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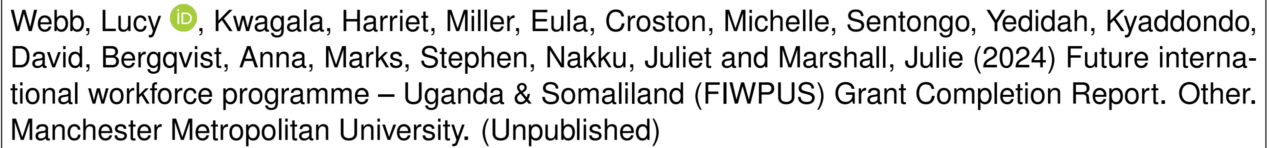
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Future international workforce programme – Uganda & Somaliland (FIWPUS)

Grant Completion Report

February 2024 (Delivered December 2022)

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Partner Institutions

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Butabika National Referral Mental Health Hospital, Kampala (Butabika Hospital)
Makerere University, Kampala
Manchester Metropolitan University (Man Met)
Nottingham University (Notts Uni)

Summary

We have completed a review of current guidelines and evidence regarding international nursing standards for education and practice, and updated this review to ensure it is relevant to 2022. This is evidenced by a written report.

Two Beacon sites were identified for the development of community practice placements, and have been audited. Both audit documents and a narrative report of site development have contributed to the development of a draft development plan.

The Mentorship train the trainer and Mentorship training module have been developed. Both streams of activity and evaluation provides evidence for future educational activity in Uganda and the UK. See below:

Mentorship train the trainer material and resources have been uploaded to PADLET (a free educational sharing platform) and training delivered to the tutor cadre at Butabika School of Nursing (BSPN). The train the trainer module has been evaluated formally, providing evidence of impact and illustrating needs for any cultural adaptations required for further training across the UK/UG partnership. The evaluation also provides evidence of wider pedagogic adaptation needs for both Uganda and UK nurse training, especially considering accommodation for overseas students and providing de-colonised learning material in the UK.

Mentorship continuing professional development (CPD) module material and resources have also been uploaded to PADLET and the programme of study has been delivered by the Butabika School tutors to clinical practitioners. This module is also evaluated for content, delivery format, cultural appropriateness, pedagogic style and accessibility. This evaluation has also contributed to consideration for future training development in both the UK and Uganda.

A range of key stakeholders have been interviewed and consulted to identify the priorities for mental health nurse training locally. This has included practitioners, policy makers, educators and service users and their families.

The project has also provided a needs assessment for the curriculum development and started the change process by initiating conversations about supporting a degree-level programme with key stakeholders such as the Ministry of Health and the Ugandan Nurses and Midwives Council.

GENDER EQUALITY AND SOCIAL INCLUSION (GESI)

What we learned

It has been highlighted in this project that stigma in mental health in Uganda is transferred onto mental health workers who then also carry the stigma of working with mentally ill patients. Also, that the nursing student cohorts are predominately female, but include a similar proportion of males to mental health cohorts in the UK. Leadership roles in the teams in Uganda appear to be mostly female-led but the training in specialist mental health nursing can be dominated by medical and psychology practitioners who tend to be male. We have identified a need for nurses to be trained by nurses and that nursing in Uganda should ‘grow its own’ nurse leaders, especially in mental health.

Social and gender inclusion

The majority of staff in this project receiving training, included in the partner membership and working as volunteers in the project are female. This is to be expected in the nursing profession however the proportion may not be representative of gender distribution in the profession, especially in mental health nursing which has a higher proportion of males than general adult nursing. The gender difference at Butabika School varies from time to time in terms of students admitted. The Tutors and mentors are mostly female. The female trainees are still the majority in psychiatric nursing program.

At community level, it is mostly women as first line health workers in Uganda. The community practice development therefore enhances gender equality in access to mental health services, as most informal caretakers at community level are women.

Among the stakeholders consulted were the carer (relatives of patients) category who were females and most VHT (voluntary health trainer) leaders are female. Peer mental health workers were previous mental patients who had recovered and these did very good in assisting in the mobilization of carers. We therefore ensured social inclusion for those who may be vulnerable and seldom heard by ensuring our consultation process included those receiving care and support and were represented in the consultation.

How the project can enhance GESI
Nursing in Uganda represents a route to post school education, professional training and career development and economic independence, which includes establishing women within the professional layer in the workforce. A current focus in global nurse workforce development also emphasises the need for greater leadership and management skills, and ability to increase nurse leaders to champion the profession towards autonomous practice for a more balanced health workforce and improved health systems. The focus for this project is to develop mental health nurse training to improve standards of practice and skills. Through this development, uplifting nursing training towards contemporary international standards presents an opportunity to provide women and girls with professional skills, role models and routes to economic independence.

Students come from both rural and urban areas so this can offer empowerment to trainees who may lack resources to gain further education and training and develop their careers. The mental health nursing course is not suitable for some learners with disabilities – in line with international standards for nursing which require 'fitness to practice' in both physical and professional terms. However, the Butabika nurse training is open to those with chronic illnesses including mental health conditions controlled on medication access training.

We have identified also that developing nurses in community practice provides those in more rural and traditional communities with greater access to knowledgeable healthcare. Our training evaluation has identified a need for professional update training, development of training resources in community settings and improved leadership and management training within the curriculum. This development of nursing skills towards autonomous community-based practice should enhance health promotion and access to seldom heard or represented individuals with mental health issues, helping to overcome stigma, labelling and lack of representation and health access.

ACTIVITIES CARRIED OUT

See Appendix A

CHALLENGES

See Appendix B

DATA COLLECTION SUMMARY

Review of literature – international nursing standards.
Review complete and evidenced in a standalone report.
Report identifies key CPD and pre-registration modules for updating existing and new trainees.

Mentorship Train the Trainer and Mentorship module evaluations.
Train the Trainer module prepared, provided and delivered. Evaluations analysed. Data collected on attendees' characteristics (gender, stakeholder status, area of practice, etc)
Mentorship module delivered by BPSN tutors to clinical staff over 6 weeks (1/2x6).
Attendance over 20 clinical nurse practitioners. Module evaluations complete and analysed.
Report on evaluation analysis identifies pedagogic needs, delivery modes, cultural and environmental requirements, acceptability of training and adaptations required.

Audit of placements.
Two sites audited for practice placements for student MH nurses. Audit forms completed and analysed.
Needs assessment for development of sites completed and needs identified.

Stakeholder consultations.
Interviews and consultations completed with range of stakeholders: nurse tutors and students, community practitioners, medical clinicians, service users and relatives, community representatives, VHTs (community health workers), policy makers in health and education.
Covid-19 lockdown in Uganda meant switching from planned open space group events to individual interviews. This was more time consuming on staff and travel expenses, however, it may have facilitated better inclusion and a more in-depth evaluation. Also, it facilitated a more flexible approach to engaging policymakers in the process as they were more difficult to engage and include.

MoSCoW tool completion (exploration of identified needs and priorities for MH nurse training).
Consultation process with stakeholders complete. MoSCoW mapping complete, key knowledge and skills and resources identified.
Priorities for development mapped along TOC process. Time pressures caused by the funding transfer delay meant that the stakeholder consultations were late resulting in a limited time to complete the MoSCoW tool analysis. However, this was overcome through the willingness of the Makerere partners.

Draft curriculum development plan.

The outline plan provides the basis of curriculum updating for BSPN towards degree-level nurse training in mental health. All strands of the project have contributed to the development of the curriculum outline, and projected development plan through a theory-of-change structure. The findings for the plan highlight the need for further engagement of Uganda's Ministry of Education and Sport, and the Ministry of Health as the development of degree-level training of mental health nurses requires recognition of the academic and professional outcomes at this level, and acceptance of the need for nursing leadership within mental health nursing. Currently, there is no mental health nurse representation on the Ugandan Council of Nurses, and debate as to whether mental health nursing at degree level should be a specialist role. The curriculum has therefore been developed to incorporate specialist nurse outcomes at degree level, while retaining certificate and diploma level mental health nursing registration options.

PROGRESS AGAINST MONITORING AND EVALUATION PLAN

See Appendix C

PARTNERSHIP DEVELOPMENT

There has been a good working relationship. The partnership contributed to the success of the project. Each partner had a unique contribution to this project as reflected in the work schedule. We benefited from also including a partner from Makerere University to take the lead on the stakeholder consultations as this provided research expertise and language and cultural understanding.

To conduct projects remotely, more advanced technology in IT needs to be adapted to allow clinical supervision on the new platforms for teaching, conducting sessions and notes reviewed later, widening internet to communicate at a distance. Face to face working would be a much better way of learning and exchanging knowledge. Exchange visits do more for learning from each other than remote communication, not just because of IT barriers. Blended forms of project working may be a way forward: to have exchange visits for training and experiencing cultural and environmental differences, and differences in practice, and then supported packages for training online.

We have learned that there is a need to continue to develop a model community practice placement, more resource persons, more training manuals, curriculum, field visits, improved network.

Advice to others would be to ensure good communication and have dedicated administration and partner leads, engage as many stakeholders as possible, construct a working schedule so

that everyone knows what their particular responsibilities and deliverables are, and review frequently.

project benefits back to the UK

Knowledge and understanding of adapting learning materials for cultural appropriateness in mental health nursing – to benefit both overseas development and delivery of nursing training resources to overseas student cohorts in the UK – both for pre-registration and continuing professional development. We have also learned the strengths and limitations of providing distance learning if providing training to Ugandan learners. This experience emphasises the need for scoping visits prior to provision of online resources, and the need to support online learning with quality train-the-trainer courses for tutors first in order to support end-user training to nurse students/clinicians.

This learning also informs the decolonisation of our UK pre-registration and CPD nursing curricula. We have identified the specific needs in cross-cultural mental health teaching, especially important where cultural understanding of mental health and illness is more variable between HICs and LMICs. At the same time, we have experienced difference in pedagogy that requires more attention to be given to non-UK students who are used to open class debate and discussion, and the development of critical thinking, while sub-Saharan African students may be more used to a didactic and hierarchical approach. This is important in nursing where we focus in the UK on autonomous practice and leadership/advocacy in nursing, while Ugandan nurses may be still developing these elements from being overshadowed by medical practice and models of care.

It has also provided opportunities for early career researchers to be involved in the project. It is important to mention that this is not just a UK benefit as involvement in the project has also benefitted junior tutor staff at BSPN.

We plan to disseminate findings through peer reviewed nursing-relevant journals and other dissemination avenues, and we have been able to strengthen and sustain our international networks for this project and future projects.

FUTURE PLANS

Now that we have established a working partnership and identified educational needs from our three forms of evaluation (MoSCoW, training evaluations, placement audits), we plan to commence a scoping review of CPD needs with the intention to develop a new curriculum and deliver the CPD identified for educators and existing clinical nurses, and develop the training to be made available to student nurses.

For the curriculum development, there is need to specify the content for the different levels of trainees. We need to determine whether this should be a speciality at a higher level of training and at lower levels have models incorporated in the existing curriculum.
Need to adapt the mentorship training as short course (6 months) training program for clinical mentors.
There is need to further the training of the staff in the School in community mental health nursing at masters level. This will better support the community mentorship training and support other CPD updating to modernise existing practice.
The Bachelors program in psychiatric nursing is paramount exchange program to benchmark.

We hope that THET will be able to support the continuation of this development work in the near future.

SUMMARY ON PROJECT WORKING

During Covid, it became very important to ensure good online communication for partners in the LMIC, and this required significant expenditure on equipment in Uganda that exceeded the proportion allocated for this call. Understandably, the proportions represented pre-Covid requirements where international travel and face-to-face meetings and delivery of training was the norm. We applied for and were awarded additional allocation for equipment, however, this proportion limitation made it difficult to allocate funds for each area of expenditure.
Further projects for education and training post-Covid, however, are likely to rely increasingly on online communication and use of online learning, Zoom meetings, both to take advantage of the increase in usage of IT for communication and education, and to improve sustainability by reducing flight travel in view of climate change requirements. It may be necessary to re-consider the proportion allocation for equipment if IT upgrading is required, or perhaps have a separate allocation for IT where it is required.

FEEDBACK ON THE PROJECT BY THE TEAM:

Lucy Webb, UK partner project lead.
This has been a terrific project for the UK team in learning about the challenges and styles of nurse training in Uganda. In such a different environment there are clearly challenges but also a lot of strengths in working with few resources. In the UK we have become too reliant on technology to train students and should learn – and remember – to focus on the fundamentals of the student-tutor relationship. To train nurses, teachers need to be role models and practice/demonstrate nursing professionalism as much as having expert knowledge to impart to students. The recent reliance in the UK on distance learning and teaching during Covid lockdowns, and the increasing pressure to have bigger classes in large lecture rooms, take away the personal touch that students rely on to learn how to practice.

This is why mentorship in practice is so important as this is where the students learn how to be a nurse – from other nurses who are already doing the job.

Yedidah Sentongo, retired principal of BSPN and co-lead for LMIC.
This has been a very good learning experience mixed with covid 19 lockdown but there was a lot of determinations from all partners to ensure that the project kicks off and aim realized. It was a good learning experience notably TOT and TOM (mentorship training) participants yearned to have the physical presence of the facilitators from MMU and wished to have more Ugandan culture orientated explanations. It was also fascinating to learn that TOT participants were thirsty future scholars. All participants appreciated the value good mentorship in producing skilful and competent nurses for future generation.

Ugandan mental health nurse: *I am a psychiatric nurse but not well versed with sociology. But we should be able to answer the questions of students. When I am a trainer, I should be able to give hope to the people I am training.*

Ugandan Community nurse: *We need [mental health training] at various levels. We need this [training project] so that we can avert the problem early enough before we can have major community mental health problems. If identified early it would help.*

Uganda Nursing and Midwives Council representative: *The biggest challenge in this country is a tendency to rely on doctors at different levels to train nurses. Nursing is a profession of its own and unlike doctors; it emphasizes care which the doctors cannot train on. So in the training of nurses at all levels we need to be trained by fellow nurses since in the world, we have nurses with masters, doctorate and post doctorate levels, the trainers/lecturers should be drawn from these as opposed to using doctors to train nurses.*

Ugandan Medical practitioner: … *in Uganda, these are the courses we have and it's like we are stuck on those ones, we have a clinical officer course everybody should go for that course, we have psychiatry, everybody should go for that. But now let us innovate and I really congratulate you and thank you for this innovation.*

Ugandan Student nurse: *They (the new planned curriculum) should have much [more] placements in communities rather than in hospitals.*

Ugandan mental health nurse tutor: *Mentorship training will equip nurses with the knowledge and skills that will help nurses in their role as mentors, for example, the nurses will be able to create effective learning environments, they will be able to assess students.*

Nurses will vary methods of instruction to suit different learning [ ] styles and they will be able to identify failing students and help them.

APPENDIX A: PROJECT ACTIVITIES

Planned month	Activity	**Progress of activity:** Did this activity take place on time, did it progress as planned, were there any challenges you faced, how did you overcome them?	Key individuals involved in delivery	Implementation sites
august 21	Ethics approval process in UK	On time. No problems	LW, JM.	Man Met, UK
August 21	Desktop review & literature updating: international standards of community MH nursing, & community MH curricula for non-Western locales	Completed but needed updating in 2022 – to ensure new material was included. See Jan entry.	EM, LW, AB	Man Met, UK
August 21	Ethics applications, Makerere, and Makerere team recruitment	Ethics application delayed. Delayed funding transfer.	DK	Uganda
Sept	Stakeholder engagement	Key stakeholders identified. Engaged in December.	YS, DK, HK	Uganda
	Identification of practice settings	on time.	YS	BSPN and community health settings.
Oct	BSPN mentorship training tutor group team created.	on time.	HK	BSPN
Nov	Recruiting staff for mentorship training	on time.	HK, YS, BSPN Team.	BSPN & Butabika Hospital
Nov	Teaching and learning (mentorship) training available for BSPN staff (asynchronous learning materials and exercises)	5 draft sessions prepared, adapted and approved by BSPN,	MC, LW, YS, HK, & BSPN team	BSPN, Man Met, Notts Uni.

(June)	IT needs assessment for BSPN	This has already been performed prior to project but needed updating to fit budget allowance.	HK, JN	BSPN, Butabika Hospital
	IT improvements BSPN: upgrading and equipment sourcing	Delayed (funding transfer delays).	Contractor overseen by BSPN	BSPN
Dec	Stakeholder engagement	complete on time.	DK, HK, YS.	BSPN, Butabika Hospital, Makerere University
Jan	Community nurse skills Train-the-Trainer delivery to BSPN (asynchronous online training) and evaluation	Delivered first three weeks of January as live online sessions.		Man Met, Notts, BSPN (delivered online)
Jan-Feb	Audit of practice settings – identification of resource needs (inc. staff training)	Audit tool created jointly by UK partners, BSPN & community nursing staff	Lead by YS	BSPN & community nursing staff (and service users?)
Jan-Feb	Mentorship training delivered to clinical practitioners	On time, delivered over 6 weeks. Good attendance (n>20)	Lead by HK BSPN team	BSPN, Butabika Hospital, community health settings
Feb	Outline draft curriculum development	Constructed outline draft. Finalised as outline in Feb following stakeholder data.	LW, EM, MC, AB	Man Met, Notts Uni, UK
Jan - March	1st Open Space stakeholder meeting	converted to one-one interviews due to covid restrictions.	DK, YS	Makerere University, BSPN, Butabika Hospital, & community settings
March	2nd Open Space meeting: Stakeholder consultation on first draft	No longer appropriate due to conversion to one-to-one interviews	DK, YS	
March	2nd consultation feedback analysis (inc. cultural appropriateness)	From respondent validation and tutor and student evaluation analysis	HK, YS, LW, EM, MC, AB, SM, BSPN Team.	BSPN, Man Met, Notts
March	Analysis of audit data	Two community placements audited	MC, YS	BSPN community settings
April	Finalised CPD portfolio developed. Scheme of	In outline form only. It was found that this needed to be aligned to an overall curriculum development plan	LW, EM, HK, YS, BSPN Team.	BSPN.

	work for community module finalised	that addresses pre-registration MH nursing as well as CPD training.		
April	Finalised curricula pro forma developed.	Curriculum draft developed	LW, EM, HK, YS.	BSPN
April	Final implementation plan developed for next development steps.	Report for development plan incorporated into evaluation report and draft curriculum	LW, EM, HK, YS.	BSPN.
April/May	Analysis of findings for UK impacts	Collation, analysis and evaluation of stakeholder consultations, training evaluations and literature review for application to UK nurse education practice	EM, DK, AB, LW, SM, MC	UK team and Makerere University
	Please add further rows as required.			

APPENDIX B: Challenges

What was the challenge?	What can you learn for the future?
e.g. challenges to communicate with local project coordinator due to weak internet connection in the area of intervention	
Communication challenges due to weak internet with key partners during Uganda lockdowns: unable to use BSPN internet for partner meetings.	Upgrade of IT available to key personnel (at home via laptops and broadband contracts) during the project would improve communication. We also switched to whatsapp and email to communicate. However, internet challenges are an ongoing issue in Uganda when it rains or when hubs are not available to personnel.
Major delay in transferring funds to Ugandan partners. This was largely due to covid lockdowns in UK and severe interruptions of department functioning at Man Met.	This was eventually overcome by creating a 'preferred provider' payment system with Makerere and Butabika Hospital as a common and well-known route to fund transfer for Man Met. This will remain the key route for these partners in future. They are now 'on the system'.
Covid. As above, covid lockdowns in both Uganda and the UK were major obstructions to delivering the initially planned project. Adaptations to the project were ongoing and needed to respond to covid waves and mitigation strategies such as lockdowns.	Project remained achievable due to continual flexibility and pragmatism. As this was an unprecedented barrier to delivering the original project, mitigation could not be planned. However, by focusing on the overall goals, and lots of understanding and problem-solving by Ugandan partners, the key goals have been achieved. However, BSPN too needs to learn from this experience how this happens and to put in place improved methods to adapt to challenges.
Time difference challenge: to deliver training from UK to Uganda with a 3 hour time difference.	This meant very early starts for the UK team. Exchange visits would overcome these problems. Teaching online also limits the impact of the teaching impeding teaching interactiveness, group discussions, relating to students and encouraging exchange of ideas.
Busy schedules of some of the national level stakeholders – leading to multiple appointments before engagements could be conducted.	Flexibility enabled undertaking the consultation activities.
Reduced project time due to covid lock downs and delayed funds transfer	Critical thinking and flexibility on how to replan and carryout the require activities, selflessness was key working with minimal rest.

Concurrent programs running at the same time. Staff (clinical) leaving their places of work to come and attend sessions. Power supply.	Program was successful though it was hectic running school programs and training with the same resources. Need to schedule the training during holiday. Facilitating staff with IT gadgets and internet facility. It was good there was no much interruptions with electricity but need to devise other source of generation of electricity, especially if relying on online training and communication. Need to have a fulltime coordinator for such projects who is also a school staff. Need to separate human resource persons for the training: have a dedicated HR assistant to support the rollout of the training.

APPENDIX C

PROGRESS AGAINST MONITORING AND EVALUATION PLAN

Goal – what is the overall aim of your project?	**Goal Indicators – how will you know you have achieved your goal?**	**Baseline**	**Targe t**	**Actual**	**i. What is the data collection tool?** **ii. How was the data collected?** **iii. By whom?** **iv. When?**	**Challenges:** **i. Have you encountered any challenges in collecting data?** **ii. If you were not able to reach your target, what are the reasons for that? Please provide some narrative**
Establish baseline skills and resources to roll out community MH nursing training in practice settings	Construction of 1 culturally appropriate CPD portfolio and 1 pre-reg community practice module	1 portfolio	1	1	I. Standard internationally recognised teaching and assessing audit tool (as	Delays due to covid lockdowns in Uganda – BSPN was closed until November and movement restrictions stopped personnel

	Identification of resource needs for 2 Beacon Sites for community practice placements BSPN tutorial staff completed community CPD train-the-trainer module	1 audit for 2 community practice placements ≥4 tutors trained on ToT	2 4	2 22	currently used by UK universities & adapted to suit Ugandan context) II. Observation methodologies & audit/evaluation tools III. By monitoring and evaluation team from Makerere University & BSPN research team IV. Throughout consultations and completion audit and evaluations (for portfolio & modules)	carrying out preparation work. Alternative was to use the literature review to identify key topics for CPD module development. Delays were overcome by re-scheduling and teamwork in BSPN to set a timetable for training and auditing. We also separated the stakeholder consultations from the training resource development. That meant that the resource development was not held up by the need to get data from the stakeholders. Essential feedback was obtained from the BSPN team instead. Stakeholder data was then used for planning outline CPD curricula pro forma for further skills needs, and the portfolio outline.
Outcomes – what health system changes do you expect to see by the end of your project?	**Outcome Indicators – how will you know that this change is happening? (Please include a target figure where appropriate)**	**Baseline**	**Target**	**Actual**	**i. What is the data collection tool?** **ii. How was the data collected?** **iii. By who?** **iv. When?**	**Challenges:** **i. Have you encountered any challenges in collecting data?** **ii. If you were not able to reach your target, what are the reasons for that? Please provide some narrative**
Implementation plan in place for integration of community MH nursing provision in curricula	Completion of stakeholder consultation process and draft portfolio/module evaluation Completion of Theory of Change-style modelling for adoption of new curriculum	20 1	20 1	70 1	I. MoSCoW priorities tool and observation/interview methods II. Stakeholder consultation event III. M&E team from Makerere & BSPN research team IV. On completion of analysis of consultations.	Delays in starting data collection process but target met and exceeded. Good range of stakeholders included but limited to 2 policymakers. Curriculum plan requires further input from policymakers before finalisation.

BSPN capability in delivering CPD and pre-reg community nursing module	BSPN tutor staff (4+) completed train-the-trainer modules	4	10	22	I. Assessment of learning tool (bespoke evaluation questionnaire) II. Online or via digital media III. Man Met nursing team IV. On completion of modules	target met and exceeded
Identification of resource needs for 2 key practice placement sites	Evaluation audit of 2 key practice placement sites	2	2	2	I. Community nursing education placement audit – adapted for Ugandan context II. Observation visit to placement sites III. BSPN staff & community nursing staff IV. January 2022	target met
Outputs – what changes do you need to occur in order to achieve your outcomes?	**Output Indicators – how will you know that this change is happening? (Please include a target figure where appropriate)**	**Baseline**	**Target**	**Actual**	**i. What is the data collection tool?** **ii. How was the data collected?** **iii. By whom?** **iv. When?**	**Challenges:** **i. Have you encountered any challenges in collecting data?** **ii. If you were not able to reach your target, what are the reasons for that? Please provide some narrative**
Up to date review of current international nursing standards for mental health nursing	Completion of review of current and future trends in international nursing standards	1	1	1	I. Narrative literature review II. Literature Search engines and library databases III. Man Met team IV. August and update in January 2022.	No challenges. target met.
Structured participatory consultation with key stakeholders in Uganda	Consultation of key stakeholders in the identification of pre-reg and CPD learning needs, delivery approaches and minimum resource needs (i.e., online platforms, formats).	20	20	35	I. MoSCoW tool and semi structured interview schedule II. Interviews and focus groups III. Makerere team IV. January & February	Delayed by covid lockdowns and slow transfer of funds to Ugandan partner. Target achieved later in the project schedule.
Evaluation of draft curricula plans for cultural and resource appropriateness.	Follow-up consultation with approximately 5-10 representative stakeholders on draft curricula.	5	10	5	I. SWOT-style analysis II. Review of draft by BSPN tutorial team	Delays in rolling out stakeholder consultations have meant this process has been shortened to a review by BSPN tutorial

					III. BSPN & Man Met teams IV. On completion of draft plans	staff rather than a respondent validation approach using a sample of stakeholders (although tutorial staff are also stakeholders). Target achieved.
Audit carried out on 2 community practice placement sites	2 placement sites will have been identified for audit	2	2	2	I. International standard education audit for student nurse placements II. Audit site visit & consultation with community practice nurses III. BSPN research team & community practice lead nurses IV. January	No challenges. The audit tool was adapted from current UK tools and simplified through consultation with BSPN personnel and community practice nurses: for cultural and environmental appropriateness. Target achieved.

Partnership Development Goals		
Principle of Partnership / hallmark	**Goal**	**Achievements in relation to goal – please provide some narrative around the progress which your partnership has made towards achieving the objectives set. Consider activities you have carried out which may have demonstrated alignment with the Principle or Hallmark, or evidence of a change in attitude or process.**
Principle 1: Hallmarks of good practice: A. Partnerships have a clear rationale with a formal, written document, e.g. memorandum of understanding B. Partnership plans and objectives are clearly linked to identified needs for both the HIC and LMIC. They are formally reviewed on a regular basis C. Project activities are prioritised and planned with measurable outcomes D. Exit strategies are developed when appropriate	A. MoU completed. B. Schedule of work created for all partners, clarified and agreed. Regularly reviewed, roles clarified as changes made due to Covid and finance delay forced revisions. C. As above, activities identified, clarified and agreed changes as needs arose. D. Took advantage of the opportunity to apply for non-pay extension. Agreed with all parties and date confirmed by all parties.	A. MoU completed between Butabika Hospital and School of Psychiatric Nursing, and Manchester Metropolitan University. B. Schedule of work created, and adapted as demands changed and problem-solving was put in place. BSPN were responsible for facilitating Train-the-Trainer delivery and were responsible for delivering and evaluating the mentorship training module. Man Met was responsible for creating learning material and resources, delivering Train-the-Trainer and collating and analysing evaluation of both sets of training delivery. C. There was by necessity frequent adaptation of the schedule of work due to covid lockdowns in Uganda and a delay in transferring funds from Man Met to Ugandan partners. This delayed the project progress but training was delivered on time. Additional time to complete the project enabled analysis and reporting of the findings and good quality monitoring and evaluation. D. As above, the non-pay extension was agreed by all parties and enabled quality analysis and evaluation of findings.

Principle 2: Harmonised and Aligned – Your partnership's work is consistent with local and national plans and complements the activities of other development partners.	To ensure final curriculum plans are in line with national health system needs, stakeholder requirements and national governance (i.e., Ugandan Ministry of Health, Ministry of Education, Nurses & Midwives Council)	
Hallmarks of good practice: A. Partnership plans reflect national health priorities or are designed to influence national priorities B. Partnerships' plans build on an institution's strategic health plan C. Partnerships are supported by senior management and colleagues in each partner institution D. Partnerships engage national regulatory, governance and research bodies with the potential to support and learn from their work more broadly or in the longer term E. Partnerships collaborate where possible with other NGOs and INGOs to maximise effectiveness	As above	A. This project partnership reflects national priorities and aims to develop national health systems to achieve these. This work aims to develop mental health nursing training to uplift standards of professionalism and expertise for future need. The UK team in this partnership provide support for the Ugandan partners to promote this aim. B. As above, the Ugandan partner's strategic plan is to develop the curriculum into a degree-level programme that delivers an international standard nursing workforce. C. The Director of the National Hospital and the Principal of the School of Nursing in Butabika are the senior management in this instance and partners in this project. D. A key outcome beyond the goals for this project is to promote the development of an updated and uplifted curriculum for nursing training in mental health. In this, Ugandan partners are engaging with UNMC, and relevant Ministries to promote the curriculum development. By consulting a range of stakeholders (who include representatives of regulatory governance agencies) the project involves them at an early stage. E. There is less need at this stage to engage with NGOs except to develop the practice placements and make better use of NGO providers to enhance student practice experience.
Principle 3: Effective and Sustainable – Your partnership operates in a way that delivers high-quality projects that meet targets and achieve long term results *Hallmarks of good practice:* A. Partnerships involve a wide range of stakeholders to ensure continuity and local ownership B. Partnerships explicitly recognise barriers and challenges to health systems	To produce a curriculum plan for future nurse training that can be sustained for a 5-10 year period.	A. Stakeholders consulted include nurse tutors, nurse and medical practitioners, service users and their families, communities, nurse students, and representatives from governance organisations. B. The consultation and evaluation elements incorporated environmental and cultural appropriateness in the development of the curriculum plan. C. The partnership is mostly made up of mental health nurse tutors, researchers and practitioners, with the addition of a psychiatrist, medical anthropologist, psychiatric philosopher and communication

strengthening, such as health worker movement and unreliable supplies C. Partnerships are made-up of interdisciplinary teams to encourage resilience and adaptability to changing priorities of the partner's needs D. Projects are based on recognised good clinical practice, health system strengthening quality standards and good international development practices E. Projects are appropriate to the resources (such as equipment and staff) available		difficulty professor (speech and language). It was important that most of the team were mental health nurse tutors but the wider team provided different perspectives on the project. D. The evidence review ensured that the curriculum development was based on good practice, current and future workforce needs and international guidelines. E. The project faced difficulties with Covid-19 lockdowns in Uganda when staff were unable to access the School resources. However, these issues were overcome, and equipment needs had been assessed and included in the project delivery goals.
Principle 4: Respectful and Reciprocal –Your partnership listens to one another and plan, implement together. Your partnership ensures bidirectional learning where both HIC and LMIC partner gain learning. *Hallmarks of good practice:* A. Partners clearly define roles and equitably share responsibility for project planning, management and implementation B. Partners explicitly define HIC and LMIC need and learning outcomes for both Partners C. Partners listen to and engage with each other's needs and ideas D. Partners identify and respect each other's strengths and weaknesses, and engage frankly and positively with difficulties in their relationship and external challenges	To ensure work is carried out with equal and appropriate division of responsibilities and consultations; to ensure a co-productive method to deliver the project.	A. A Schedule of work was consultatively designed to apportion responsibilities and tasks between partners. B. It was clear what each partner aimed to achieve from the project. These were overlapping and complementary on the whole. The UK team also identified a need to better understand cultural and environmental differences in nursing pedagogy to benefit nurse training in the UK. C. Communication was key to ensuring outcomes and processes were agreed. Meetings were conducted via Zoom throughout the project, a shared drive was produced to share documentation (Dropbox for Business) and emails and reports supported informal communication. D. Key difficulties presented mainly from not being able to conduct exchange visits. Zoom communication was a poor alternative but did enable live meetings. It was recognised that Ugandan partners are the experts on what works in that environment. The UK team shared understanding of UK nurse education practice but recognised the need for dialogue and feedback to ensure environmental adaptation.
Principle 5: Organised and Accountable – Your partnership is well-structured, well-managed and efficient and have clear and transparent decision-making processes *Hallmarks of good practice:* A. Partnerships have clear, stable governance structures that are not over reliant on individuals	For all partners to have a clear understanding of their roles and responsibilities, and to contribute co-productively to the project.	A. There were clear role leads in all teams for different tasks, and deputies to support. Time pressures meant that there was too much reliance on the leads to deliver at the late stages of the project. This was due to both Covid lockdowns and a delay in transferring funds to Ugandan partners.

B. Partnerships engage individuals with the appropriate experience and expertise sharing roles and responsibilities clearly between both partners C. Partnerships develop and use clear communication channels D. Partnerships develop an effective fundraising strategy that draws on multiple sources of income including financial or in-kind support from both partners E. Partnerships develop transparent financial systems with shared accountability for financial monitoring F. Partnerships use procurement processes to minimise costs and cost variability while maintaining quality of inputs G. Partnerships develop effective volunteer management processes and review and update emergency protocols on a regular basis H. Partnerships keep records and reports of significant activities, results, decisions and transactions, and share them as appropriate		B. Both HIC and LMIC partners engaged teams to support the responsibilities. C. See Principle 4, C. D. This principle impacts mainly on the UK partner which used volunteering of time and use of research allocation from the employer to support the project. E. Use of THET financial monitoring was helpful in achieving this. F. This only applied to Butabika as only they needed to request quotations and estimates for IT equipment and support. G. There was little need for volunteer management for this project. Future projects that involve exchange visits will require these processes, risk management and emergency protocols. The UK partner organisation already has these protocols in place for overseas projects. H. All activities have been monitored and recorded, with reports of findings and outcomes.
Principle 6: Responsible – Your partnership conducts their activities with integrity and cultivate trust in their interactions with stakeholders *Hallmarks of good practice*: A. Partnerships keep up-to-date with current advice and adhere to international guidelines and best practice for international developmentorganisations B. Partnerships are open to admitting mistakes and reflect and respond appropriately	To conduct consultations and interviews using ethical protocols.	A. Both HIC and LMIC partners conducted activities in line with in-country ethical standards. Ethical approval was gained in both countries to manage data collection, data storage and management of consultees/participants. B. A review of the project partnership to identify strengths, weaknesses and responses will be conducted to identify areas for improvement for future projects. C. All partners are professionally registered practitioners who need to adhere to professional standards of their governing bodies. D. As above. E. As above.

C. All activities are conducted with honesty and respect for others D. All those participating in project activities comply with the relevant professional codes for health workers E. Risk associated with project activities is assessed on an ongoing basis and a duty of care is provided to all those participating in project activities		
Principle 7: Flexible, Resourceful, and Innovative – Your partnership proactively adapts and responds to altered circumstances and embraces change through learning from partner countries. *Hallmarks of good practice*: A. Partnerships propose ways to overcome challenges together that are mindful of context and the need for sustainability B. Partnerships are flexible in adapting partnership objectives in response to changing circumstances, especially when there are multiple partners involved C. Partnerships use innovative methods such as new technologies where appropriate in their approach to training health workers and are open to knowledge and ideas from their partner countries.	To deliver the project goal through available means.	A. We have met several challenges due to Covid-19 lockdowns, new ways of working, and delays in the finance transfer that held up the project in Uganda, so we have had to adapt the project throughout. Our ways of working have adapted and we have used innovations to overcome these. For example, conducting Zoom teaching, creating a shared drive, and providing a free-to-access education platform website (PADLET) to support the training. These are now permanently available. B. As above. C. As above.
Principle 8: Committed to evidence gathering, joint learning and ongoing adaptation – Your partnership monitors, evaluates and reflects on their activities and results, articulates lessons learned and shares knowledge with others.	To create further learning and evidence beyond the scope of the project goals.	

Hallmarks of good practice: A. Partnerships nurture a culture of reflection and learning with debriefing, monitoring and evaluation integrated into plans from the outset B. Partnerships allocate resources for monitoring, evaluation and learning C. Partnerships work together to identify what works, what doesn't and what can be learned from this D. Partners debrief and share widely the learning they gained from their partners E. Projects incorporate lessons learnt from their work and that of others when planning		A. We have built in research processes into the project which will enable all partners to extract added benefits from the evidence gathering and learning. These activities will continue beyond the project period and will include analysing evidence to enhance UK nurse training, creating better understanding of Ugandan health systems development in mental health, and examining Ugandan understandings of mental health to better inform global mental health service development. B. We have allocated resources for M&E by adding our Makerere University partner to the project. This will also enable continuing collaboration to analyse and evaluate the data that goes beyond the project goals. C. This has underpinned the project itself. It is key to our goals to evaluate what works and what does not, what needs adapting and examining the differences between what was proposed and what needed to be changed. D. As above in principle 6, B, we plan to carry out a debrief exercise to examine what we can learn for future working. E. As above.
Principle 9: Committed to gender, equality and social inclusion (GESI) – Your partnership considers unequal power relations and inequalities experienced by individuals as a result of their social identities and conduct GESI activities and analysis to ensure GESI is mainstreamed into organizations, programmes, interventions and activities. *Hallmarks of good practice:* A. Partners conduct a GESI needs assessment to identify groups at risk of marginalization, vulnerability, and exclusion to target within their projects B. Partnerships incorporate GESI related activities into planning, delivery and review of programmes, interventions, and services C. Partnerships ensure meaningful participation of key groups in planning, delivery, review and monitoring of programmes and services	To ensure good quality co-productive working and knowledge exchange between partners.	A. GESI is a key issue in mental health nursing, for both practitioners and patients/families. We recognise the stigma and marginalisation of those who have mental illness and their families, and this includes stigmatisation of those who work in mental health services in Uganda. A key promoter of equality for our project is the development of mental health nursing into a degree profession that incorporates leadership and management in the profession to champion mental health and be an agent for change. B. As above C. We have included patients, patient families, community members and student nurses within our stakeholder consultation to ensure all voices are heard and represented. These views also inform the curriculum development, as well as promoting person-centred and holistic care and patient and public involvement into service planning. Limited time precludes respondent validation of the final draft plan, but this will be a key element of the next stage of our partnership. D. As above, we aimed from the outset to include equally all views in our data collection and analysis.

D. Partnerships collect and analyse data disaggregated by relevant social stratifiers to inform planning, delivery, review, and monitoring of programmes and services (sex, age, disability, etc.) E. Partnerships ensure equal access to project benefits for the identified groups		E. Project benefits at this early stage of curriculum development focuses on developing good quality training for student mental health nurses. However, the longer-term benefits aim to deliver quality person-centred mental health care that addresses and recognises diversity, values-based psychiatry and empowerment as part of a nursing ethos.