Develop benchmarks for raising the standard of care based on identified centers of excellence in the Region.
10. Facilitate development of skills and tools for strengthening advocacy capability among nurses and midwives.
11. In collaboration with the Faculty of Clinical Practice, develop career paths that recognize and reward further education, training and experience for nurses in clinical practice.
12. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

8. Faculty of Research:

6. Continue efforts to build and strengthen research capacity including skills in the writing of scientific papers for publication by nurses and midwives at country and regional levels through mentoring and peer review support.
7. Identify and share research study findings and best practices from the region that may be replicated in other ECSA member states.
8. Develop research proposals and identify potential Partners for funding research activities within the region
9. Set targets for research study publications in refereed journals to be achieved by ECSACON members over specified periods and develop a system to monitor progress.
10. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

9. ECSACON Secretariat:

7. Ensure that ECSACON website is kept up to date with information and details of recent and upcoming ECSACON events and activities including global trends.
8. Work with ECSACON Chapters, to compile a list of all Nursing and Midwifery programmes available in each of the ECSA countries including admission requirements, period of study,

application procedures and fees payable and have this information on the ECSACON website.

9. Work with the ECSA Secretariat to ensure that these recommendations are considered at policy forums such as the DJCC and Health Ministers' Conference.
10. Coordinate resource mobilization and support from Partner organizations towards the implementation of the recommendations made at the Quadrennial Conference.
11. Coordinate the implementation of these recommendations through the various faculties and the CNR.
12. Prepare a plan of action with target dates for implementing the above recommendations and other planned activities by the Faculty.

10. ECSACON Partners and Supporters:

1. Continue to support the development of ECSACON programmes and the implementation of the above recommendations.
2. Keep ECSACON among your network of organizations to work with in the ECSA region.
3. Work with ECSA countries, the Secretariat and ECSACON to identify priority areas for collaboration.

7. The 5th Quadrennial General Meeting 4th -5th September, 2014

Thursday 4th September, 2014

Chairperson: Mrs Maleshoane Monethi Seeiso-ECSACON President

1. Delegates Register According to Faculties:
8:30-10:30 Conference delegates registered according to their Faculties (The four Faculties of Education, Clinical Practice, Leadership and Management and Research).This constituted a voters' roll document.

2. Meeting opened with a prayer from Ms Hagar Mapondera from Zimbabwe.
Chairperson invited delegates to stand for a minute of silence in memory of all the nurses and midwives who have passed on since our last quadrennial meeting.

3. Appointment of Rapporteurs:
Volunteers for the assignment were invited. Gustav Moyo from Tanzania and Dorothy Matebeni from South Africa volunteered.

3. CNR Committee Report on Resolutions

- Change of name of College from ECSACON to ECSACONM to include Midwifery
- Establishment of the Faculty of Regulation

4. Matters arising from the minutes of the 3rd Quadrennial General Meeting of ECSACON, 26- 27 August 2010

i) ECSACON Fellowship

The position paper on the ECSACON Fellowship Program was presented and endorsed. The draft guidelines for offering ECSACON Fellowships have been developed. The guidelines will be modified to suit the requirements for fellowships under the College of Health Sciences.

ii). Strategic plan

It was reported that the strategic plan was finalized and shared with countries for adoption. The current strategic plan ended in 2012.
There is a need to revise the strategic plan and develop another one for next five years.

iii). Activity report Presented by Sheillah Matinhure

iv. Midwifery project

The project was able to recruit the Midwifery Project coordinator who worked for two years. During her tenure in the office she managed to organize one regional meeting for midwifery tutors from universities that expressed interest to establish Masters Degree in midwifery.
The project provided technical assistance to universities embarking on establishing the Masters in Midwifery Degree programs.

v) Executive Committee meetings;

The need to have more face to face Executive Committee meetings was noted;

Two executive committee meetings were organized; one in August 2011 and another one in July 2014. During those meetings the major decisions made were;

- Endorsing the chairperson of the faculty of Research Ms. Mavis Nxumalo
- Selection of keynote speakers for Biennial Conference held in Mauritius in 2012 and the Quadrennial Meeting organized for Zimbabwe.
- Deliberated to invite Director General of ECSA Health Community as the member of Executive Committee of ECSACON in addition to being an Ex-officio member so that she/he takes the active role in major decisions.

vi) Fistula Care curriculum

The curriculum was finalized and launched during the ECSA Health Ministers Conference held in Arusha, Tanzania in 2013.

vii) Marketing ECSACON to non-members

It was noted that the current recruitment pace of new members is slow ; therefore, CNRs were reminded to be vigilant and to revitalize recruitment of members.

So far efforts have been made to recruit more members and even more countries. Namibia has been able to rejoin the college while South Sudan has finalized the process waiting for ratification by General Meeting. Rwanda is in the process of finalizing their efforts to join the college.

viii). Membership fee

The motion to increase membership fees was adopted.

ix) Venue and date for the next Scientific Conference and Quadrennial Meeting

The dates and venue were set. Kenya was supposed to host the 2012 Biennial Scientific Conference but declined along the way then Mauritius rescued the situation.

Reply: Kenya delegate apologized for the inconvenience and explained that they had declined to host the Scientific conference as the country was holding national elections. Kenya has now agreed to host the Biennial conference in 2016 and the Quadrennial conference in 2018.

x. Other Comments from the Floor

- Minutes from the 2010 meeting should have been e-mailed to delegates.
  Reply: Senior Programme Officer, Sheila Matinhure explained that the minutes were sent to CNR members.
- Could additional funding be sought to retain the position of the Midwifery coordinator?
  Reply: The Senior Programme Officer and the Midwifery Coordinator prepared and submitted proposals for funding.
- Are countries going to be involved in the development of the Strategic Plan? **Reply:** Yes, all the countries will be involved.
- A request was made to hold future conferences at venues that have tourist attractions such as the Victoria Falls.

- A question was raised as to whether the Professional Regulatory Framework should be revised and the answer given was that the Committee will work on the matter.
- Title of ECSACON. It has been proposed that the title of ECSACON be changed to ECSACONM in order to recognize midwifery.

Approval of the minutes: Mr Wakida proposed approval and Ms Nxumalo from Swaziland seconded.

5. President's Report for the Period 2010-2014- Mrs Maleshoane M. Seeiso

Report outline

a) Introduction
b) Capacity building activities
c) Collaborative activities
d) New membership
e) Conferences
f) Advocacy activities
g) College of Health Sciences
h) ECSACON Fellowships

a). Mandate of ECSACON: Strengthen nursing and midwifery education, practice, management, including leadership and research in order to effectively respond to health issues of the region.

Programme Objectives

i) Create a unified forum for nursing and midwifery to address professional and health issues.
ii) Promote reciprocity for licensure and practice and maximize utilization of scarce resources.
iii) Support production of relevant health learning materials.
iv) Respond to changing health needs based on operational research
v) Conduct appropriate and relevant capacity building activities
vi) Facilitate and encourage national, regional, international and interdisciplinary collaboration
vii) Formulate policies and rules for effective functioning of ECSACON.
viii) Provide leadership in nursing and midwifery in the ECSA region.

Activities of the College will contribute to meeting Strategic Objectives of the ECSACON Strategic Plan

- **Achievements: Information Generation & Documentation & Research**
  Produced and circulated ECSACON brochures and African Journal of Midwifery and Women's Health
- **Achievements: Institutional Capacity Strengthening- On Midwifery Programme**
  Obtained approval for a 2–year support for the post of a coordinator for the Masters in Midwifery and Women's Health programme.

Provided technical support to 5 universities in establishing the Masters in Midwifery program.
Organized the regional workshop for universities intended to initiate the masters in Midwifery Program.

- **Achievements: ECSACON Executive Committee meetings**
  Two ECSACON Executive Committee meetings were held:
  a) August 2011, June 2014
- **Achievements: ECSACON Conferences**

  Successful ECSACON Biennial and Quadrennial Scientific Conferences held:

  a) 10th Scientific Conference in Mauritius 2012
  b) 11th Scientific Conference here in Harare 2014
- **Achievements: Policies & Guidelines Development**
  a) Developed and disseminated the fistula care curriculum
  b) Developed the prototype Curriculum on Essential Newborn Care
  c) Developed framework on CPD through ARC
  d) Supported development of prototype curriculum on TB
- **Achievements: Capacity Building**
  a) Trained 22 TOTs in Fertility awareness methods of Family planning
  b) Trained more that 30 nurses and midwives in Helping Mothers Survive
  c) Trained more than 200 nurses tutors and clinical preceptors in Helping Babies Breathe
- **Achievements: Resource Mobilization**
  a) USAID/EA greatly supported this conference and many other programmatic activities including trainings.
  b) ARC has been able to support establishment and sustaining of the website.
  c) We have got support through Afya Bora fellowship to have the interns to support ECSACON
  d) More that $150,000 mobilized to support 10th Scientific Conference in Mauritius
- **Achievements: Network and Collaboration with other Organizations**
  a) Worked with Jhpiego in field testing the HMS training kits.
  b) Worked with WHO in developing Competency based generic curriculum for the Afro region.
  c) Worked with ICAP, Jhpiego, ARC, WHO etc in organizing 11th Scientific Conference.
- **Achievements: College of Health Sciences (CHS)**
  a) Participated in task force to establish the CHS
  b) Form part of the Senate of the College of Health Sciences
  c) ECSACON President Chairs the Administration Committee of the CHS
  d) The VP is the member of the Finance Committee of the CHS
  e) Fellowship Programme now to be guided by the CHS constitution

- **Way Forward**
  a) Design Regional short & Long courses for nurses and midwives
  b) Produce and market the African Journal of Midwifery and Women's Health and ECSACON newsletter
  c) ECSACON Fellowship
- **Challenges**
  a) Resources Constraints especially financial & human
  b) Increased disease burden
  c) Weakened Health Systems
  d) Curricula challenges

6. Application for ECSACON membership

6.1 The- application of South Sudan was considered- A motion for admission was proposed by Mabel Magowe of Botswana and seconded by Luke Kodambo of Kenya. South Sudan was accordingly welcomed as a new member of ECSACON.

6.2. Re-admission of Namibia as a member of ECSACON

The application for re-admission by Namibia was considered. A motion for admission was proposed by Khumbulani Mbuya of Zimbabwe and seconded by Wakida from Uganda. Namibia was duly re-admitted as a member of ECSACON.

6.3 Rwanda, Ethiopia and Angola also would like to become members of ECSACON and attended the 11th Scientific Conference and 5th Quadrennial Meeting as Observers. They still have to formally submit their applications for consideration as members.

7. Additional Information -ECSACON Website:

i). ARC has been sustaining the ECSACON website with funding.

ii).The meeting was informed that there are already on-line courses on the ECSACON website.

8. Financial Report for the period from 01st July 2013 to 30th June 2014 by Mr in 2013 **Julius Lee- ECSA Senior Accountant**

	Source of revenue	Amount in USD	
		2013/2014	2012/2013
1	Membership Registration and subscription	3,630	17,994

	fee – individual		
2	Membership subscription fee NNA/NNC	6,043	1,800
3	Conference registration fee	3,180	30,893
4	Hire of ECSACON gowns	0	100
5	Sale of souvenir	0	760
	Total income	**12,853**	**51,574**

	Description	**Amount in USD**	
		2013/2014	2012/2013
1	CNR and Scientific conferences	0	42,876
2	Salaries and allowance	0	3,603
3	Administrative costs	561	328
	Total expenditure	**561**	**46,806**

	Description	**Amount in USD**	
		2013/2014	2012/2013
1	Total Income	12,853	51,547
2	Less: Total Expenditure	561	46,806
3	Additional Funds during the year	12,292	4,741
4	Add: Funds brought forward from previous year	33,230	28,490
5	**Fund Balance At The End Of Financial Year**	**45,523**	**33,230**

	Description	**Amount in USD**	
		2013/2014	2012/2013
1	ECSA support to ECSACON office	62,086	64,911
2	**Program support**		
a)	ECSA HC	-	21,209
b)	USAID/EA	49,789	48,070
c)	Future group	-	5,000
d)	IPAS	-	5,000
e)	IRH	-	43,854
f)	JHPIEGO	-	10,000
	Total expenditure support	**111,875**	**198,044**

Observations made from the budget Presentation

I.) raising activities from within the organization are weak such that ECSACON relies heavily on funding from Partners and ECSA office in Arusha.

ii) Expenditure outstrips income by far

iii) ECSACON financial records are audited together with ECSA's head office records. It would

be too expensive for ECSACON to have its financial statement undertaken separately.

Adoption of the Financial Report-Proposal for acceptance by Mrs M. Mothobi from Zimbabwe and seconded by Dorothy from South Africa.

Friday, 5th September, 2014

Chairperson: Ms Cynthia Chasokela, ECSACON Vice President

1. Opening prayer: Dr Ruth Mkhonta from Swaziland

2. Briefing by the Zimbabwe Electoral Commission on the election procedures to be followed. They informed the delegates that the positions of President and Vice President were unopposed. Mrs Susan Otieno for President from Kenya and Gustav for Vice President from Tanzania were therefore duly elected.

Voting by Faculty was conducted by election monitors. The results of the elections were as follows:

8. Election of Office Bearers for the Period 2014-2018

The elections were held in accordance with the ECSACON Constitution, and the Zimbabwe Electoral Commission presiding. The following were duly elected:

President: Susan Agunda Otieno (Kenya)
Vice President- Mr Gustav Moyo-Tanzania

Faculty Chairpersons

Clinical Practice –Sarah Siyunda-Zambia
Education – Dolorence Wakida- Uganda
Leadership and Management – Marylin Msibi-Swaziland
Research – Cynthia Chaibva- Zimbabwe

CNRs

Botswana- Ms Keoagetse Kgwabi
Kenya – Mr Jeremiah Mainah
Lesotho –Ms Flavia Poka
Malawi – Ms Thokozile Lipato
Mauritius-Ms Haywontee Ramphul
Namibia- Awaiting nomination from country
Seychelles – Ms Gylian Mein
Swaziland- Ruth Mkhonta
South Sudan- Janet Michael
South Africa – Awaiting nomination from country
Tanzania – Ms Jamila Hamudu
Uganda –Ms Matte Florence Rita
Zambia – Ms Priscar Mukonda

Zimbabwe –Ms Regina Kanyemba

Faculties were given the time to elect Deputy Chair persons, Secretary and Treasurer.

9. Closing Ceremony of the 11th Scientific Conference and the 5th Quadrennial Meeting at the Rainbow Towers –Harare

Programme Director –Ms Khumbulani Mbuya
The programme commenced with the singing of the National Anthem led by student nurses from Parirenyatwa School of Nursing. Prayers were presented by Dr Wutaunashe and Safinah Kisu Museene

Director General Closing Remarks-

Read by Mr Ernest Manyawu, Director of Operations and Institutional Development. ECSA Health Community as the D.G. had to leave earlier.

He felt honored to participate in the Closing Ceremony on behalf of the DG- Prof Yoswa Dambisya who had to rush back to Arusha for other pressing matters.

He expressed appreciation to the Government of Zimbabwe, Ministry of Health and Child Care and the Local organizing Committee.

He noted that it was good to mention that, ECSACON is the first College which was established by the Conference of Health Ministers and operates under the auspices of ECSA Health Community. Indeed, ECSACON makes the ECSA Health Community proud.

On behalf of the Director General, he applauded the organizers for having organized such a high caliber Scientific Conference and a Quadrennial General Meeting that has now elected new ECSACON office bearers.

He noted that the College has come up with a number of pertinent recommendations to the DJCC, Health Ministers, Faculties and CNR and the Secretariat in the areas of Continuous Professional Development (CPD), including long and short term courses and specialization. Now, ECSA has the College of Health Sciences through which ECSACON can offer Fellowships in various specialties. The outgoing CNR was in the taskforce that established the CHS. ECSA will work with the new ECSACON CNR and will provide the necessary support to make this happen.

He also noted the recommendations on research. This is a recurring recommendation in your conferences. I believe there is a lot of research going on in your institutions of higher Learning. But where are these researches published? Every 2 years, ECSACON holds a Scientific Conference so where are the quality Abstracts presented here going to be published? Can ECSACON think of a Scientific Journal? He challenged ECSACON to really put a serious thought in that proposal.

As noted that this region is currently experiencing many health challenges, the recent threat being the Ebola in our neighboring region of West Africa, we all have to be vigilant and delegates were urged that as they return to their countries they should take up Nursing/Midwifery leading roles (as per the main theme of the conference) in putting systems in place to prevent this Epidemic or control it if it comes.

As ECSA, the contribution that ECSACON is making in various areas is appreciated such as those in:

- Accelerating achievement of MDGs
- Implementing Primary health care and
- Universal Health coverage to mention but a few.

He expressed gratitude to ECSACON President, ECSACON members and other nurses and midwives for their tremendous efforts in providing health services to the 200 million plus people of the region as nurses are found in all health care settings even in the most remote parts of the countries and under very difficult circumstances.

He noted with satisfaction that South Sudan and Namibia have made a crucial decision to join ECSACON. This has already created an entry point for ECSA HC to now work with these countries to join the Health Community

Currently, the active member states forming ECSA Health Community are; Kenya, Lesotho, Malawi, Mauritius, Seychelles, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Finally, he thanked the ECSACON Secretariat for their contribution in organizing this successful event and conveyed again ECSA Health Community's sincere gratitude to the Republic of Zimbabwe for being very supportive to ECSA Health Community and ECSACON in particular.

Parirenyatwa School of Nursing sang their farewell song for the Conference delegates.

Hand over Ceremony and Remarks by the outgoing ECSACON President- Mrs Maleshoane Monethi-Seeiso

. The handing over ceremony- transfer of power-(symbolized by the Presidential chain,) from the outgoing President to the incoming President followed after which the outgoing President made her final speech.

It is with great pleasure that I am giving these few closing remarks especially as I reflect the events of the past 7 days.

The outgoing President commenced her remarks by welcoming the Guest of Honour, Brigadier General Dr. Gerald Gwinji- The Permanent Secretary for Ministry of Health and expressed

appreciation to him that he made himself available for the Closing Ceremony despite his busy schedule.
She highlighted the major activities of the Conference and the General Meeting including the pre-conference activities. The pre-conference workshops and meetings were held in collaboration with partners during the first two days and they included the Satellite meeting on establishment of ECSACON website and CPD Library. The Website underscored the need to improve communication regionally and internationally amongst ECSACON members and collaborators. The CPD Library signifies commitment to Capacity building, and provision of quality of care in the region for the benefit of consumers of services.

Other Pre-conference activities included Practical application of the Family Planning Training Package, introducing Antenatal corticosteroids for women in preterm labor as well as disseminating State of World's Midwifery Report. These underscored the need for nurses and midwives to contribute towards improvement of maternal, newborn and child health outcomes.

On behalf of all ECSACON members she thanked the sponsors and organizers of the pre-conference activities.

She informed the Guest of Honor, that the 3-day Scientific Conference whose theme was: "Increasing access to quality nursing and midwifery care: Nurses and Midwives taking the Leading role." Had been very successful and achieved the intended objectives.

She noted with the ECSACON delegates felt very much honored and humbled to have had the world Nurse leaders to grace the conference. These were the President of the International Council of Nurses (ICN), the President of the International Confederation of Midwives (ICM) and the President of the Commonwealth Nurses and Midwives Federation and Nurse & Midwives' leaders from the WHO and JHPEGO. The Conference had also noted with satisfaction that there were nurses from Namibia, Angola, Cote Devoir and South Sudan. New members were also admitted to the ECSACON Family. These are South Sudan and Namibia. This shows the manner in which nurses and midwives are committed to collaboration, sharing of innovative ideas and high impact interventions, aspiring for excellence, provision of quality of care and contributing to universal health coverage.

The powerful keynote and sub-theme papers presented and high quality abstracts presented contributed to the success of the Conference.

The outgoing President expressed great appreciation for the support that received from the Government of Zimbabwe, The Ministry of Health and Child welfare and the tremendous support from the Nurses and Midwives of Zimbabwe led by the Director of Nursing Services – Ms. Chasokela, who has been the Vice President of ECSACON for the past four years. They were diligent, task focused professional, displayed ethical conduct and still managed to present abstracts and take leadership roles and responsibilities. We thank them very much.

Gratitude and appreciation is further extended to Partners who contributed immensely technically and financially towards the Scientific Conference. Without this support, it would

have been difficult to run a successful conference. High level of representation was received from USAID, Jhpiego and WHO.

ECSACON also wishes to particularly express appreciation and gratitude to the Director General of ECSA Health Community. Despite being new in the office, he prioritized ECSACON and came to support technically and financially to ensure the success of this conference.

Finally, the outgoing President acknowledged the support she received from the Members of the Council of National Representatives (CNRs) for the job well done, in overseeing some of the technical and administrative aspects of the conference. Without the support of the outgoing CNR, the term of office just completed would not been associated with the achievements witnessed over the past 4 years.

In conclusion, the outgoing President reaffirmed that, Nurses and Midwives are committed to providing holistic care to populations of the ECSA region. They need support from all the policy makers, Ministries and Governments. Without strong health systems, the effectiveness of nurses and midwives may not be realized to the full potential. The Conference has come up with pertinent recommendations that will be presented to the DJCC and HMC for consideration and ECSACON members are appealing for support as they intensify advocacy efforts for resources, conducive environments, better incentives that will enable nurses and midwives in the ECSA Region to carry out their mandate.

Acceptance Speech by Susan Agunda Otieno- New ECSACON President

Ms Susan Agunda Otieno, the new President thanked the delegates for the confidence that they have demonstrated in her by electing her unopposed as ECCSACON President for the period 2014-2018. She extended special thanks and appreciation to the outgoing President Mrs Maleshoane Monethi Seeiso and her team for the remarkable contribution they made in the last four years towards strengthening ECSACON.

She extended an invitation to all ECSACON members to support her and her team and to re-commit to Regional collaboration, cooperation and networking with other member states and organizations. She expressed her readiness to work with all stakeholders and to advocate for an enabling environment and policies that will strengthen nursing and midwifery education, practice, management and leadership and research for the improvement and delivery of quality health care to the ECSA Region communities.
In order to fulfill these ambitious goals resources are required. As President, she stands ready to listen to all the suggestions and or proposals that ECSACON members may bring forward to advance the organization's objectives.

She emphasized that ECSACON needs the older members for their experience and wisdom and the young ones for their energy. As President she will nurture passionately and encourage the young to carry the torch of the College. She will use her shoulders and height to lift the members of ECSACON high so that they can see far. The important role of unity of purpose towards the goals and planned activities was emphasized . Now is the time to unite and speak with one strong voice.

In conclusion, the President quoted the African proverb that says," If you want to go fast, go alone, if you want to go far go together". ECSACON will go far because all the members will move together. Long live ECSACON! Aluta Continua.

Closing Speech by Guest of Honour- Brigadier General Dr G. Gwinji- Permanent Secretary, Ministry of Health and Child Care

Dr Gwinji started by conveying warm greetings to all the delegates. He noted that the Government of Zimbabwe through the Ministry of Health and Child Care is pleased to have hosted this conference particularly because it coincides with the 40th Anniversary of the ECSA Health Community.

He expressed the hope that the delegates have had an enjoyable and safe stay in the country and encouraged those who are able to remain in the country for a few more days to take time to visit some of the well known tourist attractions such as the Victoria Falls, the Great Zimbabwe Monument and the Game Parks.

He noted with interest the Theme of the Conference which was: "Increasing access to quality nursing and midwifery care-Nursing and Midwives taking the leadership role". He is looking forward to receiving Conference Recommendations which will be supported through the ECSA governance structure which includes:

- ECSA Conference of Health Ministers
- The Advisory Committee
- The Directors' Joint Consultative Committee
- Programme Experts Committees
- The Secretariat which is headed by the Director General and is located in Arusha .

The Permanent Secretary pointed out that ECSA Community member states are concerned about migration of highly qualified health professionals from the Region to continents that offer better incentives. They have fought hard to get a resolution on WHO Global Code of Practice on the International Recruitment of Health Personnel. (WHA63.16, May 2010). He pointed out that this is a tool that nurses and midwives should be acquainted with and take advantage of as it holds governments accountable to improve their conditions of service and institute retention packages.

Dr Gwinji informed the delegates that ECSA Community governments have demonstrated political will in supporting Human resources initiatives. Health Ministers through the Health Ministers' Conference have passed a total of 13 resolutions addressing the plight of human resources for Health in aspects that include leadership, capacity building, retention, incentives, improved performance and excellence. Nurses and midwives form the bulk of such workforce

and without them, the health systems would collapse. So these resolutions are particularly directed towards nurses and midwives.

Dr Gwinji went further to appreciate all nurses and midwives for their commitment to remain in the region and provide services in the face of so many challenges. He urged nurses and midwives to continue to lobby and mount intensive advocacy to the Health Ministers conference so that conditions of service continue to improve. He also noted that ECSACON is yet to offer fellowship programmes. He promised to take it upon himself to advocate for support with his colleagues in their meetings and during the Health Ministers' Conference.

He congratulated the in-coming ECSACON CNR he looked forward to working with them.

Finally, he expressed his appreciation to the Local organising committee led by the DNS and outgoing Vice President of ECSACON, Ms. Cynthia Chasokela for excellent work in organising the Conference and seeing to the welfare of all the delegates. He concluded by wishing the delegates safe travel as they return to their countries and declared the meeting officially closed.

Vote of Thanks by Beauty Dube, Nurse Tutor, Gwanda Hospital School of Nursing

Ms Dube thanked all the delegates and acknowledged that their travelling to Zimbabwe entailed sacrifices of time and finances. She also thanked the governments of the participating countries who have continued to support ECSACON through their Ministries of Health, the Partners and Sponsors who have also provided support in different ways.

The delegates who gave presentations were also appreciated as they gave substance to the Conference. The various groups, organizations, teams and individuals were thanked for their contribution in making the 11th Scientific Conference and 5th Quadrennial Meeting a success- The Ministry of Health and Child Care was thanked for their unwavering support and for also sponsoring a number of nurses and midwives who would otherwise not been able to attend the Conference, the outgoing CNR team for their work over the last four years which included the holding of this Conference, the local organizing team under the leadership of the ECSACON Vice President who is also the Director of Nursing Services, Ministry of Health , Zimbabwe, the Rainbow Towers staff for their efficient hosting services and last but not least, the Parirenyatwa School of Nursing choir for spicing the Opening and Closing ceremonies with good music.

The closing prayers were given by Dr Wutaunashe and Ms Safinah Kisu Musene.

Meeting of the new and outgoing Executive Committee and CNRs.

Immediately after the closer of the 11th Scientific Conference and 5th Quadrennial meeting ,the new and outgoing Executive Committee and CNR's held their meeting.

Appendix 1: List of Participants by Country

East, Central and Southern Africa College of Nursing (ECSACON)
11TH Scientific Conference and 5th Quadrennial General Meeting
1st to 5th September 2014 Harare International Conference Centre; Harare

List of Delegates by country

Angola:

1. Dr Avelina Nalwendo
2. Prof Onorio Lucas
3. Dr Anna Dionisio
4. Joao Mayuke Muxidi
5. Edson Tavares
6. Elizabeth Mpunga

Botswana:

1. William M Baratedi
2. Victor Mokowe
3. Jane Mooketsi
4. Ruth Mokgetu
5. Opelo Mercy Rankopo
6. Khumo D Modisaeman
7. Fanny L Matimba
8. Keoagetse Kgwabi
9. Mabel Magowe
10. Tebogo Glan Tshenyego
11. Kelebogile Swity Molatlhegi
12. Ogar Rapinyana
13. Mosidi T Mokotedi
14. Morero Kgosintwa
15. Lakshmi Rajesoapan
16. Hannah Kan-Kigo

Ethiopia:

1. Eshetu Haileselassie Engeda

Kenya:

1. Philomena Maina
2. Rosemary Okova
3. Doris Naitore Mwenda – Odera
4. Trutea Misanya Munyendo
5. Jeremiah Mainah
6. Susan Nzisa Musuva
7. Pauline Bakibinga
8. Anne Kabimba Wawire
9. Agnes Wangechi Karuga
10. Luke Simba Kodambo
11. Elizabeth Oywer
12. Jostine Mutinda
13. Grace Miheso
14. Getrude Opiyo
15. Judith Symphirose A Wanyonyi
16. Agnes Waudo
17. Susan Otieno
18. David Wambua,

Lesotho:

1. Maleshoane Moneth-Seeiso
2. Tlalane Ramaili – Letsie
3. Flavia Moetsana – Poka
4. Reentseng Masakoane
5. Motlatsi Tsoeu
6. Makhabiso Ramphoma
7. Motsoari Sebonoano Malekhori
8. Adeline Chabela
9. Ann Molise Nthabiseng
10. Semakaleng H Phafoli
11. Lydia Keketsi Mokotso
12. Makholu Nthabeiseng Lebaka
13. Mpoeetsi Makau
14. Esabela Nyangu

Malawi:

1. Dr Bvumbwe
2. Getrude Chiupungu
3. Agness Timonge Mpota
4. Flemmings Nkhandwe
5. Stella Kamphinda
6. Elizabeth Mpunga

Mauritius:

1. Lochun Sunilduth
2. Ramchandensighn Purushutuu
3. Adhin Anil
4. Sawock Ajaysingh
5. Ramphul Haywontee
6. Aubeeluuz Sookarum
7. Sookun Ravindranath
8. Sookun Waheda

Seychelles:

1. Martha Faure

South Africa:

1. Mrs …..
2. Heather Sam
3. Prof Christa Vander Watt
4. Dr Nonhlanhla Makhanya
5. Dorothy Matebeni
6. Anthony Vassen

South Sudan:

1. Judith Cenie Ondogo
2. Marinasilvio Ajeng
3. Cecilia Raphael Drobila
4. Janet K Michael

Swaziland

1. Sthembile M Motsa
2. Mavis P Nxumalo
3. Thembi Phetsile Dlamini
4. Catherine J Sihlongonyame
5. Nkosazana Ruth Mkhonta
6. Isabella Zwane
7. Msibi Marilyn Michaeline
8. Eunice S Hhalaza
9. Nomathemba C Nxumalo
10. Cynthia H Dlamini
11. Phumelele Dlamini
12. Dr Sifiso I Sithole
13. Nomsa Magagula
14. Mummcy Dlamini Mashwama
15. Nkosinathi Rejoice Nkwanyana (nee Maphalala)
16. Margaret Lubhedze
17. Sakhile Khetsiwe Salome Masuku
18. Nonhlanhla A Sukati

Tanzania:

1. Maarite R F Wamai
2. Cecilia Singiwe Ngoma
3. Edna Kalikwenda Kajuna
4. Hania Johansen Bwahamo
5. Flora Anderson Kimaro
6. Lillian S Kiungai
7. Redemptha Matindi Kabunduguru
8. Mercy David Lyimo
9. Dr Rita Mutayoba
10. Loveluck Mwasha
11. Bridgita Joseph Furaja
12. Angelina Sepeku
13. Mark Owino Ogweyo
14. Judith N Msagati
15. Francisca Materini Kwezi
16. Joyce Alicen Kalafya
17. Grander Mutapa
18. Paul Magesa

19. Irene Gilbert Chilewa
20. Mariam A Kinshagah
21. Brenda Mhiso Kitali
22. Dafrosa W Mzava
23. Mary Joseph Lyanga
24. Bernadina Rambau
25. Ziada J Sellah
26. Johari Yusufu
27. Nusura Simba Kessy
28. Rahel Rajabu Mshana
29. Neemaeli Samuel Mbisa
30. Faustina Kissinde
31. Mary John Christopher
32. Agnes Nambeye Hassan
33. Uwezo Theresa Nkomolla
34. Mwanaid Ndazi
35. Ipyana A Miller
36. Halima Nambole Bantu
37. Melina Evani Lumambo
38. Athimani Saidi Kasase
39. Fridah L Mwakiposa
40. Josephine Lwambuka
41. Dorcas Paul Jidayi
42. Robert Aloyce Mallya
43. Mwajuma Mussa Mwihumbo
44. Gandiosa Tibaijuka
45. Hadija A Mkuwa
46. Beatus H Lukona
47. Bridgitte Lucas Mungwe
48. Lena Mfalila
49. Redemptha Matindi Kabunduguru
50. Cecilia Evarest Mushi
51. Salome A Kassanga
52. Joan Wilbert Karomba
53. Fatuma M Kanuti
54. Agness Lazaro Laizer
55. Bertha Aloyce Matiya
56. Gerwalda P Mumba
57. Meckitrida Mashauri Ngorongo
58. Joyce Kahamba Mwambije

Uganda:

1. Patrick Kibirango Mpiima
2. Margaret Nnalubowa Kidega
3. Kyaligonza Atwoki David
4. Masereua Zakayo Black
5. Atim Joyce Lucy
6. Twikirize Jeniffer
7. Annet Natalia Seebugenyi
8. Hellen Dhugira
9. Catherine Betty Odeke
10. Betty Kemigisha
11. Naikesa Robinah Modoi
12. Wakidu John Kennedy
13. Helen Mukakarisa Kataratambi
14. Janet D Obuni
15. Annet Dolorence Mamirembe
16. Sr Stella Josephine Namatovu
17. Christine Nsobuga Namubiru
18. Museene Kisu Safinais

ZAMBIA:

1. Ruth Mzumala
2. Loyce Munthali
3. Lastina Tembo Lwatula
4. Fredah Mulusa
5. Theresa Sikayo
6. Mable Mwape Kabwe
7. Exilda I Sumbukeni
8. Ristica Rose Ziwa Phiri
9. Mwinga N Tulosi
10. Emily S Chipaya
11. Florence Mulenga
12. Olive Ngandu
13. Inutu Mbangweta
14. Bertha Kaluba

15. Judith Chulumanda
16. Agnes M Sitanzye
17. Maliwa Elizabeth Mwiinga
18. Mercy Chibende
19. Martha Ndhlovu
20. Cecilia Ngoma
21. Joyce M Chongo (Mulilo)
22. Priscar Sakala Mukonka
23. Col Pauline Nkoloma
24. Eleanor Judith Msidi
25. Peggy Chibuye
26. Ndubu M Milapo
27. Catherine M Ngoma
28. Mary Louisa Zimba
29. Jennifer Munsaka
30. Regina Yeta
31. Lillian Mphuka
32. Beatrice Zulu
33. Josephine W Mubita
34. Bupe Mumbi

Zimbabwe:

1. Cynthia M. Z.Chasokela
2. Muriel Mothobi
3. Regina Piano Smith
4. Regina Nsipa Kanyemba
5. Mbuya Khumbulani
6. Irene Rugare Sambo
7. Cynthia W. Chaibva
8. Lilian Gertrude Dodzo
9. Rose Ndlovu
10. Helen Mavhaire
11. Judith Audrey Chamisa
12. Rose Mary Katumba
13. Clara Spiwe Nondo
14. Patricia Mbetu
15. Rumbidzai Mugwagwa
16. Zvemoyo Jeri
17. Sekai Shoko
18. Beauty Mberi
19. Victoria Chingawo
20. Daniel Mashava
21. Abigail Kapfunde
22. Spiwe Mildred Chiganga
23. Dorothy J Chirindo
24. Susan Shonhiwa
25. Clara Spiwe Nondo
26. Monica Mufutumari
27. Margaret Nyasha Majena
28. Naume Tavengwa
29. irisons Pauma
30. Blessing Dzemwa
31. Rumbidzai Pauline Matongo
32. Edward Makondo
33. Sarah Goba
34. Elizabeth Marian Chadambuka
35. Inviolata Pswarayi
36. Ronicah Mushaninga
37. Frances deSales Misi
38. Monica Miriam Mbawa
39. Mary Chiweshe
40. Hamufare D Mugauri
41. Petty Jogo
42. Dade Getrude Pedzisai
43. Ndakachinyei Mashonga Robson
44. Margaret Beaulah Tengende
45. Edna Dhliwayo
46. Auxilia Chidemo Munodawafa
47. Norah Faith Matereke
48. Jabulani Chisipo
49. Roseline Changondolo
50. Katso Tazwa
51. Alice Kachere
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60. Dhlana Amon
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63. Chikosha Jennifer
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65. Mercy Ruth Zulu
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67. Elwell Moyo
68. Sibanda Susan
69. Kamudyariwa Shepherd
70. Chirengwa Ndinashe
71. Thabani Willard Jaffet
72. Ndlovu Naomi
73. Gwezere Nivard
74. Shayanewako Simba
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76. Veronica Mudziti (Tutor)
77. Nevison Senga (Matron III)
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2. International Confederation of Midwives : President Frances…….
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9. JHPIEGO: Dr Peter Johnson
10. JHPIEGO: Dr Leslie Mancuso
11. American College of Nurses and Midwives: Tina Johnson
12. ECSA Secretariat: Director General Prof. Yoswa Dambisya

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