

THE ADHERENCE OF FIVE NURSING SCHOOLS IN AFRICA TO REGIONAL EDUCATIONAL STANDARDS: AN EVALUATION REPORT

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ABSTRACT

Background: Programme review has been used to evaluate and formulate conclusions about the strengths and effectiveness of *programmes*. This article presents findings of the internal and external programme reviews which were conducted in five nursing schools in the African region. These reviews were guided by educational standards developed by the three World Health Organisation Collaborating Centres for Nursing and Midwifery Development in Africa with the support of the World Health Organisation African Regional Office.

Objectives: To establish the adherence of five nursing schools in Africa to regional educational standards.

Methods: In-depth case analysis was conducted, with each school forming a case. Data sources were all stakeholders and data were collected through interviews, focus groups, document analysis and observations.

Results: The results reflected diversity in educational programmes and adherence to some of the educational standards. The educational programmes were striving to address the needs of the respective societies; curricula were coherent, with significant clinical exposure; there were

productive international partnerships from which schools benefited significantly; and stakeholders were involved in addressing problems related to education and training. Weaknesses included inadequate teaching resources, a limited pool of suitably qualified academic staff, a lack of adequately prepared mentors and role models in the clinical areas; as well as a lack of specialist training and limited options within programmes if graduates wanted to specialise in certain areas.

Keywords: Adherence, quality assurance, nursing education, nursing schools, educational standards, programme evaluation, programme review, Africa.

INTRODUCTION AND BACKGROUND

According to Thomas, Rajacich, Al Ma'aitah, Cameron, Gharaibeh and Delahunt (2002), programme review is one way of monitoring the quality of a programme of study and promoting growth in nursing education. Such an exercise is used to formulate and evaluate conclusions about the strengths and effectiveness, and the weaknesses of *programmes*.

The process of quality assurance involves the setting of standards and the identification of criteria to measure each standard (Uys, Awases, Kamanzi, Kohi, Mtshali and Opare, 2006). The concept of standards is very closely linked to the concept of quality. Once standards and criteria have been decided upon, an institution can evaluate its own functioning against these standards (criterion-referenced evaluation). If data about the performance of similar institutions are available, the institutional team can compare its own performance with that of its peers. Therefore, standards are said to provide a means of measuring the degree of excellence of an educational programme and of comparing the degree of excellence of one programme to that of others. It is acknowledged that while many countries have developed or are developing national standards for nursing education, there is a move towards developing regional standards for groups of countries, such as in the WHO European Region and the African Region, to ensure uniform standards for nursing and midwifery education across the region.

Since 1997, the three World Health Organisation Collaborating Centres for Nursing and Midwifery Development in Africa (University of Botswana, University of KwaZulu-Natal and University of South Africa), have been working with the WHO Regional Office to establish a process of internal and external review that incorporates such a set of standards and criteria. The process of the development of the instrument is published elsewhere (Uys *et al*, 2006).

Barak and Breier (1990) assert that prior to implementing a *programme review*, the *process* has to be accepted by all participants. The authors identified fairness, objectivity, comprehensiveness, credibility, usefulness and effective communication as key principles that have been associated with successful *reviews*. Barak and Breier (1990) are of the opinion that adherence to these principles ensures that the academic staff, students and administrators understand why and how the *process* will be carried out.

It also helps to ensure that the *process* does not get undermined and that the results are taken seriously.

This article presents the results of programme reviews conducted in five African Nursing and Midwifery Schools, as a pilot project, with the focus on major strengths and weaknesses or developmental areas across programmes. It is hoped that the information from this article will give other Nursing and Midwifery schools on the continent a benchmark against which they might compare their own functioning. For the purpose of this article, the term “school” is used to indicate a unit offering higher education in Nursing or Midwifery, which can be a faculty, department, school or college. A “programme” is a coherent set of planned teaching-learning events that lead to a qualification and/or professional registration. A “course” is the building block of a programme and is either a semester or a year/block period of teaching-learning that culminates in a summative evaluation.

THE SCHOOLS

Five schools participated in the review. These schools are situated in the following countries: Ghana, Rwanda, Malawi, South Africa and Tanzania. Only the school in Rwanda is not a university school, but it is situated in an Institute for Health Sciences. Two of the schools had been established after 1990, while the other three have a much longer history. Although all five schools are called Schools of Nursing, three of them also train midwives. In one school the preregistration programme is a nurse-midwife programme, but in all the other schools separate programmes are offered for these two professions (nursing and midwifery). The close relationship between the nursing and midwifery profession in Africa is important for service delivery and is supported by the curriculum guidelines developed for WHO in 1998.

METHODOLOGY

In-depth case studies were conducted with each institution as a case. Cross-case analysis was conducted to obtain a global picture of nursing and midwifery programmes in Africa. Information was obtained through a wide range of stakeholders on all aspects of programme implementation. This process was guided by the WHO standards for the African region. Interviews were held with the heads of schools, programme coordinators and managers, clinicians and clinical instructors in the clinical settings. Focus groups were conducted to collect data from academic staff and students. Documents and observations during site visits were used to collect more information. Observations assisted in ascertaining the clinical reality in which the students undertook the clinical practice component of the programme.

ADHERENCE TO STANDARDS

The guidelines from the WHO were used as a basis for developing instruments to measure adherence to WHO standards. Data were collected through structured questionnaires, focus groups and interviews of purposively selected individuals. The adherence of schools to the desired standards will be discussed qualitatively in this section, first by quoting the standard and then by describing the adherence of the five schools.

STANDARD 1

Mission and objectives

Standard 1: *The nursing school has defined its mission and objectives in partnership with its constituency. The mission statement and objectives described the educational process resulting in a competent nurse, with an appropriate foundation for service in the health sector and in keeping with the roles of nurses in the health care system. The mission statement includes community needs and community development as part of social responsibility; and complies with the major health needs of the country.*

Three of the five schools had their own vision and/or mission statements distinct from that of their parent institution. It would seem to be important for a school to articulate its own mission in a more specific manner, in order to formalise the mission of the institution and to address specific health and nursing issues.

Two of the existing mission statements addressed the three main components (education, research and community service), but none of them identified a niche area of the school in terms of either education or research. Although the third institution had a clearly stated mission and objectives, the mission statement did not reflect community needs. Terminal objectives only identified community needs and community participation in community development.

STANDARD 2

Educational programme

Standard 2.1: *Learning programmes show evidence of addressing the human resource needs of the country, fit harmoniously and coherently into the total health professional education system of the country and are congruent with international trends.*

Nursing programmes offered in the schools that participated in this study ranged from nursing diplomas to doctoral degrees. Other institutions offered different types of programmes at the same level, for example diplomas in General Nursing, diplomas in Midwifery and diplomas in Mental Health Nursing. Table 1 reflects a number of programmes offered at each institution at different levels.

Table 1: Programmes offered at the five schools

| Programme | Ghana | Rwanda | South Africa | Malawi | Tanzania |
|-------------------|-------|--------|--------------|--------|----------|
| Diploma | 0 | 3 | 0 | 1 | 0 |
| B degree | 1 | 0 | 1 | 1 | 4 |
| Bridging B degree | 0 | 0 | 1 | 2 | 1 |
| Honours degree | 0 | 0 | 1 | 0 | 0 |
| Masters degree | 1 | 0 | 6 | 0 | 0 |
| Doctoral degree | 0 | 0 | 1 | 0 | 0 |
| TOTAL | 2 | 3 | 10 | 4 | 5 |

All five schools were either being in the process of curriculum review in their preregistration programme, or had done a major review since 1990 in order to align their programmes with the health needs of their respective countries. In Rwanda the revision entailed moving from a diploma to a degree programme, while in South Africa it involved moving from a traditional curriculum to a problem-based and community-based programme. In Ghana the school moved to a Bachelor of Science Nursing programme recruiting straight from school, rather than recruiting second-year university students from either Bachelor of Science or Bachelor of Arts programmes into a second-year nursing programme. The dearth of specialist and postgraduate programmes at most of the schools is evident in table 1. In Ghana more postgraduate programmes have been approved but are not operational because of resource constraints. In Malawi one of the two degree programmes is also currently inactive.

Standard 2.2: The nursing school defined the *competencies* that students should exhibit on graduation from each programme, in relation to their subsequent training and future roles in the health system.

Only three of the five institutions had clearly stated graduate competencies. In other institutions, the competencies that programmes aim to develop in students were not consistently identified by the schools reviewed. This was even the case for newer programmes, in which the content was listed without clear objectives. The school in Ghana used potential work settings to identify roles, while the South African school used a conceptual framework. The Rwandan school was in the process of using both role analysis and a conceptual framework, based on this analysis, to identify programme outcomes. Tanzania divided the competencies of graduates according to the main five roles of clinical practitioner, educator, manager, researcher and consultant.

Standard 2.3: The nursing school defined the curriculum models and instructional methods employed and showed evidence of a variety of appropriate classroom teaching strategies that are used efficiently.

Classroom approaches were relatively imperceptible to reviewers, who visited not more than one or two class sessions. One of the schools in this group was strongly focused on a community-based and process-based programme. In this school, it was easy to identify the teaching approaches from the course material. However, in the other four schools, it was not easy. While the school in Ghana maintained that it is following a process curriculum model, no indication of this approach could be found in the course material. In the Rwandan school the internal review revealed that a teacher-centred approach dominates, with students in class from 08h00 to 17h30, including a two-hour lunch break. This was, however in the process of change at the time of the external review. In Malawi the medical-surgical approach was still dominant in the curricula, although some aspects of primary health care were covered. The teaching approach used was not in line with the vision and mission of the school.

Standard 2.4: The curriculum documentation reflects a coherent learning programme that clearly shows the outcomes achieved and the educational process supporting these outcomes.

The reviewers found clear and coherent curriculum documents in all five schools, in which progression of students was well described. In three of the schools, the curricula were totally prescriptive, with students having no choice in terms of electives or placement options. In Ghana and South Africa a reasonable amount of choice was allowed in both preregistration and postgraduate programmes. Although the curricula of the first three schools had set outcomes, the educational process supporting these outcomes was not clear.

Standard 2.5: There is evidence of approval of the curriculum by the university and the professional regulatory body, and of regular curriculum review and evaluation.

The level of curriculum review and accreditation varied greatly across the five countries. In Rwanda no nursing regulatory body or higher education accreditation body exists. The curriculum was, however, developed in partnership with both the Ministries/Departments of Health and of Education. At the time of the external review, however, the Nursing Council was in the process of being established. In Tanzania, the Nursing Council does not deal with university education of nurses, only with college education. The university programmes are accredited by the accreditation body of the Higher Education sector. In Ghana and Malawi the programmes are approved by the respective universities and accredited by the Nursing Council, while in South Africa the programmes are accredited by the Higher Education Sector, the Nursing Council and the National Qualifications Authority.

Most schools did internal and external curriculum review on an *ad hoc* basis, but all had review reports or were in the process of curriculum review.

Standard 2.6: Course outlines are comprehensive documents that allow the students

to become active partners in the learning-teaching process by clarifying expectations and requirements.

Only three of the five schools provided students with comprehensive course outlines, which the students of one school described as their lifeline. . These course guidelines usually cover objectives, theory to be covered, clinical practice requirements, recommended resources, evaluation methods and criteria to be used, as well as the weight of each component. In one of these three schools the references were outdated. A need was identified to update the references in the course outlines and to teach staff how to keep abreast of recent advances in their areas of expertise. The course description in the curriculum documents or a list of chapters to be covered was all that was given in the other two schools.

Standard 2.7: The content of the subjects/courses reflects up-to-date scientific knowledge, both subject-specific and educational.

The reviewers in four of the five schools found that the courses showed sensitivity to current health needs, international programmes such as Safe Motherhood and morbidity trends such as the AIDS pandemic. This was more of a challenge in the non-university school, where the internal review identified problems with in-depth updating of material, as opposed to a superficial changing of textbooks or dates. In one of the institutions some of the content was outdated because of limited current resources and lecturers who did not possess a nursing education qualification and who were not aware of the current debates in nursing education. The internal review report found that they lacked even the basic teaching methods and principles. A need for staff development was identified as one of the strategies to address the issue of subject content not reflecting up-to-date scientific knowledge.

Standard 2.8: The curriculum adequately reflects the priority health problems or issues identified by the WHO Regional Office.

In Rwanda's current programme, infectious diseases are dealt with mainly in a course on infectious diseases. A total of 45 teaching hours is spent on this course and students also have to produce a report on the management of these diseases at a health centre. HIV/AIDS is given particular attention, with a module dedicated to it in each programme offered by the school. Another priority, maternal and child health, is dealt with in one course on reproductive health, but also in the public health module. Students do practica in all these priority areas in hospitals and health centres. In Tanzania, South Africa and Malawi priority health issues such as HIV/AIDS and adolescent health were addressed throughout the curricula in different disciplines.

Standard 2.9: The nursing school teaches the principles of scientific method and evidence-based nursing, including analytical and critical thinking, throughout the curriculum.

Only three review reports addressed this standard. In these schools all preregistration and postgraduate students are required to do a research project. In the South African school the use of a process-based curriculum further strengthens the students' critical thinking abilities. In Tanzania and Malawi the scientific nursing process and research forms a vertical strand in the curriculum and the students have to undertake a research project following all the steps of the research process. The development of analytical and critical thinking skills is facilitated by the use of teaching strategies such as case studies, problem-solving exercises and group discussions. Most of the institutions were familiar with the concept of evidence-based nursing but it was not yet forming part of their curricula.

Standard 2.10: The school identified and incorporated in the curriculum the contributions of the biomedical sciences to create an understanding of scientific knowledge, concepts and methods fundamental to acquiring and applying nursing science.

Four of the five schools indicated that in all pre-registration programmes, a fair amount of time was spent teaching biomedical subjects. Rwanda indicated that in their current programme 70 percent of the time was spent on this component in the first year, but that this decreased in subsequent years. In the new programme, the nursing component is covered in ten semester modules. The biomedical sciences are covered in nine semester modules and social and behavioural sciences in five modules. Anatomy and physiology were specifically mentioned as being part of the biomedical component.

Standard 2.11: The school identified and incorporated in the curriculum the contributions of the behavioural sciences and social sciences that enable an understanding of contextual factors of health and health services.

All the schools felt that these subjects were adequately addressed. Sociology, psychology, anthropology and demography were mentioned as examples of the behavioural sciences and social sciences. In Malawi biomedical and behavioural sciences were referred to as foundational courses required for the application of Nursing Science courses. In one of the schools that used problem-based and community-based curricula, behavioural sciences provided context in the discussion of priority health issues in the surrounding community and country. In Malawi and South Africa these courses assisted students to understand the socioeconomic, demographic and cultural determinants of health, as well as the consequences of these factors in the health of individuals, families and communities.

Standard 2.12: The school ensures that students have adequate theoretical nursing science input to prepare a generalist nurse (including community and psychiatric nursing); patient contact and acquire competence to assume appropriate nursing responsibility upon graduation.

Three of the five schools indicated satisfaction with the Nursing Science content. The

scope of the Nursing Science was adequate to prepare a sound generalist nurse. However, in Rwanda the science content was not adequately covered in one of the programmes, namely the psychiatric nursing programme taken during preregistration nursing training. This is because it is done in a separate educational stream. In Malawi a gap was identified in geriatric nursing and maternal and child health nursing.

STANDARD 3

Clinical training

Standard 3.1: The nursing school ensures access to an adequate range and depth of clinical learning opportunities for the programmes offered.

All five schools place students in a variety of settings, from primary health care to referral hospitals. All reviewers agree that there is no shortage of good clinical experience. However, most of the schools mentioned a need for adequately resourced clinical laboratories to prepare students for real practice. In one school the reviewer found that the clinical skills laboratory was grossly inadequate to meet the students' clinical learning needs. One reviewer wrote: "The students however said that in order to facilitate their clinical learning, they would recommend that the demonstration room be upgraded to a clinical skills laboratory. The clinical skills laboratory should have equipment and supplies which are ideal for performing certain procedures. Owing to limited resources in the clinical settings, the students do not have an understanding of what the norm is. A suggestion of having computers for playing CD ROMs in the clinical skills laboratory, as well as, having television sets with built in video cassette players was suggested, for the use by students for self-directed learning purposes ."

Regarding the adequacy of clinical learning settings, one school reported that some clinical facilities have to be used despite their unsuitability because of shortages of suitable clinical facilities.

Standard 3.2: The quality of staff and services in clinical facilities used for training enhances the educational outcomes.

Ensuring the quality of clinical teaching emerged as a major challenge to a number of schools owing to severe shortages of academic staff, the inadequate preparation of the area of clinical supervision, the level of training of registered nurses in the clinical settings (who require updates and in-service education to be kept abreast of advances in nursing), and gross shortages of material resources (equipment and supplies) in the clinical settings.

Efforts to address the lack of competence among nurses in the clinical settings included the appointment of clinical instructors (Rwanda), the use of highly trained preceptors (Ghana) and setting up a team of university and health service staff to address the prob-

lems (Tanzania). Nevertheless, the problem seemed to persist. The reviewers in Malawi raised the issue of clinical training as one of their main concerns, as students do not always have a proper perspective of what nursing entails. This prevents them from practising the required standards of care. In this nursing school a period of internship was recommended to afford the students an opportunity to develop their clinical competencies in order to practise safely after graduation.

Standard 3.3: The relationship between the educational and health systems is harmonious in terms of objectives, organisation, and human relations.

In general, relationships seemed to be cordial. In Rwanda there was a formal memorandum of understanding between the school and the main referral hospital setting out their cooperation in the training of nurses. In addition, all newly employed clinical instructors had to spend about six months working fulltime in the hospital to acquire experience in the clinical facilities used for clinical placements. This was not the case in the other schools, but there was evidence of joint problem solving, involvement of university staff in staff development and cordial relationships.

One review describes the following scenario: “As an attempt to address this problem, a special committee comprising of academic and hospital staff was appointed to come up with a plan to improve the quality of clinical teaching. This team is currently busy working on this task. This joint effort shows that there is a good working relationship between the school and the clinical settings. There is one academic staff member who is in a joint post, who also functions in the regional hospital as part of the hospital management. This person serves as a link between the School and the management. He is leading the team that is tasked to come up with strategies that could be useful in improving the quality of clinical teaching.”

Reviewers in Malawi reported that the school had a working relationship with both the Ministry of Education and the Ministry of Health. Although this relationship was not harmonious, the school benefited from both relationships when it came to resource allocation and quality control.

Standard 3.4: There is a clear policy on the process and structure of clinical placement and supervision/teaching to ensure that this component of the curriculum is used effectively for learning and professional development; and theory and practice are optimally linked.

The structure and process of clinical placement was deemed to be adequate in all schools. However, only one reviewer addressed the issue of clinical supervision directly. In this school (South Africa) university staff conducted formal clinical supervision. Other nursing schools used clinical instructors for clinical supervision/teaching. However, there was no close communication between academic staff and the clinical instructors to facilitate continuity and integration of theory and practice.

The schools generally did not keep records of the clinical supervision done by specially appointed clinical staff or academic staff members. This means that the schools generally have no records of this component of learning, except as a total number of hours spent in a specific setting.

Malawi experienced some difficulties in the integration of theory and practice as a result of problems with clinical teaching and supervision. The school used a block system, after which students were placed in clinical settings. These clinical settings offered learning experiences related to the theory covered during the block period. This arrangement, however, did not provide an opportunity for immediate application in clinical settings of the theory covered in class. There was some fragmentation between theory and practice. However, the school reported that it was in the process of reorganising its curricula to ensure integration of theory and practice.

Standard 3.5: The nursing school ensures that students have adequate patient contact and acquire sufficient competence to assume appropriate nursing responsibility upon graduation.

Only the Rwandan reviewer addressed this issue directly, reporting that the clinical component of the preregistration programme comprised one third to two thirds of the first year, after which it increased. Table 2 reflects the number of clinical hours covered under each discipline. The Malawian report did not provide this information. However, the total number of clinical learning hours ranged from 2 680 to 3 387.

Table2: Clinical experiential learning hours required in different schools

| Area | Ghana | Rwanda | South Africa | Tanzania |
|--------------------------|-------|--------|--------------|----------|
| Medical-surgical nursing | 1 650 | 742 | 1 180 | 1 148 |
| Paediatric nursing | 230 | 334 | 160 | 194 |
| Community health nursing | 200 | 735 | 622 | 426 |
| Mental health nursing | 260 | 656 | 640 | 651 |
| Midwifery | 340 | 837 | 785 | 435 |
| TOTAL | 2 680 | 3 303 | 3 387 | 2 854 |

STANDARD 4

Assessment of students

Standard 4.1: The evaluation system ensures reliable and valid evaluation results that effectively address academic and professional outcomes.

The general format of assessments is continuous (formative) assessment during a course and an examination at the end of the course. In Rwanda the policy requires a formative test after every fifteen hours of teaching. In all settings external examiners are used, but in some they are involved mostly in the final years. The Ghanaian school has no end-of-semester or end-of-year clinical or practical examinations. This was ascribed to a shortage of academics to run such examinations.

Standard 4.2: Assessment principles, methods and practices must be clearly compatible with educational objectives and must promote learning.

The adherence to this standard varies. In the South African community-based education (CBE) and problem-based learning (PBL) programme the reviewer found the evaluation strategies to be very appropriate. However, in Rwanda, Tanzania and Malawi there seems to be a poor match between stated objectives and the cognitive level of questions asked in the papers. The examination papers test mainly knowledge recall and comprehension. In Ghana the reviewer did not have access to examination papers.

STANDARD 5

Students

Standard 5.1: The selection and admission procedures ensure fair access to suitable candidates for relevant programmes.

The school in Rwanda is not responsible for the recruitment, selection and admission of students, who are selected by the Ministry of Education. The entry level of students varies from year to year, based on their average performance in school examinations. However, very few mature students are selected on entry examination. In the other four schools selection is done internally, based on clear criteria. In South Africa the criteria are mainly level of performance in the school end examination. In Tanzania the following is considered: level of performance in high school examination; learner characteristics, including developmental level in handling problems; and candidates' previous experience.

Standard 5.2: The size of the student intake is defined and related to the capacity of the nursing school at all stages of education and training and is reviewed in consultation with relevant stakeholders and regulated periodically to meet the needs of the community and the society.

Recruitment in two schools (South Africa and Tanzania) presents a challenge since diploma education for nurses is better known and better supported by the government. Recruitment in Tanzania is also affected by the moratorium on the employment of nurses since 1992. The government employed only six additional nurses at the beginning of 2004. Since the private sector in this country is quite small, this leaves nurses with only one option – to leave the country. So, although the Tanzanian school is trying to increase

its enrolment to make the programme economically viable, the employment of nurses is a problem.

The largest groups of preregistration students are recruited in Ghana, where between 87 and 147 students are registered annually. The group size in Rwanda is fixed by the Department of Education in consultation with the Department of Health.

Standard 5.3: Students have access to appropriate career, academic and personal support services.

In two of the schools (Ghana and Rwanda) students are supported financially by a grant from the government. In Tanzania the situation was described as follows:

The government supports nursing students financially. There are no private students. The students only serve by working one year (internship) after completing their four years of study. The university makes provision for students in the budget. Among the existing budget lines there is what is referred to as “special school requirements”. This budget is for items such as stethoscopes, sphygmomanometers, uniforms and so forth for the students. The students are assisted with this, rather than buying from their pockets. The university has introduced a cost sharing system and students buy their own shoes, nurse’s watches, and so forth. In the past these items were received from the university, as part of special school requirements.

In Rwanda and South Africa there is a Dean of Students and a whole section of the university administration dealing with student issues. In South Africa this includes a student counselling and student health service. In Rwanda it does not. In Tanzania student counselling and support are provided by academic mentors appointed by the school.

Standard 5.4: Students have direct and adequate representation on decision-making structures within the institution and student activities and student organisation are encouraged and facilitated.

Students were represented at school, faculty, senate and council level in Rwanda and in South Africa. This did not seem to be the case in the other three schools, where the system was more informal, and where students stated that they were not always involved in decisions that affected them. In Rwanda students mentioned that they had never had a female SRC president, even though there were more females in each group than males. In Malawi the students are represented in the disciplinary hearings and library committees. They were not represented in curriculum, evaluation and selection committees.

STANDARD 6

Academic staff/faculty

Standard 6.1: There are clear human resource policies including recruitment, job

descriptions, staff appraisals, continuing education and promotion that support the mission of the institution.

All five schools reported that they had adequate human resource policies. However, the school in Rwanda had no formal job descriptions or policies on staff appraisal. In South Africa there was no formal system of staff appraisal either, however job descriptions for the major categories of academic staff do exist. Personal promotion based on reaching specified goals appeared to be attainable in all five schools.

Standard 6.2: The student to staff ratio is in line with national norms and the qualifications, experience and research activities of academic staff match their teaching responsibilities.

The staff to student ratio varies from 1:18 in Rwanda through 1:25 in South Africa, to 1:80 in Ghana. In Tanzania the staff to student ratio was 1:4. All schools reported some problems with recruiting appropriately qualified academics for teaching. In both the Tanzanian and Ghanaian schools the highest academic level is that of lecturer, since nobody had yet attained the criteria set for senior lecturer level and higher. In South Africa the initial group of nurse-academics at the head of university schools of nursing was credited with other experience, but had not had sufficient opportunities to build up satisfactory academic profiles. South Africa now has enough nurses with the necessary credentials, although it is still a problem recruiting senior academics.

Standard 6.3: The staff profile shows continued productivity in the fields of teaching, research and community service.

In most of the schools academics are still busy improving their credentials, either by doing masters or doctoral studies. The Malawian report did not supply this information. The information presented was obtained from their webpage http://www.kcn.unima.mw/departments/medical_stafflist.html. In many cases staff members were pursuing these studies outside their own countries. In all schools reviewers found academics involved in service delivery and in research, over and above their teaching duties.

Table 3: Qualifications of academics in different schools

| | Ghana | Malawi | Rwanda | South Africa | Tanzania |
|----------|--------------|---------------|---------------|---------------------|-----------------|
| Diploma | 0 | 0 | 0 | 0 | 0 |
| B degree | 3 | 4 | 3 | 0 | 6 |
| Honours | 0 | 0 | 8 | 1 | 0 |
| Masters | 3 | 7 | 4 | 9 | 5 |
| Doctoral | 0 | 2 | 0 | 8 | 2 |
| TOTAL | 6 | 13 | 15 | 18 | 13 |

STANDARD 7

Educational resources

Standard 7.1: The teaching space, office space, and communal space allows for optimal achievement of educational and research objectives in an appropriate and safe environment.

Most of the schools have adequate teaching facilities, but in Ghana this is a problem since group sizes have outgrown classroom capacity. Office space is a problem in three of the five schools and in Rwanda teaching space is also inadequate. In Rwanda there is no communal staff room, and staff meetings take place in the classrooms. In Tanzania lecturers' offices do not have telephone lines. The only available telephone is in the dean's office.

Standard 7.2: The library ensures adequate access to an appropriate and adequate range of information resources.

In four of the five schools library facilities are limited or inadequate. It seems to be a general pattern across all four schools that students do not have enough money to buy textbooks and therefore they rely heavily on library books. This means that collections have to have large numbers of copies of the prescribed books. In Malawi the reviewers reported that most of the books were outdated.

In Ghana the library has a reasonable collection for the preregistration programme, but working space in the library is inadequate. There are no computers in the library for students to access Internet resources, nor can they do cataloguing electronically. The library is not air-conditioned, which is a real problem in a subtropical country. Their post-graduate collection is inadequate. In Rwanda the picture is similar, with the size of the library not only limiting its use, but also the growth of the collection. The second campus does not have a library at all. Students in Rwanda also felt that long hours of teaching limited their access to library and Internet resources. Tanzania also has limited library facilities.

Standard 7.3: Teaching and research equipment is adequate and appropriate to the students' needs. It is well maintained and utilised.

In four of the five schools the equipment in the clinical laboratories left much to be desired. Even in the fifth school, where this facility is adequate, models are rarely upgraded, nor are additional models bought owing to financial constraints. The academics used teaching material such as their office computers for research purposes as there were limited, if any, resources for research.

In three of the five schools vehicles are available to transport students and staff to the

clinical facilities. In South Africa students use public transport for such travel and the staff use private cars. Costs are reimbursed.

Standard 7.4: Regional and international exchanges of academic staff and students are facilitated by the provision of appropriate resources.

All the schools have productive international relationships and international faculties have been hosted by four of the five schools. The faculties from these schools have also visited other schools internationally on numerous occasions. Student exchanges are, however, much more limited, especially with regard to African students going on an international exchange. According to the staff, differences in programmes and a lack of funds are the main problems with such exchanges.

STANDARD 8

Programme evaluation

Standard 8.1: The school has established a mechanism for programme evaluation that monitors the curriculum and student progress. It ensures that concerns are identified and addressed.

All the schools have some mechanisms for evaluation, but they are not very systematic. In Rwanda staff concerns about the curriculum are raised and dealt with at staff meetings. In Tanzania, a review is done at the end of the year, or when the need arises. This was also the practice in Ghana and Malawi. In South Africa the students evaluate every course in writing and these evaluations are submitted to the head of the school for action and are further analysed by the Quality Promotions Unit.

In two countries (Rwanda and Tanzania) the problem of students finding jobs after graduation was mentioned. It would seem that there is a perception in both countries that better educated nurses are too expensive.

Standard 8.2: Both teacher and student feedback are systematically sought, analysed and responded to.

Reviewers did not respond to this point separately from the previous one, except to elaborate on what they had already said. Students in Rwanda said that they were never asked to evaluate their courses.

Standard 8.3: Student performance in all examinations is analysed at least annually.

In Rwanda and Tanzania pass and fail rates were calculated annually. In South Africa the levels of pass rates were calculated every semester and discussed at Examinations Board meetings.

STANDARD 9

Governance

Standard 9.1: The organisational charts reflect a governance structure which allows for the inputs of all important stakeholders, as well as for efficient and effective decision making, planning and monitoring.

Although the specific names differed between the five schools, all of them seemed to have the following type of internal structure: management committees dealing with specific programmes or tasks and a school-level management committee. Externally, most institutions have a senate and a council. Only in South Africa, where the school has full professors, and in Rwanda, where department heads sit in the senate, is the school represented in these bodies. Academic and administrative staff and student representatives also attended the senate and council meetings. These representatives were not necessarily from the nursing department, since they were voted in by their peers at a general assembly. However, the nursing department was represented at a monthly meeting between the heads of department and the school's top management.

Standard 9.2: The responsibilities of the academic leadership of the school for the nursing educational programme are stated clearly. Rules, procedures and policies are clear and accessible to both staff and students.

In some schools, for example in South Africa, the institutional policies, minutes of meetings and other documents were readily available on the school's website.. In Rwanda this information was made available in the library. In the other schools it was a bit more difficult to access such documents. In Tanzania and Malawi files containing the minutes of meetings, rules, procedures and policies were kept in the dean's office.

Standard 9.3: The budget policy is clear and coherent and the staff are active and informed participants in the budgeting process.

While some schools develop a budget (Rwanda and Tanzania), none of the schools were represented where the actual funding decisions were made. The review documents did not indicate clearly how funding decisions were made. This probably reflected the level of knowledge that faculty members have of the funding process.

Standard 9.4: The external linkage of the school reflects leadership, involvement and acceptance in the wider academic community.

The response to this statement was similar to the response to Standard 7.4.

Standard 9.5: Student records should be kept as long as the student is alive, in order to obtain professional registration in different countries.

This was done in South Africa, where both computer and hard-copy records were kept of the hours students spent in different components of the programme (both classroom and clinical). Records of students' performance were also kept. In Rwanda this was not done. Records were kept by class groups in different places and were therefore very difficult to find. Records of each student's clinical hours were not kept, although there was a general record based on the curriculum plan.

DISCUSSION AND RECOMMENDATIONS

Programme evaluation showed diversity in educational programmes. WHO (2000) asserts that the concept of standards is very closely linked to the concept of quality. Societies need to be sure that educational standards ensure quality and, thus, protection of the public by producing nurses and midwives who are competent to practise and committed to offering good-quality service. The programme reviews revealed some adherence to set standards for nursing and midwifery in Africa. Priest (2001) asserted that another purpose of evaluation is to identify strengths and weaknesses as basis for further development. The strengths of the five programmes seem to be that a coherent curriculum is usually in place, with adequate teaching of nursing, biomedical, and social and human sciences. Clinical exposure to all levels of the health system is also significant. All the schools seem to have productive international partnerships, from which they benefit significantly. The nursing programmes are in line with the needs of each country and are informed by the WHO's priority areas. The stakeholders are involved in the planning of new programmes and in addressing some of the teaching-learning issues. There is strong involvement of students in decision making.

One of the main weaknesses is in the area of resources – libraries, clinical laboratories and supplies and equipment in the clinical areas. While lack of adequate academic staff is a problem in some schools, the lack of adequately prepared mentors and role models in the clinical areas is a more general problem. Two further weaknesses might also be linked to resource limitations, namely the lack of specialist training and the limited options within programmes. Weaknesses that nurse educators should be able to address are the lack of descriptive course outlines and the lack of permanent student records.

It is recommended that nursing schools in the African region conduct regular reviews in order to monitor and improve the quality of their programmes. There is a great need to build the capacity of nurse educators and clinical instructors in order to improve the quality of nursing education. Collaborations with international institutions may assist in this area. It is prescriptive curricula and the biomedical model dominating most of the schools should be revisited because programmes have to be responsive to the needs of society. Establishing or upgrading clinical skills laboratories will provide useful support to clinical teaching. Programme outcomes should be aligned with teaching/learning methodologies and assessment strategies. Human and material resources, which have a great influence on the nature and quality of the graduates produced, need to be addressed.

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