AFRICA NETWORK FOR ASSOCIATE CLINICIANS (ANAC)

COMMUNITY OF PRACTICE (COP)

STRATEGIC PLAN

2013-2017

May 2012

(Draft 3)

TABLE OF CONTENTS

ACRONYMS

AC	Associate Clinician
AIDS	Acquired Immuno Deficiency Syndrome
AMDD	Averting Maternal Death and Disability
AC CoP	Africa Network for Associate Clinicians Community of Practice
CO	Clinical Officer
CoP	Community of Practice
COST Africa	Clinical Officer Surgery Training Africa
EmONC	Emergency Obstetric and Neonatal Care
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information Systems
Jhpiego	An Affiliate of Johns Hopkins University
JICA	Japanese International Corporation Aid
MD	Medical Doctor
MDG	Millennium Development Goals
ML	Medical Licentiate
MNH	Maternal Neonatal Health
SSZ	Surgical Society of Zambia
SWOT	Strengths, Weaknesses, Opportunities, Threats
THET	Tropical Health Education Trust
WHO	World Health Organization
HRH	Human resource for Health

ACKNOWLEDGEMENTS

We would like to take this opportunity to thank the members of the Africa Network for Associate Clinician - Community of Practice (AC CoP) for making the valuable input to have this strategic plan developed. We also extend the Network gratitude to Ms L Lwatula for facilitating the process and for her expertise. We thank AMDD – USA for supporting the Network with the resources to produce one such important document.

List of Contributors

Zambia

Tanzania

Mozambique

Malawi

Burkina Faso

Kenya

Uganda

South Africa

FOREWORD

This AC CoP Strategic Plan is for the period 2013-2017, the first strategic document is developed to guide the CoPs' direction, towards stimulating stakeholders' interest and support for training, practice and regulation of AC education and practice. The document has been developed with input from 5 member countries, and in close consultation and collaboration with the secretariat throughout the process.

For a long time now ACs have been providing health care to populations without due recognition. The strategic plan takes cognizance of the member countries disease burdens and is an effort in making a case for the ACs contribution towards making health services available and accessible, with the ultimate goal of contributing to the overall reduction of morbidity and mortality in member countries and beyond.

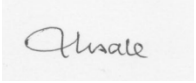
The health services provided by ACs range from treating communicable and non-communicable diseases, integrated reproductive health including family planning especially long term methods, child health, general and obstetric surgery and managing health facilities. With most of these countries experiencing shortage of human resources for health, AC services have been increasingly on high demand, leading to unofficial expanded role of the AC. However, task sharing is increasing legitimating their scope of practice.

Human resources as one of the pillars of heath service delivery, requires that they have the right skills, are motivated and in adequate numbers. The need to improve the education and training of the AC cannot be underscored, because it directly affects the quality of care the AC will offer. In the same token recipients of health services also need to be protected by the providers; hence regulation of education and practice of the AC will add value to their services.

The SWOT analysis and information collected from various stakeholders generated the following critical/strategic issues:

- Creating a strong Secretariat and strengthening partnerships
- Unifying and fulfilling members expectations of the AC CoP
- Recognition of ACs training and practice across the region including regulation

This Strategic Plan therefore attempts to outline strategies and objectives, activities and performance indicators which include monitoring and evaluating the implementation of the strategic plan.



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EXECUTIVE SUMMARY

The Associate Clinicians (AC) are health care professionals who include assistant medical officers, clinical officers, medical licentiate practitioner, clinical associates, health officer (surgery, obstetrics and gynaecology), physician assistant, surgical technician and técnicos de cirurgia.

The title AC formerly known as the Non-Physician Clinician was revised and adopted at a meeting held in Geneva at WHO in April 2012. According to the WHO definition there are two levels as described below:

1. Associate Clinician

A professional clinician with basic competencies to diagnose and manage common medical, maternal, child health and surgical conditions. They may also perform minor surgery. Associate Clinicians are generally trained for 3 to 4 years post secondary education in established educational institutions. The clinicians are registered and their practice is regulated by their national or sub-national regulatory authority. Pre-requisites to Associate Clinician training can be different among the countries.

Related cadre terms: clinical officer, medical assistant, health officer, clinical associate

2. Advanced Associate Clinician

A professional clinician with advanced competencies to diagnose and manage most common medical, maternal, child health and surgical conditions, including obstetrics and gynaecology and surgery practice. Advanced associate clinicians are generally trained for 4 to 5 years post secondary education in established educational institutions and or 3 years post associate clinician training. The clinicians are registered and their practice is regulated by their national or sub-national regulatory authority.

Related cadre terms: assistant medical officer, clinical officer, medical licentiate practitioner, health officer (surgery, obstetrics and gynaecology), physician assistant, surgical technician. These descriptions have not in the past distinguished between the AC and advanced associate clinicians.

Associate Clinicians perform critical clinical functions, conventionally also practiced by medical doctors. At global, regional and national levels, ACs are increasingly recognized as part of the team of health workers providing lifesaving health care services, even in the most remote areas. Currently ACs are recognized in 47 of the 54 AC-COP African countries.

The Africa Network of Associate Clinician Community of Practice was established in August 2010 in Lusaka, Zambia, which hosts the Secretariat. The current membership is led by Zambia, Malawi, Mozambique, Ethiopia, Tanzania and Burkina Faso; with associate membership from Sierra Leone, Liberia and South Sudan. The network encompasses ACs, Ministry of Health staff, professional associations, advocacy organizations, educators, donors and community members.

The network seeks to strengthen political and professional support for ACs, improve quality and development of AC training in MNH and other priority health services to contribute to the overall reduction in morbidity and mortality.

The network also resolves to advocate for resources to increase the number of ACs and ACs training institutions, equipment including supplies to sustain the quality of ACs services in member countries in order to contribute to the achievement of the MDGs 4, 5 & 6 by 2015 and beyond.

The network has established an on line community forum to keep members informed of emerging literature on:

- Training, maternal, neonatal and other priority health services,
- Sharing AC experiences with stakeholders,
- Promotion of professional identity of ACs,
- Supporting best practices in AC training and practice
- Relevant research activities.

The situation analysis of the internal and external environments revealed a number of disparities within the network member countries relating to political, economic, social, education, training and regulation of AC. Building a strong foundation for the network will require member countries making concerted efforts in taking a positive response to the identified issues. The network will strive to raise the profile of members so that the ACs can reposition themselves in health care systems through implementation of the following strategies:

- Establishment of Secretariat and formation of Country AC Structures/Chapters
- Capacity Building and Advocacy
- Partnership and Resource Mobilization
- AC Education, Training, Practice and Regulation
- Research
- Monitoring & Evaluation.

The main goal of the network is to foster a community of practice among AC members in order to contribute effectively towards the reduction of morbidity and mortality in maternal, neonatal and priority diseases. The strategic directions outlined in the logical framework for the implementation of activities to meet the set indicators are outlined below:

STRATEGIC DIRECTION 1: ESTABLISHMENT OF SECRETARIAT AND FORMATION OF COUNTRY AC CHAPTERS

Core Program Intervention:

- Develop and implement organizational management structure and system for improved program performance, documentation of results, transparency and accountability.

Objective 1:

- Improve the performance and accountability of AC CoP by institutionalizing functional and responsive organizational structure and systems for enhancing the technical, managerial and leadership capacity for secretariat staff and the general membership

Expected Outputs

- AC CoP organizational structure developed
- Secretariat office established and fully functional
- Governance and Operational Guidelines developed

STRATEGIC DIRECTION 2: CAPACITY BUILDING AND ADVOCACY

Core Program Intervention:

- Capacity building and advocacy for expanding membership, increasing regional presence and participation of members in AC CoP.

Objective 2:

Promote membership and increasing members' role in AC CoP through participation in CoP activities.

Expected outputs

- Membership service unit established, with country chapters increased from 6 to 10 in five years
- Communication channels for sharing professional news and for advocacy established
- Strengthened board and secretariat through training in governance and advocacy

STRATEGIC DIRECTION 3: PARTNERSHIP AND RESOURCE MOBILIZATION

Core Program Intervention:

- Forge collaboration and maintain mutually reinforcing relationship with governments of member countries, professional Communities of Practice, donors, members and the communities.

Objective 3:

- Strengthen partnerships and networking for effective collaboration and coordination of activities and expanding the resource base of AC CoP

Expected Outputs

- Resources mobilized through proposals and membership subscriptions
- Professional and academic papers presented at conferences on AC education and practice
- Increased donor base
- AC CoP website developed and managed

STRATEGIC DIRECTION 4: EDUCATION, TRAINING, PRACTICE AND REGULATION

Core Program Intervention:

- Strengthening AC practice through standardization of education and training; facilitating engagement of CoP members to proactively engage in policy and program reform

Objective 4:

- Promote the status of ACs profession for increased acceptance and utilization of ACs services in member countries, region and beyond through strengthening education, practice and regulation.

Expected Outputs

- AC core competencies identified
- Advocacy for AC Professional ethics and code of conduct/practice enhanced
- Continuing medical education strengthened
- E-mailing list established and active
- E-learning introduced and all members oriented on use
- AC training institutions accredited to Regulatory bodies

STRATEGIC DIRECTION 5: RESEARCH, MONITORING AND EVALUATION

Core Program Intervention:

- Model best practices, document, analyze and share results, institutionalize system for regular reporting, monitoring and evaluation of activities.

Objective 5:

- Inform policy and program by modeling best practices, improving program outcomes through evidence based practice and use of data and information for decision making.

Expected Outputs

- Best practices shared
- Research studies conducted
- Secretariat staff capacity building attained
- Ongoing monitoring conducted
- Decisions made based on information and data collected

The Africa Network for ACs program will endeavor to develop the foundations for a sustainable ACs workforce in selected developing countries, focusing on training ACs, strengthening education, developing practice standards, developing and strengthening national ACs associations.

1. PREAMBLE

1.1 Preamble

The Associate Clinicians (AC) are health care professionals who include assistant medical officers, clinical officers, medical licentiates practitioners, associate clinicians, health officers, physician assistants and técnicos de cirurgia. They perform critical clinical functions, conventionally also practiced by doctors. At global, regional and national levels ACs are increasingly recognized as part of the team of health workers providing lifesaving health care services, even in the most remote areas. Currently ACs are recognized in 47 of the 54 African countries. In some of the countries ACs practice and training are regulated by the respective health professional regulatory bodies.

The name Non-Physician Clinician was not generated by the member professionals. In collaboration with stakeholders the Network changed the name to associate clinician at a meeting held in Geneva under the auspices of the WHO.

ACs are providing sustainable valued health services from the community level to secondary care in collaboration with medical and para-medical health care workers and are committed to continuously improving the lives of women, children, men and families through the provision of quality health services. The AC CoP strive to work with the Governments of AC Member Countries, cooperating partners, other stakeholders and the people of Africa to reduce maternal, neonatal and child morbidity and mortality and effectively integrate other health related and social services.

1.2 The Africa Network of Associate Clinician Community of Practice (AC CoP)

TheAfrica Network of Associate Clinician Community of Practice (formerly Africa Network of Non-Physician Clinician Community of Practice) was established in August 2010 in Lusaka, Zambia, which hosts the secretariat. The current membership is led by Zambia, Malawi, Mozambique, Ethiopia, Tanzania, Burkina Faso,Republic of South Africa,Kenya and Uganda with associate membership from Sierra Leone, Liberia and South Sudan. The network encompasses ACs, Ministry of Health staff, professional associations, advocacy organizations, educators, donors and community.

The network seeks to strengthen political and professional support for ACs, improve quality and development of AC training in MNH and other priority health services to contribute to the overall reduction in morbidity and mortality.

The network also resolves to advocate for resources to increase the number of ACs and ACs training institutions, equipment including supplies to sustain the quality of ACs services in member countries in order to contribute to the achievement of any MDGs of interest by 2015 and beyond.

The Network's on line community offers a forum to keep members informed of emerging literature on:

- Training and maternal, neonatal and other priority health services,
- Sharing ACs experiences with stakeholders,
- Promotion of professional identity of ACs,
- Supporting best practices in AC training and
- Relevant research activities.

1.3 Mission

A recognized health care professional network whose agenda is to contribute to improving standards of training, regulation and practice of ACs in collaboration with other members of the health team to promote the delivery of quality Maternal and Child Health, HIV/AIDS and other priority health services.

1.4 Vision

To be a network of ACs that contributes to national, regional and global health priorities.

1.5 Philosophy

The Africa Network of Associate Clinicians (AC) philosophy is based on the following principles:

- Health is a fundamental human right, and people have the right and responsibility to freely participate individually and collectively in the planning and management of health services
- Respect of professional diversity and team work as a pillar to service delivery
- Transparency and accountability to network functions
- Integrity and impartiality in allocation of the network resources
- Efficiency and professionalism among its members
- Information, research and knowledge sharing among members and stakeholders
- Capacity building and professional progression for practicing ACs.

1.6 Goal(s) of the Network

To foster a community of practice among AC members in order to contribute effectively towards reduction of morbidity and mortality from maternal and neonatal complications, as well as from other causes.

1.7 Objectives

- Create local and international awareness on the work of ACs
- Develop network country structures
- Keep abreast the members of the Community of Practice with updated literature in training and health related information
- Provide technical support to member countries in the development of AC Associations and or Affiliations
- Collaborate or conduct research in health related issues
- Share experiences of ACs with other stakeholders
- Support best practices in training of ACs
- Advocate for regulation of AC training and practice
- Contribute to solutions of human resources for health in Africa

1.8 Priorities

- Propose interim Network structure
- Develop Action Plan (Network vehicle)
- Develop Network Constitution and operational guidelines
- Establish Network office
- Sensitize of ACs and Membership drive
- Register Community of Practice/Network
- Develop sustainability plan (fundraising)
- Participate in national, regional and global meetings
- Provide technical updates to members on trends in ACs practice and health care
- Coordinate member countries efforts
- Promote evidence based practices (Research)

1.9 Intermediate

- Strengthen Secretariat

1.10 Long term

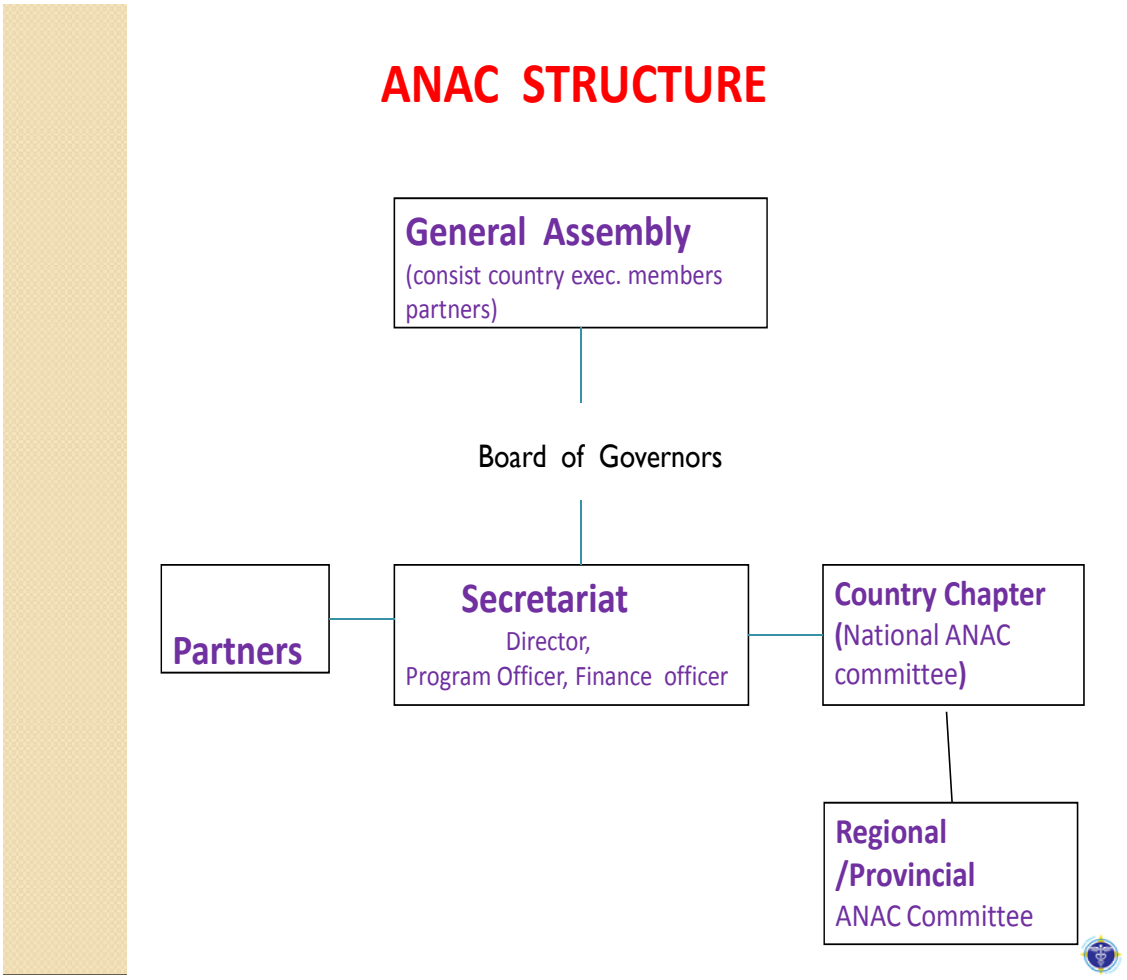
- Establish a centre of excellence for ACs education and practice

2. ORGANIZATIONAL OVERVIEW

2.1 Interim structure

The Network for AC CoP is headed by the regional coordinator based in Lusaka, Zambia, and a sub coordinator for the West African network for AC, based in Burkina Faso. There is also a liaison and financial officer based in Lusaka, Zambia at the Network Secretariat. Based at member country level are Focal persons (6 currently). All office bearers are engaged on part time basis. The network is supported by a cooperating partner, the Averting Maternal Death and Disability (AMDD) Project, based at Mailman School of Public Health, Columbia University, New York, USA.

2.2 Proposed structure



3. CONTEXT

Despite varied member countries improvements of the health sector, the disease burden has continued to increase, while health care delivery has been constrained by lack of or inadequate human, material and financial resources, and causing unsatisfactory performance towards the achievement of the Millennium Development Goals (MDGs). The high disease burden in Africa is compounded by several factors, including the impact of high maternal and neonatal mortality, the HIV/AIDS epidemic, high poverty levels and poor macroeconomic situation. Despite discrete and sustained improvements in some indicators, it is unlikely that Africa will meet most of the MDGs by 2015.

Many African countries have ACs working at various levels of the health care delivery system. The shortage of HRH in several African countries for the delivery of essential health services has led to the expanded role of the AC. However the recognition of AC role has not been fully valued by both local and international institutions. This is demonstrated by the lack of clear career progression path, poor remuneration and promotion ladder, lack of regulatory framework to support their training and practice and lack of capture of data on ACs.

Recent studies conducted in Tanzania, Malawi, Mozambique and Ethiopia have shown that ACs do effectively deliver quality health services in medicine and essential surgery specially lifesaving maternal and neonatal care (Cumbi, et al 2007, Pereira, et al 2010). This evidence, coupled with the absence or shortage of doctors in health facilities has prompted some member country governments to call for the increase in numbers of ACs through training in order to fill gaps in physician led health care.

Although scaling up training has been implemented in many of these countries, it is observed that investment in infrastructure, equipment, faculty, financial resources and regulatory policies has not been addressed. This situation affects the quality of training and practice of AC.

3.1 Situation Analysis

The AC member countries face significant changes and challenges such as the high disease burden compounded by the high maternal and neonatal mortality where AC

member countries have mortality rates ranging from over 500 to 900/100,000 births (The UNFPA State of the World's Midwifery 2011), HIV/AIDS epidemic, critical shortages of health personnel; deteriorating health infrastructure; on-going restructuring of the health sector; weak economies; and inadequate funding to the health sector. All these factors have significant implications on the organization and management of the health services. Such a situation calls for "prioritization" of interventions and systems, paying particular attention to areas that would make significant impact, at low cost and sustaining health service delivery. These include provision of preventive and promotive health services such as the availability of emergency obstetric and neonatal care (EmONC), general surgical interventions (traumatology) medical emergencies and the prudent management of health services delivery. The ACs play a fundamental role in the delivery of such services (Cumbi, et al 2007, Pereira, et al 2010).

Human resource is one of the elements which determine the availability and accessibility of quality of health service delivery. In order to fulfill this it is required that the human resources for health are well trained, motivated and adequate in numbers. Henceforth the AC CoP will ensure the prioritization of such interventions as in promoting the recognition of AC and their contribution to delivering health services through improvements in education, regulation and association.

Member countries are training AC using different curricula. While the education of AC requires strengthening and standardization, the AC CoP has a task to work with member countries and stakeholders in promoting the identification of essential competencies for enhancing technical knowledge and skills. The provision of essential and basic trainings which introduces AC to new medical/surgical technologies and evidence based practices and enabling them to share experiences and information will have a significant impact in improving performance, efficiency and effectiveness.

The regulation of AC education and practice has not been consistent within and across the CoP member countries partly because the AC competencies have not been well defined. The CoP will therefore work with member countries in ensuring that the education of AC meets these identified standards in order to raise the profile of the profession. In this respect the AC CoP will play an indispensible role in strengthening the education and practice, which will ultimately lead to improving health care services.

Other professions are well represented through association, while many ACs do not belong to any such organizations, a situation that puts them at a disadvantage as they do not have a mouthpiece through which to channel their concerns and or grievances. The AC CoP will therefore work with member countries to form such associations where necessary or encourage affiliation to already existing structures.

This strategic plan has been prepared to address factors that have significant implications on the organization and management of health services and in relation to the AC and their role in contributing significantly to the delivery of improved health services.

3.2 Background

3.2.1. Introduction

Following the Non-Physician Clinician Community of Practice Africa Regional meeting convened in Lusaka from 17th to 19th August 2010 with a follow up meeting in Zambia, 4 – 5th August 2011. The Africa Network for ACs Training was created with two regional secretariats put in place. Chainama College would coordinate the East Southern region members comprising; Tanzania, Malawi, South Sudan, Mozambique, Ethiopia and Zambia. The founding Regional Coordinator is David Lusale.

The West Africa regional secretariat comprises Burkina Faso, Sierra Leon and Liberia. Dr Charlemagne Ouedrago is the coordinator.

Table 1: Current list of Country Focal Persons and secretariat coordinators

No	Member Countries	Name of current Representatives
1.	Burkina Faso	Charlemagne Ouedragos
2.	Ethiopia	Chuchu Girma
3.	Malawi	Charles Mulilima
4.	Mozambique	Thomas F. Zimba
5.	Tanzania	Cosmas C. C. Maro
6.	Zambia	Annel Bowa
7.	Republic of South Africa	Edwin
8.	Kenya	Kenneth
9.	Uganda	Charles
	Associate Members	
10	Liberia	John Mulbah

11	**Sierra Leone**	**Samuel Sidique**
12	**South Sudan**	**Makur Karion**

3.2.2. Terms of Reference

The terms of reference (TOR) were compiled. Submissions were received from the focal persons. The network would improve upon them at a later period. The TOR are for;

- Regional Secretariat
- Country Coordinators
- Regional teams
- Focal Persons

Application to Global Health Workforce Alliance

The AC CoP is a member of the Global Health Workforce Alliance (WHO) since 2010.

3.2.3 Regional office activity plan and budget (Zambia)

For office support equipment, the bookkeeper and secretariat assistant would need a desk top each and a laptop for the Regional Coordinator. Other needs as per attached budget. Chainama College opened a separate bank account with Barclays Bank for easy monitoring and reporting to all stakeholders in Feb 2011. The Africa network website was initiated by Jody Lori and is operating at www.ibp@AC .org.

3.2.4 Training Audit

A training audit was conducted for the AC by the American College of Nurse Midwives (ACNM), with support from AMDD and working closely with the AC COP focal persons. The audit was conducted in Zambia, Mozambique, Malawi, Tanzania, Ethiopia and Burkina Faso. (Network Report August 2011)

Ifakara – Course in maternal and neonatal health for survival

A course for ACs practicing in maternal health was held at Ifakara, Tanzania in September, 2009 & 2010 and attracted 55 participants drawn from Zambia, Malawi, Ethiopia, and Tanzania. Experts were from USA, Ethiopia, Tanzania, Netherlands, Sweden, Zimbabwe, Malawi and Zambia. The course was developed and supported by AMDD, with Prof. Staffan Bergstrom acting as senior advisor to AMDD at the time, and

with the Ifakara Health Institute, The course has since gone on to be developed into a more formal course focused on upgrading AC skills in EmOC and continues to be offered at the Ifakara Health Institute.

4. HEALTH SECTOR PERFORMANCE AND DISEASE BURDEN

The AC CoP member countries have a high disease burden ranging from acute to chronic diseases, HIV/AIDS, non-communicable and communicable diseases, most of which are preventable. To compound this situation is the needlessly high maternal and neonatal disability and deaths that occur to such a high magnitude as resulting in 10 to 15 million long lasting illnesses and injuries, 3 million neonatal deaths and another 3 million still births (UNFPA Report, 2010). ACs do make a difference in providing critical health services that contribute to averting most of the causes of this catastrophic situation, through direct care or indeed surgical interventions. It is estimated that if Emergency Obstetric Care were availed to every woman in need, this can reduce the number of women dying in pregnancy and childbirth by 75 per cent. (WHO,2009).

The deadline for the achievement of the MDGs is also fast approaching, with a number of these countries not ready to meet their obligations by 2015. It has been observed that the health related MDGs 4, 5, and 6 are most affected by this incapability, owing to varying reasons, among them a lack of policies that support the cause of women and girls, human resource for health crisis and the low resource allocation to the health sector.

Most of the AC CoP member countries have for the past decade been experiencing a critical shortage of human resources for health to deliver even the basic essential health services. This situation prompted governments to introduce the non-physician role, primarily to deliver emergency surgical interventions especially in rural areas where there were no doctors. Over the years this role has evolved and with surfacing of task shifting concept, the demand for AC services is high, calling for the increase in numbers and recognition of this cadre. Stakeholders are therefore working with governments to ensure health services are availed to the citizens. Refer to table below on selected Impact Indicators on Health Sector Performance against 6 MDGs in AC Member Countries for the current status on MDGs.

Table 2: Impact Indicators on Health Sector Performance against 6 MDGs in AC Member Countries for the current status on MDGs

Country Name	NMR	IMR	U 5MR	MMR	HIV Prevalence	Malaria U5 Case FR
Burkina Faso	370/1000	93/1000	169/1000	560/100,000	0.77%	163/1000
Ethiopia	35/1000	68/1000	109/1000	470/100,000	3.5%	44/1000
Liberia	37/1000	74/1000	119/1000	990/100,000	1.7%	87/1000
Malawi	30/1000	66/1000	112/1000	675/100,000	10.6%	75/1000
Mozambique	41/1000	48/1000	147/1000	408/100,000	12.5%	80/1000
Sierra Leone	49/1000	114/1000	198/1000	970/100,000	1.5%	103/1000
*South Sudan	*37/1000	*66/1000	135/1000	2,054/100,000	3%	*106/1000
Tanzania	34/1000	73/1000	116/1000	950/100,000	06.2%	28/1000
Zambia	35/1000	70/1000	110/1000	591/100,000	14.3%	40/1000

Source: Google website for each country

*Statistics obtained for Sudan

5. RATIONALE FOR DEVELOPING STRATEGIC PLAN FOR AFRICA NETWORK FOR AC COP

The Network has been implementing its activities without any strategic direction. The associate clinician community of practice (AC CoP) was established with the principal objective of advancing the ACs interests in relation to the profession and practice. AC CoP has been engaged in capacity enhancement programs for its members and advocating for the improvement of the health of women and families. Unlike other professional communities of practice, AC CoP does not have a regular and reliable budget and flow of resources. However as a starting point this has been facilitated by AMDD. Consequently, the community of practice is informed by evidence. Creating a clear strategy based on evidence has multiple advantages such as providing a sense of direction and purpose on which all activities can be aligned. The strategic plan can also be utilized for mobilizing resources for the implementation of activities as it becomes a reference document for development partners to get information about the organization, its achievements, challenges and other governance guidelines. This is the reason for the leadership of Africa Network for AC to initiate the development of this strategic plan which is made possible with funding and technical support from AMDD who is the major cooperating partner.

The strategic plan will augment the contribution of Africa Network for AC CoP. Its performance would guide the Network and strengthen partnership with stakeholders. The need for having a strategic plan has been expressed at various forums such as the regional meeting on “reducing maternal death through the training of Associate Clinicians (AC); task shifting” held in Lusaka, 2010 and 2011 and in the Africa Network for AC progress report of September 2010.

The objective of this strategic planning document is to:

- Provide an overview of **Africa Network for ACs CoP**, its vision, mission, core values, operations and membership;
- Describe its collaborative partnerships in member countries, with the Health sector, development partners and other stakeholders;
- Outline the major strengths, weaknesses, opportunities and threats to the achievement of the Community of Practice objectives and the wider vision of improvements in the health status of member countries;
- Recommend key strategic actions for the Community of Practice for the next five years in order to reposition itself as a recognized key health partner in the achievement of MDGs 4, 5 and 6 in member countries and beyond by:

- establishing a unique and valuable proposition involving the activities of AC CoP
- Outline the budgetary requirements for the implementation of proposed activities
- recommending approaches that will ensure the building of strategic trust and commitment from stakeholders in support of the implementation of the strategic plan; and
- ensuring accountability, governance mechanisms are institutionalized and functional within the **Africa Network for ACs CoP**

5.1 The strategic planning process/methodology

The consultant selected to write the strategic plan developed by a set of three questionnaires which were circulated via AC focal persons in the 6 Network member countries to encourage wide participation to the process. It was envisaged that this approach could facilitate member countries support and ownership of the strategic plan. Member countries were given two months within which to respond and send their contributions to the secretariat. Responses were received from 4 member countries except for Burkina Faso and Ethiopia who did not provide feedback. Information collected from these sources was compiled and used as the foundation on which this five year strategic plan is based.

The exercise has also benefited a lot from data and information collected from secondary sources such as the ***Africa Network for ACs meeting and training reports.***

The consultant worked very closely with the secretariat through meetings and ACs who in turn provided strategic guidance, direction and additional information for the strategic planning process. This strategy is therefore prepared using the contributions of the stakeholders highlighted above using participatory and consultative approaches.

6. OPERATING ENVIRONMENT

6.1 INTERNAL ENVIRONMENT ANALYSIS

6.1.1 Organization, Structure and Governance

The AC is a professional organization for Associate Clinicians (AC) who comprise clinical officers, assistant medical officers, medical licentiates, associate clinicians and técnicos de cirurgia and are primarily found in Africa. The current membership of the AC stands at 6 countries with 3 associate members.

The organization structure of the AC CoP will operate at Executive Board, Secretariat, Country and General Membership levels whose duties and level of authority are outlined below.

6.1.2 Organizational Structure of AC

Governance and Leadership

The AC CoP will be headquartered at the Secretariat in Lusaka, Zambia, will have four (4) full time employees and headed by an Executive Director (ED). Directly under ED will be the Admin/Finance Officer who will support and oversee the activities of country offices. The secretariat office will be supported by an Administrative Assistant who will supervise the Driver/Office Assistant. At Country Level there will be part-time Country Coordinators, reporting to the Admin/finance Officer, will be assisted by Regional Coordinators. The Executive Board comprising 6 elected members (4 South East and 2 Western) will oversee the functions of the CoP network.

The General Assembly

The General Assembly will comprise all members of AC CoP and is the supreme governing body. The General Assembly will meet once a year to discuss pertinent issues regarding the function of AC CoP, concerns related to the professionals, the profession and the delivery of services. It will also discuss and endorse activity and audit reports, approve the annual plans of action and budget and appoint auditors. In accordance with the by-laws, the General Assembly will convene when necessary.

The Executive Board

The Executive Board will deal with policy matters, strategic plans and annual reports and presents programs and proposals for the approval of the General Assembly. In addition to this, the Executive Board will provide strategic leadership to the Secretariat and the Community of Practice. Members comprise both Non AC members and AC CoP representatives and will be appointed by a panel comprised of donor organizations

and AC country/member associations. Each board will serve a 2-year term of office, subject to re-election for 1 more 2 year term. The Board will oversee the work of the Secretariat, and provide guidance and advice. The Executive Director, Admin/Finance Officer and Country Coordinators will be closely involved in the management of the Community of Practice.

The Secretariat

The Secretariat will be responsible for carrying out the decisions of the General Assembly, the Executive Board (EB) and managing the day-to-day activities of the Community of Practice. The Secretariat will carry out regular administrative duties such as signing of cheques. Each transaction will be signed by two signatories, of the three official signatories, who shall comprise the ED, Board Chair person and the Trustee/ board member. In line with the five-year strategic plan and on the basis of the SWOT analysis a minimum organizational structure that enables the Secretariat to function well is outlined on page 16

In the hierarchy of the organizational structure after the General Assembly, the Executive Board follows and then the Secretariat and country representatives coordinators. The operational modality between the Secretariat and Country representation requires the Board's strategic decision –function under the leadership of the Secretariat.

With regard to the organizational structure of the Secretariat the following areas are being suggested for the Executive Board (EB) consideration: The ED will conduct Program Planning and implementation, Financial Management, Resource Mobilization and Monitoring and Evaluation, while the Country Chapter Coordinators will Manage Technical Programs, Membership, Advocacy, and Research and reporting to the ED (See the AC Proposed structure on page 16).

Country Structures/Chapters

The current country structure identifies the country representatives who are leading the CoP activities on voluntary basis. Country structure functions poorly as these representatives are occupied with other competing activities. Under the newly proposed structure these representatives who will be called **country coordinators** will become part-time employees of the CoP, so that they will be accountable to the organization.

The country coordinators will therefore function under the leadership of the secretariat and reporting directly to the **Admin/Finance Officer**.

The main duties will be to manage the AC CoP country office, ensuring that information on CoP filters to the general membership through their in country **Regional Coordinators,** who will work on voluntary basis to;

- Support the implementation of CoP activities by ensuring the needs of their country members are communicated to the secretariat

- Ensure prudent management of resources allocated by secretariat for activities
- Submit reports to secretariat on all activities conducted on behalf of CoP
- Participate in advocacy and member recruitment activities and maintain country membership database
- Carry out resource mobilization activities for local activities
- Support AC training institutions (faculty development, strengthening didactic and practical instruction, mentorship)
- Advocate for policy change to enhance AC professionalism and identity.

The country regional coordinators will assist the country coordinator in day-to-day duties.

AC Program Interventions – Achievements and challenges

Achievements

AC CoP receives financial support and technical assistance from AMDD. Since its inception in 2010, the network has achieved the following milestones:

- Conducted short-term trainings (CME) to train ACs in priority health services such as EmONC in collaboration with partners.
- Organized annual conference to discuss professional issues on health care delivery and to share best practices in training and practice
- Developed network website and shared information with members and stakeholders
- Garnered interest of other partners to support AC CoP activities and promote AC visibility in the health care field.
- Supported members to participate in international conferences and research projects.
- Involved in advocacy for members and the network at regional and international forums.
- Encouraged the development of national chapters/associations

Challenges

1. Operational

- The secretariat is managed by staffs that are part time
- Country structures/chapters have not been fully developed
- The AC CoP does not have a strategic plan and established management and governance guidelines, both at secretariat and country level.
- Limited resource base as the AC CoP activities are currently being supported by one partner, this has also delayed the establishment of a fully functional secretariat.

2. Regulatory

- Lack of clear AC educational and regulatory guidelines in some of the member countries.
- Unclear AC job specification and descriptions

3. Others

- Difficulty in accepting the role of the AC within health care teams by some professionals.
- Limited AC visibility in the health system.
- Inadequate peer networking
- Limited participation at local and international global health forum

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6.2 EXTERNAL ENVIRONMENT ANALYSIS

The following external features will affect the AC Network at various levels.

Political

1. Lack of political will may hinder career development for ACs
2. Lack of supporting government policies can derail progress in the implementation of activities of the network

3. Poor prioritization of training programs for health care system contributes to low output of human resource for health, which ultimately affects the provision of accessible health services.

Economic

1. The cost of training may hinder potential AC trainees.
2. Inadequacy of infrastructure development for health and training depends on availability of stable economic status and political will.
3. Adequate funding is essential for the network to successfully implement activities.

Consumers of services

1. Poor acceptance of ACs by community in some member countries hinders the accessibility to health care and this can impact negatively on the image of the profession.
2. Lack of information/ poor knowledge of the community on the differences between ACs and other formal cadres like MDs may mask their need for these cadres
3. Achievement of satisfactory quality care
4. Reduction in morbidity and mortality

Technology

- Inadequate technological advances can have negative impact on teaching, diagnostics and treatment.
- Poor Internet connectivity may impair communication among members.
- Functional Internet services can contribute to effective sharing of information and experiences among AC members through the website.

Social

- ACs will get to know each other through the network
- Sharing of experiences by peers at local and international levels.
- Encourages motivation of peers, member countries and network partners.
- Capacity building for individuals and countries

6.3 STAKEHOLDERS COLLABORATORS ANALYSIS					
SN	**Stakeholders and Collaborators**	**Level of Influence**	**Expectation(s)**	**Things to be done**	**If not done**
A. Stakeholders					
1	Members	High	- Promoting their rights and interests - Providing information - Expanding membership - Adopting code of ethics - Capacity Building - Advocacy	- Promoting rights and interests - Continuing education - Providing information - Expanding regional offices - Adopting code of ethics - Support training programs	AC existence and credibility will be questioned Members will leave the Community of Practice
2	Staff	High	- Important positions in the Secretariat should be filled ASAP - Clear AC allocation of roles/responsibilities between the Board and the Secretariats - Guidelines/protocols and systems in place	- Advertise/recruit and fill the vacant positions - Adopt governance and other important manuals - Develop Financial sustainability systems	- poor performance - High staff turnover - Pressure on the Executive Board
3	Executive Board	High	- Good governance of the secretariat - Committed leadership - Good performance and commitment from the staff - Active membership and support from members - Regional chapters/protocols established, mentored and supported	- Implement the procedures/ protocols to ensure transparency - Implement result-based planning - Commitment from donors, staff and government - Functional relationship established	- instability - Contribution is not acknowledged - Diminishes the visibility of AC

			- Pro-active participation in policy/program review and dialogue - Good support from Governments, donors and partners	/maintained between the central and regional/country offices	
4	Donor	High	- Deliver Result - Adherence to MOU - Quality and timely reports - Documenting results - Transparency and accountability - Promote ACs profession	- Implement project activities as per set goals - Submit reports including financial reports - Document results for future funding - Proactively engage on strategic advocacy and dialogue to promote the profession	- Diminished resource base - Narrowing scope of operation.
5	Governments	medium	- Establish/maintain functional relationship with the Ministries of Health and regional offices - Monitoring the quality of education in ACs training institutions - Indicate clearly the contribution of AC to health outcomes - Model best practices & lessons learned to inform policy and program	- Seek collaboration - Harmonization - Partnership - Reporting	- Failure to contribute to bigger health goals - Lack of recognition for efforts - Duplication of efforts
6	Professional societies	High	- Information sharing on priority health issues	- Experience sharing - Cross-network	- Poor cooperation - Lack of support

	(At country level)		- Regulation and practice - Cooperation in influencing policy - Joint research - Partnering in joint project implementation	collaboration - Establish close ties - Build capacity - Provide Up-to-date information - Cooperate on common issues	- Disinterested members from professional societies - Loss of trust and mutual respect
7	Education institutions	High	- Knowledge sharing - Joint research - Curriculum development - Partnership for capacity building	- Develop working relationship - Strengthen close ties - Sharing training curricula and expertise - Develop training material data bank	- Inadequate cooperation, lack of synergy and missed opportunity. - Low credibility / profile of the Community of Practice. - Lack of minimum standards of training and practice
8	Community	High	- Quality service from professionals - Accountability of professionals	- Maintaining service standards and ethics	- Mistrust and eventually poor image - Poor utilization of services

6.4 SUMMARY OF THE SWOT ANALYSIS

Strengths	**Weakness**
1. Members are motivated and committed 2. Advocacy meetings are taking place in the country 3. Government is showing interest in supporting training and deployment 4. Regulatory bodies showing interest to regulate training and practice 5. International collaboration within and outside the region. 6. Training institutions providing local support. 7. Development of minimum standards in EmONC. 8. Establishment of a website. 9. More ACs are being trained. 10. Programs have been accredited in some countries. 11. Some training centers are located in good hospitals that can offer adequate practical exposure to students. 12. Career development is now open in Tanzania for programs like CO and CA due to establishment of BSc. Clinical Medicine 13. Diversity in skill and can provide wide ranging skills 14. Training cost relatively affordable by respective governments 15. Retention of ACs in country is high.	1. Delay in establishing full secretariat 2. Lack of vibrant local AC associations 3. Inadequate country funding to reach out all ACs 4. Poor retention strategies to faculty and ACs 5. Unreliable internet services 6. Inadequate essential equipment for education, training and health facilities 7. Inadequate capacity for coordination of AC activities 8. Limited networking and advocacy among and within Associations 9. Lack of guided career structure for ACs 10. Limited international recognition
Opportunities	**Threats**
1. Existence of career development structures 2. Evidence of local and international recognition 3. Evidence of collaboration and networking locally and internationally 4. Research evidence on performance of AC (task analyses Mozambique, Malawi, Tanzania and Zambia) **5.** AC contribution to improvement in maternal and neonatal mortality and other priority health services **6.** Collaboration with other professional associations 7. Demand for ACs is high in many areas 8. Interest of stakeholders who support AC programs(SSZ, COST	1. Non acceptance of AC as independent professional by some physicians 2. Limited participation in regulatory bodies activities 3. Lack of political support and representation at policy level (career progression, training regulation and

Africa, AMDD, Jhpiego, WHO, JICA, Clinton Foundation, THET, SolidarMed) 9. Promotion of task sharing in the health system 10. Accredited members to the regulatory bodies 11. Affiliated AC programs to Universities in some member countries 12. Transformation of AC colleges into university status	recognition) 4. Lack of human resource training policy

7. MAIN STRATEGIC/CRITICAL ISSUES

Based on the result of the SWOT analysis and information collected from various stakeholders, the following critical/strategic issues have been identified:

Strengthening partnerships and creating a strong Secretariat

- Placement of full time secretariat staff and development of governance guidelines
- Establishing working modalities between the secretariat, regional and country offices
- Increasing number of partners working with AC CoP to enhance visibility
- Stronger documentation of results on AC practice through publications, conference presentations and network website on best practices.
- Resource Mobilization for AC CoP activities which presently has a high donor dependency

Unifying and fulfilling members expectations

- Advocacy for the AC CoP
- Driving need for accountability and advocating for ACs affiliations with regulatory and other professional bodies
- Building trust and getting the confidence of the governments and that of the consumers of health services
- Strengthening training exposure for members

Standardization of ACs training across regions

- Improving professional quality; meet standard of ACs practice through identification of AC core competencies for priority health services such as on MNCH (EmONC IMCI), HIV/AIDS, Malaria, and others.
- Development/review of AC curriculum to align with national, regional and global standards/protocols (WHO, WFMES and country specific treatment protocols)
- Development of job descriptions/specifications
- Recognition of the importance of regulating training and practice of AC

7.1 STRATEGIC DIRECTIONS

On the basis of the strategic issues that came out from the SWOT analysis five (5) strategic directions/core program intervention areas are identified. These are:

Establishment of Secretariat and Formation of Country AC Chapters; Capacity building and Advocacy; Partnership and Resource Mobilization; AC Education, Training, Practice and Regulation; Research and M&E.

Strategic Direction: Establishment of Secretariat and formation of Country AC chapters

Core Program Intervention: Develop/implement organizational management structure and system for improved program performance, documentation of results, transparency and accountability.

Objective 1: Improve the performance and accountability of AC CoP by institutionalizing functional and responsive organizational structure and systems for enhancing the technical, managerial and leadership capacity for secretariat staff and the general membership

Activities:

- Develop organizational structure that responds to the five-year strategic plan of AC CoP.
- Develop and implement constitution and operational guidelines - Board to delegate Secretariat to act with full authority and responsibility
- Appoint AC Board members
- Develop and implement regional/country chapters/protocols and introduce decentralization and delegation between secretariat and country offices
- Train/orientate secretariat and country chapter coordinators on CoP program management
- Establish a program management unit responsible for all technical areas of AC CoP which include: 1) education, training, practice and regulation; 2) advocacy & publication; 3) resource mobilization; and 4) research, monitoring and evaluation
- Develop and implement comprehensive financial guidelines

Strategic Direction: Capacity building and Advocacy

Core Program Intervention: Capacity building and Advocacy for expanding membership, increasing regional presence and participation of members in AC CoP.

Objectives 2: Promote membership and increasing members' role in AC CoP through participation in CoP activities.

Activities:

- Establish a membership service unit responsible for all membership development, representation and partnership affairs
- Develop data base on members profile and expertise and update regularly
- Increase the number of Non-Physician Clinician Community of Practice in the region (from 6 to 10 by the end of the five years period)
- Increase membership by 100% by 2015
- Update members on the activities of AC CoP, emerging issues and decisions taken
- Create more opportunities to increase participation of members in AC CoP activities according to expertise
- Engage members in advocacy and sensitization activities
- Share best practices through conferences and other forums
- Celebrate International Day of ACs on rotational bases
- Convene the General Assembly meeting/annual conference on rotation basis
- Increase AC's membership in national and international professional societies and networks
- Increase the frequency, quantity and quality of AC publications and dissemination of ACs bulletin/newsletter. Publish and distribute 1,000 copies (200 of bulletin/newsletter copies each year)
- Train the Executive Board on leadership and advocacy

Strategic Direction: Partnership and Resource Mobilization

Core Program Intervention: Forge collaboration and maintain mutually reinforcing relationship with governments of member countries, professional Communities of Practice, donors, members and the communities.

Objective 3: Strengthen partnership and networking for effective collaboration and coordination of activities and expanding the resource base of AC CoP

Activities:

- Take an inventory of international Communities of Practice and organizations that are engaged in health and establish partnerships
- Establish an agreement-based partnership with local professional Communities of Practice for a sustained information exchange, experience sharing and mutual support in health care development
- Train the Executive Board on fund raising/resource mobilization
- Train staff on organizational/program development
- Seek AC 's membership in CoP member countries
- Prepare the profile of potential donors and submit proposals in alignment with their requirements
- Compile and disseminate information on the overall contribution of AC to maternal, child health and priority health services
- Design and implement fund raising and resource mobilization strategies
- Maintain and sustain existing funding partnership
- Design strategies to improve membership fee collection
- Develop and manage AC CoP website
- Expand donors' base for the purpose of sustaining funding through assessing the needs of members and health problem areas.

Strategic Direction: Education, Training, Practice and Regulation

Core Program Intervention: Strengthening AC practice through standardization of education and training; facilitating engagement of CoP members to proactively engage in policy and program reform

Objective 4: Promote the status of ACs profession for increased acceptance and utilization of ACs services in member countries, region and beyond through strengthening education, practice and regulation.

Activities:

- Facilitate the identification of AC core competencies
- Advocate for standardization of ACs education and practice through harmonization of AC curricula to national, regional and international guidelines (ECSA-HC, WHO, WFMES)
- Advocate for professional ethics and code of conduct/practice
- Advocate for clear job descriptions and specifications
- Promote continuing medical education through training/updates on emerging and priority health services such as; Comprehensive Emergency Obstetric Care (CEmOC), Basic Emergency Obstetric Care (BEmOC), Family Planning (FP), Infection Prevention (IP), Quality of Care (QoC), research techniques, Information Technology (IT), Post Abortion Care (PAC) and new technologies that supports delivery of quality health services
- Encourage scholarship and participation in scientific conferences
- Design and implement strategy for peer support mechanism to facilitate on the job trainings.
- Establish e-mailing list and disseminate research and other publications through Internet
- Introduce/maintain e-learning in collaboration with other partners
- Advocate for accreditation of AC training institutions

Strategic Direction: Research, Monitoring and Evaluation

Core Program Intervention: Model best practices, document, analyze and share results, institutionalize system for regular reporting, monitoring and evaluation of activities.

Objective 5: Inform policy and program by modeling best practices, improving program outcomes through evidence based practice and use of data and information for decision making.

Activities:

- Identify applicable best practices, pilot, document and analyze results as appropriate to the context
- Undertake research and identify issues/bottlenecks in the improvement of health status of people in member countries
- Undertake Joint research with other professional societies
- Assess and identify issues that have prominence to ACs practice in member countries and forward recommendations to governments for action
- Support research activities in ACs training institutions and practice units/facilities
- Initiate and collaborate in the selection of national research agenda for the improvement of maternal and child health, HIV/AIDS and other priority areas
- Train staff on organizational/program, reporting, documentation, monitoring and evaluation
- Undertake regular monitoring work and evaluation as appropriate
- Enhance the organizational culture to use information and data for planning and decision-making and improve program performances.

MONITORING AND EVALUATION

The implementation of AC CoP strategic plan will be monitored timely and regularly. Data will be collected for this purpose quarterly, semi-annually and annually. The reports will contain summarized comparison of planned activities and achieved outputs and utilization of resources. The preparation of the monitoring report is the responsibility of the research, monitoring and evaluation sub-unit. The details on the role and content of the monitoring reports will be clearly spelled out in the internal M&E guideline/ manual. Program progress review process and evaluation of the program outputs will be based on the logical framework matrix (Appendix 1).

A review process provides an important opportunity for members to take stock of program implementation, exchange views and experiences, to facilitate problem solving and possible reorientation of the program. AC CoP will arrange review meetings. The most important assessment of the review meeting should be sustainability of the Community of Practice, in-depth analysis of implementation of strategies, planned activities, projects and related problems.

The plan should be frequently monitored, whereas the mid-term evaluation will be undertaken after two and half years of its implementation. However, considering this is the first strategic plan, AC CoP will require reviewing the progress annually in order to track its performance and adopt changes as appropriate. Evaluation of AC CoP strategic plan of implementation will be undertaken by ACs in collaboration with key stakeholders.

The objective of the mid-term evaluation will be to review progress i.e. how resources were used, whether planned activities were carried out and objectives met. The Mid Term evaluation should enable AC CoP to review its intervention, determine which activities have not been completed, and to formulate a revised operational plan for completing all activities and strategies outlined in the main plan document. AC CoP will conduct final evaluations towards the end of the strategic plan period using an external evaluator.

Refer to proposed key questions that reviews may consider when conducting M & E activities on next page:

CONSIDERATIONS AND KEY QUESTIONS FOR THE REVIEWS

Some of the key questions during the review could include but not limited to these:

- Are the objectives and indicators still relevant?
- Is there need to change, drop or add to the objectives or indicators?
- Are the activities still appropriate?
- Have any activities been completed, and if so, how successfully?
- Are there any activities that should be rolled forward, dropped or added?
- Is the number of planned activities appropriate, too few or too many?
- Is there need to prioritize the activities for the remaining period of the strategy? If so, prioritize from highest to lowest.
- For new activities, what are the appropriate indicators?
- Any other observations, advice, input from and for the programmer staff?

ANNEX I. LOGICAL FRAMEWORK MATRIX (LFM)

Strategic Direction: Establishment of Secretariat and formation of Country AC chapters

Core Program Intervention: Develop/implement organizational management structure and system for improved program performance, documentation of results, transparency and accountability.

Partners: AMDD, SolidarMed,

Objectives	Indicators	Time Frame	Means of Verification	Responsible Party	Risks and Assumptions
Objective 1: Improve the performance and accountability of AC CoP by institutionalizing functional and responsive organizational structure and systems for enhancing the technical, managerial and leadership capacity for secretariat staff	• AC CoP organizational structure developed • Secretariat staff job descriptions developed • Secretariat staff positions filled • Secretariat office established • Constitution developed • Operational Guidelines developed	January 2013 2013 2013 2013 2013 2013 2013 2013	Reports Interviews Observations Project car Functional Office Job advertisements Job descriptions Organogram Management	Executive Boardz, Network interim Secretariat and Regional/Country Offices	Political and economic stability Flexibility of the donors and continuity of funding

and the general membership	• AC CoP Board formed • 10 country chapters formed • All (7) secretariat staff and 6 country coordinators oriented trained in program management • Program management unit established within secretariat (4) • Financial guidelines developed • Monitoring and evaluation tools developed • Channels of communication between secretariat and country offices established	2013 2013 2013 2013 2013	Tools and guidelines		
Strategic Direction: Capacity building and Advocacy **Core Program Intervention:** Capacity building and Advocacy for expanding membership, increasing regional presence and participation of members in AC CoP.					

Partners: AMDD, SolidarMed,					
Objectives	**Indicators**	**Time Frame**	**Means of Verification**	**Responsible Party**	**Risks and Assumptions**
Objectives 2: Promote membership and increasing members' role in AC CoP through participation in CoP activities.	▪ Membership service unit established ▪ Membership data base established ▪ Number of AC CoP member countries increased from 6 to 10 ▪ Membership increase to 100% by 2015 ▪ 20 postings made via emails on activities of AC , emerging issues 20 AC CoP members involved in advocacy opportunities ▪ 20 CoP members participate in scientific meetings ▪ International Day of ACs Inaugurated and celebrated in 4 countries ▪ 5 General Assembly meetings convened in 4 countries ▪ 50 % AC 's attain membership in national and international professional societies and	January 2013 2013 December 2013 December 2013-17 2013-17 2013-17 December 2017 2013-17 2013-15	Reports Documentation Interviews Surveys Observations	Executive Board, AC CoP Secretariat Regional/country Offices General membership	Political and economic stability Flexibility of the donors and continuity of funding Number of donors Acceptability of AC by other professions

	networks ▪ 1,000 copies (200 of bulletin or newsletter copies each year) ▪ Executive Board and secretariat staff trained on leadership and advocacy				
Strategic Direction: Partnership and Resource Mobilization **Core Program Intervention:** Forge collaboration and maintain mutually reinforcing relationship with governments of member countries, professional Communities of Practice, donors, members and the communities. **Partners:** AMDD, SolidarMed,					
Objectives	**Indicators**	**Time Frame**	**Means of Verification**	**Responsible Party**	**Risks and Assumptions**
Objective 3: Strengthen partnership and networking for effective collaboration and coordination of activities and	▪ Inventory of international Communities of Practice and organizations in health conducted ▪ Executive Board trained in fund raising/resource mobilization ▪ Secretariat staff trained in organizational/program development ▪ 5 proposals accepted out of 7	April 2013 2013-14 December 2013-15 December 2013-17	Reports Documentation Assessments Interviews Surveys Observations	Executive Board, AC CoP Secretariat Regional/country Offices General membership	Political and economic stability Flexibility of the donors and continuity of funding Number of donors

expanding the resource base of AC CoP	submitted ▪ 10 papers presented at conferences on AC practice ▪ Existing funding partnership sustained ▪ Strategies for membership fee collection designed and implemented ▪ AC CoP website developed and managed ▪ Donor base increased from 1 to 4	2014 2013 2013-14			Acceptability of AC by other professions
Strategic Direction: Education, Training, Practice and Regulation **Core Program Intervention:** Strengthening AC practice through standardization of education and training; facilitating engagement of CoP members to proactively engage in policy and program reform **Partners:** AMDD, SolidarMed,					
Objectives	**Indicators**	**Time Frame**	**Means of Verification**	**Responsible Party**	**Risks and Assumptions**
Objective 4: Promote the status of ACs profession for increased acceptance and	• AC core competencies identified • AC curricula enhanced to national, regional and international guidelines (ECSA & WA-HC, WHO, WFMES)	2013 2013-15 2013-14	Reports Documentation Assessments Interviews	Executive Board, AC CoP Secretariat Regional/country Offices General	Political and economic stability Flexibility of the donors and continuity

utilization of ACs services in member countries, region and beyond through strengthening education, practice and regulation.	• Professional ethics and code of conduct/practice developed • Job descriptions and specifications developed by member countries • All AC CoP members attend Continuing medical once every quarter in priority areas • 10 abstracts accepted and presented at scientific conferences • 50% members attend OJT • E-mailing list established and active • E-learning introduced and all members oriented • 60% AC training institutions accreditation by tertiary TI or Regulatory body	2013-1 2013 2013-17 2013-17 2013-17 2013-15 2013-14 2013-17	Surveys Observations AC Registers	membership	of funding Number of donors Acceptability of AC by other professions
Strategic Direction: Research, Monitoring and Evaluation **Core Program Intervention:** Model best practices, document, analyze and share results, institutionalize system for regular reporting, monitoring and evaluation of activities. **Partners:** AMDD, SolidarMed,					

Objectives	Indicators	Time Frame	Means of Verification	Responsible Party	Risks and Assumptions
Objective 5: Inform policy and program by modeling best practices, improving program outcomes through evidence based practice and use of data and information for decision making.	• 10 AC best practices shared • 2 major research studies conducted • 2 Joint research with other professional societies conducted • 3 policy recommendations submitted and accepted by 3 countries • 2 country specific ACs training institutions research conducted • Secretariat staff trained in organizational/program, reporting, documentation, monitoring and evaluation • Ongoing monitoring conducted • Decisions made based on information and data collected	2013 2013-172014-17 2013-17 2013-17 2013-17 2013-17 2013-17 2013-17 2013-17	Reports Documentation Assessments Interviews Surveys Observations	Executive Board, AC CoP Secretariat Regional/country Offices General membership	Political and economic stability Flexibility of the donors and continuity of funding Number of donors Acceptability of AC by other professions and communities

ANNEX II BUDGET

Activities	Budget (US$)	
	Year 1	Year 2-5
I. Establishment of Secretariat and formation of Country AC structures/chapters		
Identify office space	No cost	No cost
Procure furniture and office equipment	20,000	No cost
Procure project car	50,000	No cost
Establish a program management unit responsible for all technical areas of AC CoP	No cost	No cost
Establish a membership service unit responsible for all membership development, representation and partnership affairs	30,000	10,000
Establish resource mobilization and advocacy unit	3,000	No cost
Establish financial management unit	No cost	No cost
Develop and implement governance manual (Constitution and Operational Guidelines)	25,000	No Cost
Develop and implement regional/country chapters/protocols	25,000	No Cost
Develop and implement a comprehensive financial guidelines	2, 000	No Cost
Strengthening the reporting, documentation and monitoring and evaluation (M&E) system	No cost	No Cost
Submit periodic and comprehensive financial and activities report on time	No Cost	No Cost
Launch/update website and promote its use	10,000	40,000

Develop data base on members profile and expertise and update regularly	5,000.00	No Cost
Establishing e-mailing list and dissemination of research works and other publications through Internet	No Cost	No Cost
Initiate and promote strategies for AC members providing community service	5,000	10,000
Salaries	**264,000**	**264,000**
Total Budget for Establishment of Secretariat and formation of Country AC chapters	479,000	324,000

II. **Capacity building and Advocacy**		
Establish membership service unit	No cost	No cost
Established membership data base	2,000	2,000
Increase number of AC CoP member countries from 6 to 10	No cost	No cost
Increase membership to 100% by 2015	No cost	No cost
Send 20 postings via emails on activities of AC, emerging issues	No cost	No cost
Train 20 AC CoP members in advocacy opportunities	10,000	No cost
Send 20 CoP members to participate in scientific meetings	15,750	63,000
Inaugurate and celebrate the International Day of ACs in 4 countries	10,000	40,000
Hold General Assembly meetings annually	10,250	41,000

50 % AC 's attain membership in national and international professional societies and networks	No cost	No cost
Disseminate 1,000 copies (200 of bulletin or newsletter copies each year)	4,000	12,000
Sign MOU with local professional societies for a sustained informati exchange, experience sharing and mutual support in the health development	No cost	No cost
Train Executive Board and secretariat staff in leadership and advocacy	5,000	No cost
Total Budget for Capacity Building	57,000	159,000
III. Partnership and Resource Mobilization		
Conduct inventory of international Communities of Practice and organizations in health	No cost	No cost
Train Executive Board in fund raising/resource mobilization	20,000	No cost
Train Secretariat staff in organizational/program development	40,000	No cost
Develop and submit 7 proposals to potential donors	2,500	10,000
Write 15 papers on AC practice for presentation at international conferences	10,000	40,000
Sustain existing funding partnership by adherence to set agreements	No cost	No cost
Design and implement membership fee collection Strategies	No cost	No cost
Develop and manage AC CoP website	5,000	20,000
Increase Donor base from 1 to 4	No cost	No cost

Total Budget for Partnership and Resource Mobilization	68,000	70,000
IV. Education, Training, Practice and Regulation		
Identification of AC core competencies	No cost	No cost
Enhance AC curricula to national, regional and international guidelines (ECSA & WA-HC, WHO, WFMES)	No cost	No cost
Development of AC Professional ethics and code of conduct/practice	2,000	No cost
Development of Job descriptions and specifications	No cost	No cost
Conduct AC Continuing medical education activity once every quarter in priority areas CoP members	20,000	80,000
Develop 3 abstracts per quarter for presentation at scientific conferences	3,000	12,000
Encourage OJT for continuous medical education	No cost	No cost
Compile E-mailing list of all members	No cost	No cost
Introduce and orientate members to E-learning	No cost	No cost
Support accreditation of AC training institutions by tertiary TI or Regulatory body	No cost	No cost
Total Budget for Education, Training, Practice and Regulation	25,000	92,000
V. Research, Monitoring and Evaluation		
Undertake situation assessment of the working environment of ACs	NC	NC
Piloting best practices, document and analyze results – community oriented model projects that can serve the people and facilitate learning (US$ 4,500,/project	4,500	17,000

X 3 projects /five-year)		
Undertake three operations research in five-year to advice the government the way forward to the challenges of maternal child hea and priority areas- quick win to realize MDGs 4 & 5 (US$ 25,000/research)	25,000	100,000
Initiate and conduct joint research activities with professional societi on issues of mutual interest (contribute US$ 16,000/research X 2 researches in 5 years)	12,000	24,000.00
Submit to AC CoP member country governments 3 policy recommendations	NC	NC
Support 2 research activities in ACs training institutions (US$ 10,000/Year/research X 5 years)	15,000	30,000
Train all Secretariat staff in organizational/program, reporting, documentation, monitoring and evaluation	10,000.	5,000
Undertake regular monitoring and evaluation activities and produce reports (10,000/year)	10.000	40,000
Practice the use of data and information to facilitate decision making for improving program outcomes	NC	NC
Total Budget for Research, Monitoring and Evaluation	US $76,500	US $216,000
25% Administrative costs	US $110,500	US $148,000
Total Budget for program	US $816,500	US $910,000

ANNEX III

SECRETERIAT	UNITS	MONTHS	TOTAL
EXECUTIVE DIRECTOR	8000	12	96000
ADMIN/FINANCE OFFICER	5000	12	60000
SECRETARR/ADMIN ASSISTANT	1000	12	12000
DRIVER/OFFICE ASSISTANT	1000	12	12000
SUB TOTAL	**15,000.00**	**48**	**180,000.00**
COUNTRY OFFICES			
COUNTRY COORDINATORS	**500**	**12**	**6,000**
GRAND TOTAL	**15,500.00**	**60**	**186,000.00**

N.B: Remuneration is within the context of the Non Governmental Organization trends

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