SHORT VERSION

EVALUATION OF

THE MSF ACADEMY FOR HEALTHCARE'S BASIC CLINICAL NURSING CARE TRAINING

KENEMA AND OLD FANGAK

April 2023

This publication was produced at the request of the MSF Academy for Healthcare, under the management of the Stockholm Evaluation Unit (SEU).

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This report is a summary version of the full evaluation report and was prepared by the SEU.

BACKGROUND

This evaluation focuses on the basic clinical nursing care (BCNC) training initiative implemented by the Médecins Sans Frontières (MSF) Academy in Kenema, Sierra Leone since 2020 and in Old Fangak (OFG), South Sudan since 2021. The evaluation specifically covers the first implementation of BCNC in these locations to the point of the graduation of the first cohort of nurses in May/June 2022.

THE MSF ACADEMY FOR HEALTHCARE

The MSF Academy for Healthcare describes itself as "an intersectional[1] training initiative that focuses on strengthening the skills and competencies of frontline healthcare workers, with the will to have a long-term impact on the quality of care provided in the countries where MSF intervenes. The Academy does this by developing and implementing competency-based curricula that are tailor-made to MSF operational needs, using a learning cycle based on theoretical knowledge and workplace practice, accompanied by clinical mentoring[2]". The following diagram summarises the main aspect of the Academy.

Overview of the MSF Academy for Healthcare.
Source: MSF Academy for Healthcare General Overview May 2022

[1] The term 'section' refers to the 25 independent national associations working under the MSF charter.
[2] MSF Academy Activity report 2021

THE BASIC CLINICAL NURSING CARE (BCNC) INITIATIVE

The BCNC training programme sits within the wider hospital nursing and midwifery training initiative with the overall objective of strengthening skills and competencies in nursing and midwifery with the aim to improve quality of care[3]. "The overall objective of the BCNC is to strengthen skills and competencies of staff providing nursing care in all participating hospitals, with the aim to contribute to a sustainable improvement in the quality of care"[4].

The BCNC programme uses a competency-based approach to learning which blends classroom training with bedside clinical mentoring on the wards of the relevant MSF health facilities associated with the training. The BCNC approach in Kenema and OFG was implemented by Academy staff working in-country. The intended participants in the training are staff providing nursing care to patients in an MSF supported health facility. However, there is flexibility in some contexts to include staff from outpatient departments, nurse aides and staff working with other organisations, for example staff from MSF's partner South Sudan Medical Relief (SSMR). In Kenema the BCNC is compulsory for all national nurses employed at the MSF Hangha Hospital.

The Academy has developed and adopted a standardised modular curriculum which is intended to have the potential to be implemented in any context where MSF and the Academy identify (1) the need for this training, (2) where there are adequate training facilities and (3) a MSF supported hospital to allow for work-based training and mentoring. The application of the curriculum to date has included flexibility where necessary or pragmatism; for example, removing training for procedures that are not utilised in a given context.

THE BCNC IN KENEMA AND OLD FANGKAK

Kenema and Old Fangak (OFG), South Sudan were selected for inclusion in this evaluation since at least one cohort of participants had completed the BCNC programme in full; this is not yet the case across all locations.

In Kenema, the Academy is based in the MSF-supported Hangha hospital (with patient care activities from 2019). It is a facility with approximately 100 beds with paediatric inpatient and outpatient departments, an intensive care unit (ICU), emergency services, maternity services (since 2022), an intensive therapeutic feeding centre (ITFC) and an isolation unit (predominantly for Lassa fever). The Kenema project is run by MSF OCB (Operational Centre of Brussels [OCB]).

MSF has had a presence in OFG since 2014 where they work in partnership with South Sudan Medical Relief (SSMR). In 2018, MSF constructed a new health facility in OFG which also provides emergency

[3] Information I this section is from the MSF Academy for Healthcare, General overview presentation May 2022

[4] MSF Academy Annual report 2021. The evaluation team is aware of some additional objective statements including a set of objectives developed in July 2022 however these were developed after the timeframe for the evaluation and have not been used in this evaluation (as stated in the inception report). Prior to 2021, there are additional reports with the objective stated as improved quality of care (https://tembo.msf.org/course/info.php?id=685). Hence different formulations of the objectives coexist.

services, inpatients services (adults and paediatrics), an ITFC, maternity services and outpatient care. The Old Fangak project is run by MSF OCP (Operational Centre of Paris [OCP]).

Only one round of BCNC was implemented in OFG. In Kenema, the BCNC training and mentoring continued beyond the first round of graduates and is ongoing. Despite some challenges with timing and completion of the training, 85% (35) of learners graduated in OFG, with all 41 active learners completing all the classroom sessions of the curriculum[5]. In Kenema, the Academy's permanent presence at the onsite training centre allows the BCNC to be provided on a cyclical basis with rolling entry for new staff. Initially 119 nurses were enrolled and at the end of 2019, 204 active learners were reported as enrolled on the BCNC course. At the time of the evaluation, 28 nurses had graduated in May 2022 and 95 were still enrolled; 34 were due to graduate in November 2022 and 61 in 2023; of these, two graduates in OFG and 16 in Kenema were female.

EVALUATION METHODOLOGY

The specific stated purpose of the evaluation as outlined in the evaluation terms of reference (ToR) was to assess the value of the BCNC programme in Kenema and OFG. Ultimately, key stakeholders wanted to know which results the BCNC has achieved, if they are worth the investment (efforts, time, resources) and if potential adaptations could increase the value of the BCNC. This exercise was planned as a comprehensive evaluation motivated by the desire for meaningful learning, for internal (intersectional) decision making on further investment and to support the roll-out of BCNC and other future programming[6]. It was also envisaged that the learning from the evaluation could increase the evidence base around frontline health worker training and be valuable for a wider range of stakeholders. However, the scope and findings of this evaluation were very specific to the two locations; it should not be assumed that the findings and recommendations are relevant to other contexts.

A set of evaluation questions (EQ) were developed from the original ToR and were framed to create an area of questioning around (1) training needs and design, (2) implementation and (3) sustainability, replicability and impact. The ET chose to answer the evaluation questions using the OECD Development Assistance Committee (DAC) evaluation criteria[7] and the HPass Learning Standards for humanitarian contexts (the Learning Standards). Additionally, the ET used the Kirkpatrick 4-level model[8] for evaluating training activities as this model is referred to in MSF reports on the pedagogical approach for BCNC. The figures below illustrates the Learning Standards and Kirkpatrick model.

[5] OFG exit report 2022 and https://msf.org.uk/article/south-sudan-graduation-day-msfs-college-within-hospital
[6] This is as stated in the ToRs, it is envisaged that the evaluation will also provide opportunities for considering areas for adaptation to the model and its implementation.
[7] The OECD DAC criteria are internationally recognised evaluation standards used for development and humanitarian work.
[8] https://www.kirkpatrickpartners.com/the-kirkpatrick-model/

Figure 2 The Eight Learning Standards

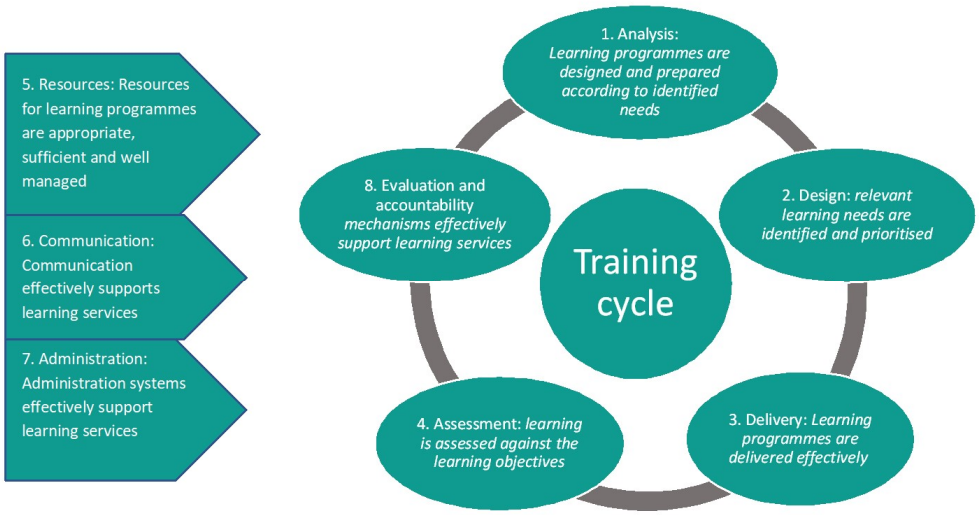
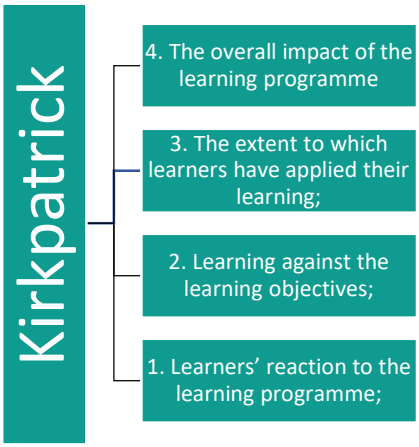


Figure 1 The Kirkpatrick Model



DATA COLLECTION

The evaluation methodology included a review of key documents provided by the Academy and identified during the evaluation along with interviews and discussions with 148 stakeholders, of which nearly 30% were students. Approximately 50 key informants per site were interviewed in addition to MSF HQ and other staff as well as external counterparts (i.e., Ministry of Health).

SUMMARY OF KEY FINDINGS

Overall, there are indications of positive changes in nurses' skills and behaviours in both locations that can be reasonably associated with the BCNC training. These are verified by reports from those who participated in the BCNC, and anecdotal evidence of observed changes by the nurse learners' colleagues. In OFG the changes in behaviours and skills is more noticeable, for example many report improvements in hygiene, infection prevention in urine catheterisation, injecting correctly, giving the right medication, better patient management including proper information to patents, blood

transmission, improved confidentiality and privacy of patients. This is in part associated to the lower level of knowledge and skills in which the learners started with in OFG (some learners had only completed primary education). The distinction between the two unique locations is also felt in terms of appropriacy and relevance. In OFG 100% of learners interviewed felt the training was relevant and all were pleased that they had the opportunity to participate. For them, one of the main challenges was that they would like to see the programme continue in OFG. Unfortunately, the programme closed however many staff are eager to continue their learning and increase the graduate cadre.

In Kenema, there are some concerns that a high proportion of learners did not find the BCNC training to be beneficial, that the new BCNC skills are not always applied, that some senior colleagues fail to empower nurses to use their skills (or favour different techniques from those taught on the BCNC) and some stated concerns about the levels of competence attained by the nurses in the absence of verified CGA scores.

The adult learning methodology for the BCNC was well considered and took into account the need to not remove nurses from the hospitals and have opportunities to directly practice skills on the ward. The design of the BCNC was for a standardised approach that could be rolled out in different locations with specific adjustments for each context. Kenema and OFG were not considered the pilot locations for the programme, however, they were the first locations to complete the full cycle of the BCNC and opportunities for learning and adapting have presented themselves both in this evaluation and also throughout the programmes. On many occasions the BCNC responded to the location's needs and the internal learning of a new innovative programme and made improvements (such as adjustments to the CGA, adaptations to assessments, curriculum, classroom time, learning journals). In both Kenema and OFG there were opportunities where the programme could have been more tailored to the specific needs/culture and limitations within each environment and more transparently communicated thereby creating opportunities for a more collaborative approach. As noted below a key finding of the evaluation is that the methodology is not widely understood and that whilst documents exist, such as the learner agreement for OFG, there has been an absence in utilisation and communication to explain the rationale, benefits and expected results of the approach. This has led to some speculation and frustrations amongst MSF employees. The ET is not presenting speculation as evaluation evidence however, it does recognise that it is, on occasion, detrimental to perceptions of the Academy and the acceptance of the BCNC.

Design

Authenticating the learning approach through demonstrating an understanding of context, improving consultation and collaborative working, and improving communication of the theory of change and anticipated outcomes.

The BCNC is a new way of working within MSF. It has received funding to kick start a transformational approach. A common finding was that the design of the BCNC was not adequately informed by a context-specific assessment. Further, the evaluation found that there was limited consultation with MSF colleagues and local stakeholders including nurses, hospital managers, communities, local and national professional bodies and government representatives ahead of the delivery. This may have

been due to the adoption of a standardised BCNC curriculum and approach to implementation, which negated the need for the BCNC to be more context specific with regards to key aspects such as mentoring frameworks, cultural/gender considerations and identifying more concrete training needs[9]. In addition, there was a sense of pressure that the BCNC needed to move to implementation after many false starts due to the pandemic and other insecurity and operational changes in South Sudan.

The BCNC's theory of change (ToC) to explain and evidence the selected learning approach and monitoring and evaluation (M&E) plan were not completed during the period evaluated and offered very limited information and no evidence to support the learning approach. The absence of these documents, and the consultative approach, appear to have also contributed to stakeholders' frustrations with the perceived lack of clarity of the BCNC's rationale, objectives, future strategy, implementation, and outcomes. This appears to have negatively impacted on the support of some within MSF for the BCNC, and possibly the Academy more widely. The lack of clear exit/handover strategies for the continuation of the BCNC, including ensuring that this is within available resources, is an unexpected oversight.

A potentially systemic issue, which goes beyond that of the BCNC but was strongly noted through the review of documents and in discussion with stakeholders, was that the Academy, and some activities, appear to not be well aligned with and/or integrated within MSF's structure and processes. For example, the evaluation identified examples of a lack of joint planning and effective (structured) communications between the Academy/BCNC teams and other MSF staff, including those working in South Sudan and Sierra Leone. While the evaluation did not explore the reasons behind, it is likely to have consequences that are currently not well understood, for example continued disconnect with the human resources/learning and development departments, and the ongoing communication and operational challenges of not being absorbed into an existing administrative and management system. This in turn has impact on many other aspects of the programme, on how it was perceived and referred to in this evaluation.

It is likely that a more collaborative and a human-centred approach to design and delivery of the BCNC would have been beneficial in creating a shared understanding of the BCNC, a sense of buy-in and ownership and also reduced some of the ongoing issues that are potentially compromising the delivery and impact of the BCNC initiative. These include some missed cultural and logistics considerations and opportunities which may have compromised the effectiveness and impact of the BCNC training. Designing around these may have made the BCNC more relevant, effective, efficient, valued and with a higher likelihood of being sustained. In addition, this approach will increase meaningful inclusion at a time when MSF is considering how to improve local ownership and decision making.

The assessment (HPass learning standard 1) of learners' needs was assessed by the ET at a sector or regional level to sufficiently provide evidence in the gap in nursing skills, especially in OFG. Further

[9] This was not the case for OFG.

bespoke analysis of the learning needs would have benefitted the programme in Kenema and more in-depth cultural assessments for the programme would have been beneficial in both locations. A competency framework was used which aided the analysis and fed into all other aspects of the BCNC. Development of the framework was an important component in the progression of the BCNC. Moving forward the framework would benefit from a revision to include outcome level statements and the tiered system to document a journey to achieve proficiency in said competency.

The design (HPass learning standard 2) of the BCNC used good adult learning methodology and was well considered in its experiential learning practice (through mentoring) to support the transitioning of skills into work practice. The specific design for each context missed cultural considerations along with the need for further consultation with the learners and staff on the ground. This impacted on all other aspects of the programme and how it was perceived. Numerous cultural and gender issues were found within the delivery of the BCNC in both locations, resulting in placing women at higher risk of gender-based violence as well as further entrenching gender inequality. The BCNC will need to address these issues through a gender and inclusion assessment and action plan and consider how to better align with 'The MSF we want to be' initiative.

Implementation

Improved inclusion and understanding of the BCNC's objectives and the learning approach is likely to lead to improved implementation. The success in the delivery (HPass learning standard 3) of the BCNC training in OFG and Kenema can be seen through improved behaviours by some of the graduates and by the overall improvement in the CGA scores. However, the evaluation also identified some challenges. This included learner motivation to attend and continue with the BCNC, particularly in Kenema. The key reasons identified for this lack of motivation in Kenema related to misplaced expectations that the training and qualifications would lead to promotion/pay rises. Whilst there is desire for further opportunities and career development and some frustrations in OFG (particularly amongst more senior nurses who anticipated more recognition after completing the BCNC), the expectations appear better managed, and learners remained highly motivated throughout the programme.

In both Kenema and OFG nearly all learners requested more time to be dedicated to classroom training and, for Kenema, this to be focused on more advanced content. Frustrations with the timings of the training sessions were significant and had wider impact for some learners even putting some at risk of partner violence due to being out of the house. In addition, there were challenges (leading to frustrations) with not being able to be signed off as competent in some procedures due to a lack of appropriate cases or the mentors not being available as they were overstretched. There was also disappointment in Kenema that the training/certificates had not been recognised outside of MSF; for example, by other potential employers or when applying to universities for higher qualifications. In Kenema many of the nurse learners who participated in the evaluation noted that they were only continuing with the course as it was compulsory, and that time is deducted from their salary if they do not attend (a decision from the project, not the BCNC). There is a risk that if the BCNC does not address these challenges it will not be able to achieve its full potential and have meaningful impact and, that in Kenema, the learning is likely to be seen as a 'tick box activity'.

The communication (HPass learning standard 6) between learners, supervisors, CMs, the Academy in Brussels, OCs was lacking consideration and consistency. This led to many miscommunications between different groups and increased frustrations and feelings of a 'top down' system that may have been resolved or reduced if communications had improved. Opportunities for feedback, consultation and 'listening and responding appropriately' (standard 6.4) are important to address in future programmes. Learners stated that they are unaware of how their feedback and concerns are relayed to managers or how they are considered. The major gap in meeting the standards appeared in evaluation and accountability (standard 8), especially standards 8.1 to 8.3 which are linked to communication and dealing with concerns, complaints and feedback mechanisms.

Monitoring and evaluating change and learning

The assessment of nurses' competency (knowledge and skills) is the BCNC's current main source of information for monitoring the nurses' progress and the trainings outputs. The competency gap assessment process (CGA) was well integrated into the design and improvements were made during the period in review. The ET notes the need for a graded or staggered competency framework which can feed into the final CGA and assessment along with a wider recognition of the certificate.

The Academy (and MSF more widely) does not yet measure change in the quality of care (QoC) provided or use nurse sensitive indictors. Both of these would provide more information of the relationship between nursing and QoC and provide a framework for evaluating the relationship between training and improved QoC. Currently the Academy is unable to demonstrate a causal relationship between any change and the BCNC (other than anecdotally). This is well understood within MSF and an issue that is being discussed. Currently there is no strategy in the Academy for systematic operational learning or research to inform any required adjustments and to extract good practices, which is a significant missed opportunity. The ET understands that the learning from the implementation of the BCNC in other locations was applied on a rolling, sometimes informal, basis without sufficient documentation. In addition, feedback from learners was largely through verbal communication (meetings) throughout the project and not documented. The lack of documentation has meant that the learning cannot be shared with the sector and that with high staff turnover there is a loss of institutional knowledge about the programme and mistakes are likely to repeat themselves.

Sustainability and impact

The ET raises some concerns regarding the sustainability and replication in the report and many of the recommendations relate to increasing the likelihood of increased impact and sustainability. Replication is seen as beneficial by many included in the evaluation, but with reservations which are shared by the ET. For example, it is not clear how the Academy has made or been held accountable for their decision making on locations for the BCNC to date. The situation is acknowledged as having changed recently with the introduction of a steering committee however the decision-making processes remain unclear for most who commented and concerns about failure to apply learning remain.

CONCLUSION

Within the first two years of the delivery of the innovative approach taken by the BCNC there have been significant successes, as well as a vast amount of learning opportunities which have been documented in this report that should be considered for future iterations.

The ET have made a range of recommendations. It is recognised that some of these recommendations may have already been taken into account in current projects including those that are outside the scope of this evaluation, whilst others have not yet been discussed or strategized within the Academy or MSF. Some recommendations could be applied in current deliveries of BCNC, whilst others may only be possible for future deliveries.

WHAT'S WORKING WELL:

The ET's judgement is that the BCNC, as evaluated in the context of the first implementation in OFG and Kenema, was successful in resulting in a total of 63 learners graduating. For some, particularly in OFG this was the first formal adult training course they had received and was a welcomed opportunity to gain a certificate and/or recognition. There are indications of positive changes in skills and behaviours that can be associated with the BCNC training in both locations. These are verified by observed changes by the nurse learners' colleagues.

The bedside mentoring approach was extremely valuable and, for many, is where they attribute the transition from theory into behavioural change within the nursing practice. The curriculum in OFG was adjusted for the context and learners felt that it was relevant to their needs. The additional classes that were added to support learners (such as maths classes) were also helpful and welcomed to support learning.

The certificates, that in OFG, were recognised with a ministry stamp were also appreciated and contributed to learners' motivation to complete the programme. The uniforms that the graduates/learners received also added to the recognition within the community of their profession and a sense of pride in their work and achievements.

CURRENT CHALLENGES:

However, there are also some concerns that a high proportion of learners in Kenema did not find the BCNC training to be beneficial, that the new skills are not always applied and of senior colleagues failing to empower nurses to use their skills or even favouring different techniques from those taught on the BCNC. There are also some stated concerns about the levels of competence attained by the nurses in the absence of verified CGA scores.

These concerns appear to be associated with a few underlying commonalities:

The lack of a clearly defined strategy and consultation, particularly at the design stage, and some gaps in effective communications between the Academy and other MSF departments has contributed to a lack of shared understanding amongst many who participated in the evaluation and potentially to lost opportunities for collaboration and leveraging synergies of working together.

In the absence of clarity some participants have developed their own understanding of the expectations, appropriateness, and assumptions of the BCNC initiative. These assumptions appear to not always be aligned to the Academy's understanding and intentions. Additionally, the Academy may not be aware of these differing interpretations and therefore unable to proactively manage expectations. This has the potential to be negative and detrimental to the Academy in gaining the endorsement and support across MSF and with some external stakeholders. Further it appears to be the source of some conflicts and frustrations among stakeholders regarding expectations towards the BCNC in terms of objectives, benefits for learners and accountability.

Importantly the lack of evidence for the learning approach, its relevance to the given contexts and examination of key assumptions made in the design of the BCNC, which would normally be included in the Theory of Change, is a concern for the ET and many included in the evaluation. The balance between time spent in the classroom and work based mentoring, and use of the Learning Companion in place of Clinical Mentors in OFG deserve closer analysis and consideration as to whether other approaches may be more appropriate in terms of local context or if some adaptations to the current programme would be sufficient (see recommendations). This lack of understanding of the rationale, and of expectations and the future strategy, has impacted this evaluation and stakeholders' grasp of and buy in of the BCNC approach. Additionally, the lack of clear exit/handover strategies for the continuation of the BCNC, including ensuring that this is within available resources, is an unexpected oversight.

Examples of some consequences of the lack of clarity include the misplaced learners' and external participants' expectations of what training delivered by an 'Academy' should 'look like'. Other examples include the stated belief (supported by documentation reviewed by the ET) that the Academy is top down in its decision making and not providing evidence to support the rationale for their decisions around the relevance of the BCNC in given contexts, the learning approach, the implementation of the BCNC and engagement with other MSF departments and the wider health/humanitarian sector.

MOVING FORWARD:

Moving forward, the Academy and MSF more broadly would benefit from improved consultation, communication, and collaboration with internal and external stakeholders, starting at the initial identification and validation of need, through to final evaluation of the difference the BCNC has made. Improved collaboration and joint planning will not only reduce replication of some of the implementation challenges experienced (for example nurses not being released for training and alignment with national accreditation processes) but potentially lead to improved effectiveness and efficiencies. This in turn is likely to increase the likelihood of the benefits of the BCNC being sustained.

It is recommended that a first step might be to engage stakeholders where current BCNC programmes are running and prioritise which recommendations (from the list below) would be appropriate to apply in the given context. Joint decision making in taking the recommendations forward is highly recommended.

KEY RECOMMENDATIONS

⇒ Recommendation 1: NEEDS ANALYSIS RELATED ACTIONS FOR ANY GIVEN LOCATION WHICH THE BCNC IS CONSIDERING WORKING IN:

- Through a collaborative learning needs assessment (with MSF OCs and the sector) undertake research/contextual analysis to ensure an in depth understanding of the needs, opportunities and challenges for each context.
- Include a gender and diversity analysis to understand how power and access issues can be addressed during design to avoid further embedding gender inequality and contribute to gender equality.
- Revise the competency framework to contain outcome level statements (rather than just clinical steps) and include required levels for each outcome which the learning can be mapped against*. Use this during CGA.
- Use the CGA tool to assess individual learning needs and create different levels of learning cohorts depending on current capacity or individual learning paths, each cohort will then work at a different pace and content. Seek to improve the understanding of the CGA approach and look at ways of increasing its value for nurse learners, their supervisors, professional bodies and future employers.

⇒ Recommendation 2: DESIGN AND SET UP RELATED ACTIONS IN ANY GIVEN LOCATION:

- Use early consultation and a participatory approach to make the BCNC more relevant and therefore more likely to be consistently applied by nurses. Through this consultation build on and research the following areas:
  - Nurses' motivation for taking training and the barriers associated with engaging in the training, these are such as enabling environment, pay and home:work balance. Include an assessment of learning preferences and the balance of classroom and mentoring time. Develop mitigation strategies to address any areas that may have impact on the nurses' motivation to participate in or complete the BCNC training.
  - Proactively creating and managing a shared understanding of the BCNC's objectives, content and delivery, along with collective buy-in to increase ownership of the BCNC, this will contribute to reducing differing expectations and frustrations (as demonstrated in both OFG and Kenema), and increased the BCNC's value to learners.
  - Recognise and discuss existing skills to reduce feelings of frustration amongst nurses.
  - Clarify the role of the BCNC in learners career development or CPD. A collaborative approach with the MSF learning and development (LND) units may be an appropriate approach.

*Examples of frameworks with outcome level statements:

- https://lampout1.alverno.edu/archives/alphistory/pdf/ability%20statements%202016%20v17.pdf
- https://www.chsalliance.org/get-support/resource/core-humanitarian-competency-framework/
- https://ta.nutritioncluster.net/sites/gtamcluster.com/files/2021-01/Competency%20Framework%20Jan%2021%20v4.pdf
- https://www.nna.gov.sg/resources-tools/nursing-competency-framework

- Complete an evidenced and comprehensive ToC, MEL and exit plans for each location to inform all stakeholders of the rationale, expectations and planned outcomes of the BCNC training. Consider the use of tools such as the RACI matrix to improve cross-sectional working and to clarify roles and responsibilities and communication, as well as expectations.
- Consider better alignment of the BCNC with national curricula to increase the value and utility of the BCNC beyond MSF.
- Review how LCs are integrated into programme for each specific context, where they add value, were safety and security is a concern plan for mitigating actions and how they can be recognised and compensated.
- Use a consultative approach to find alternative methods to manage the demand on mentoring vs caseloads and workloads for each context. This might involve mentoring in groups.
- Use the CGA findings to consider adaptations to the delivery for the BCNC.
- Actively consider the strategic use of international staff and how to improve their integration, understanding of the contexts in which they and nurses are working, and understanding of the BCNC's objectives and curriculum to allow them to better support nurses in the utility and application of skills and knowledge.

⇒ Recommendation 3: DELIVERY RELATED ACTIONS:

- Create a system that captures and responds to regular feedback from learners and staff (feedback should include whether the programme is appropriate, enjoyable, challenging, achievable and inclusive)
- Evidence how feedback about learners' progress amends the delivery process when required.
- Demonstrate how learners' progress has been responded to, including where requests cannot be supported.
- Provide greater autonomy to the hospital and CMs to adapt the BCNC to suit the context and to be more responsive to the hospital's needs, create change control processes for this that captures and justifies change but that is not overburdening or slow to respond and sign off.
- Consider additional learning techniques to allow nurses to share their experience and to promote group discussion - such as small group discussions at bedsides.
- Monitor risks during delivery and respond appropriately, including incorporation of actions from the Inter-agency Standing Committee (IASC) gender-based violence (GBV) GBV guidelines.
- Consider succession planning and retention strategies that reduce turnover whilst not setting so precedents that cannot be matched elsewhere (for example further education opportunities that cannot be offered to others).

⇒ Recommendation 4: ASSESSMENT:

- Involve head nurses and supervisors in an assessment, include an indication of the learner's journey towards a certain competency level.
- Include an indication of level of competence within assessment.
- Continue to seek accreditation of the qualification with MoH and nursing and midwifery boards with the aim of recognised and transferal credits for the BCNC course.

⇒ Recommendation 5: EVALUATION AND ACCOUNTABILITY RELATED ACTIONS:

- Within the MEL plan, develop a range of qualitative and outcome level indicators to better demonstrate progress towards the BCNC's objectives. Suggestions include the need for measures around QoC and for those less tangible outcomes such as participant and patient, even community, appreciation. A suit of QoC metrics could be tracked for ongoing process improvement, these could include nurse sensitive quality indicators (NSI) and consideration of methods to demonstrate associations between training and changes in QoC.
- Determine if there is a need for a set of QoC indicators specifically for BCNC/Academy and work independently or with others (NCWG as intersectional) to agree NSIs. Include baseline data and benchmarks, data collectability, and align with BCNC content and MoH educational standards[1].
- Include a training monitoring and evaluation plan using Kirkpatrick's 4 Stage Training Evaluation Model. This can be linked to indicators in a MEL framework.
- Create a policy and guide for supporting transparent and honest feedback from relevant stakeholders (including anonymised questionnaires).

⇒ Recommendation 6: CROSS-CUTTING RECOMMENDATIONS

- Continue to increase collaboration with nursing associations and the respective MoHs to inform future BCNC content and directions, help develop career pathways for BCNC graduates, and foster discussion on the potential for alternative certifications for healthcare workers not meeting existing licensure and certification standards.
- Continue to seek accreditation of the qualification with MoH and nursing and midwifery boards with the aim of recognised and transferal credits for the BCNC course.
- Strategize how to reduce international staff reliance and increasing contract length in field locations.
- Create support mechanisms for learners from underrepresented groups (specifically for women, people with disabilities)
- Create a plan to decentralise the decision-making process for the BCNC
- Develop at design stage (see above) an exit strategy and ensure it is realistic particularly in terms of resources required.