

Improved Health Training Education in Malawian Nursing Colleges

**Curriculum implementation  
in CHAM/NMT Colleges in Malawi**

**Final report submitted to CHAM  
and  
Norwegian Church Aid (NCA)**

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## **Table of contents:**

<b>Acknowledgements:</b>	page 3
<b>Acronyms:</b>	3
<b>Summary:</b>	4
<b>Chapter 1: Introduction</b>	<b>6</b>
1.1 Terms of Reference	7
1.2 Curriculum development - Current tendencies	8
1.3 The Malawi context	10
1.4 CHAM-curriculum policy	11
1.5 Curriculum implementation - Research Questions	12
<b>Chapter 2: Methodology</b>	<b>13</b>
2.1 Sites Visited	13
2.2 Interviews	14
2.3 Analyses	14
<b>Chapter 3: Findings</b>	<b>15</b>
3.1 Planning and management of curriculum implementations	15
3.2 Implementation of the theoretical part of the curriculum	18
3.3 Implementation of the clinical part of the curriculum	25
3.4 Perceived needs for further training	32
3.5 Quality assurance - evaluation and monitoring	33
<b>Chapter 4: Discussion</b>	<b>35</b>
4.1 Planning tools - availability and quality	35
4.2 Theoretical courses - challenging areas	36
4.3 Clinical teaching	38
<b>Chapter 5: Conclusion</b>	<b>42</b>
<b>Chapter 6: Recommendations</b>	<b>44</b>
<b>References</b>	<b>45</b>
<b>Appendix</b>	<b>46</b>

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## Acronyms

CHAM	Christian Health Association of Malawi
HINARI	Health Inter Network Access to Research Initiative (WHO mediated PubMed access)
KCN	Kamuzu College of Nursing
MTR	Mid Term Report
NCA	Norwegian Church Aid
NMCM	Nurses and Midwives Council of Malawi
NMT	Nursing and Midwife Technicians
OSCE	Objective Structured Clinical Education
PBL	Problem Based Learning
TOR	Terms of Reference

## **SUMMARY**

Curriculum development has been a part of the network project “Improved Health Training Education in Malawian Nursing Colleges” since its initiation (2005). The midterm evaluation report of the project (2008) identified a need to focus more on curriculum issues which are so crucial to the quality of an educational program. To be able to continue with a more appropriate approach to this complex area, the need for a more overall assessment of the existing curriculum implementation in the NMT colleges was brought up.

This investigation was conducted by a team of 2 Malawian and 2 Norwegian tutors assessing the following 4 areas of curriculum implementation:

- Planning tools and systems.
- The current implementation of the curriculum (both theoretical and clinical courses).
- Experienced/perceived needs, problems and challenges.
- Monitoring and evaluation tools and systems.

The main methodological approach were interviews with college management, tutors, students and hospital staff in all 9 CHAM colleges offering a NMT program in nursing. Some observation on sites were included (skills lab, library, notice boards) as well as some analyses of written documents (planning tools, course outlines etc).

The need for further work to increase the management competency in elaboration of adequate planning tools and monitoring/evaluation systems is apparent. Such tools are indispensable to be able to continually assessing the program, correcting errors as they occur and continuously improving the quality of the planning.

Another important area is the need to continue the efforts to equip the colleges with sufficient teaching and learning resources such as library resources, skills labs etc.

The most important and difficult challenge is though linked to more pedagogical and didactic problems. This investigation of curriculum implementation in the CHAM/NMT colleges in Malawi has drawn a picture of an education programme built on quite traditional pillars. The implementation of the theoretical part of the courses is characterized by overcrowded courses and teachers doing their best to transmit all the content, mainly by lectures, to student trying

hard to write down what the teachers teach. The implementation of the clinical part of the courses is characterized by a somehow poor organisation and quite limited didactic approaches (mainly demonstrations and assessment of procedures).

The problems of curriculum implementation are most probably corresponding with a lack of competence and a need for more knowledge within the group of tutors in the NMT colleges. However it is also very important to regard the problems as very closely linked to the NMT syllabus and the core curriculum itself. The syllabus (and the core curriculum) tends to promote a program focused on the delivery of a great number of topics and a very broad and comprehensive content. It also tends to focus more on the teacher as a transmitter of knowledge than on the student as a learner. Comparing this to current tendencies in nursing education the need to reconsider the NMT syllabus and core curriculum is quite evident.

In the new millennium, with an increasingly amount of new knowledge available through internet (although not yet available everywhere), health care environment will increasingly demand nurses to be “information literate” professionals, able to solve complex patient problems by using the best available knowledge). Even nurses with a NMT diploma level need to be able to recognize when information is needed and have the ability to locate, evaluate and effectively use new knowledge. A modernized educational program should put emphasis on development of critical thinking skills and commitment to life long learning, because such skills may prepare students to deal with the complex and ambiguous aspects of a rapidly changing health care system. The need to have a curriculum more focused on developing such skills is obvious.

## Chapter 1: Introduction

The network collaboration project “Improved Health Training Programme in Malawian Nursing Colleges” started in 2005 and has as a goal to improve the capacity and quality of the nursing education in Malawi. A particular scope of attention has been the CHAM-colleges, which are offering a 3 year nursing and midwifery technician diploma (NMT).

Curriculum work has been a part of the network collaboration program since the very beginning of the program in 2005. When it comes to improving the quality of a particular educational program, curriculum work is indispensable. The curriculum is a core document for any educational institution, and curriculum work goes into the very heart of educational activity and is crucial to development and change. A curriculum is “*a formal plan of study that provides the philosophical underpinnings, goals and guidelines for the delivery of a specific educational program*” (Keating 2006). A curriculum has normally a description of objectives, content, teaching/learning methods and modes of assessment in a particular education. The *implementation* of a curriculum is the delivery of a specific educational program and is dependent on the capacity and competence of the implementing staff, the management and planning as well as the resources available.

Both curriculum development and curriculum implementation had a significant role in the first phase of the project. The emphasis on curriculum development were mostly focused on improving the training curriculum in the nursing colleges through strengthening partnerships with other colleges and integration of human rights (HR) and gender in nursing education. The area of curriculum implementation was mainly addressed through:

- a) A focus on staff development by developing skills and capacities in various (new) teaching and learning methods
- b) A focus on making adequate teaching and learning resources available for the colleges.

The Mid Term Evaluation Report (MTR) of the project “Improved Health Training Programme in Malawian Nursing Colleges”, from 2008, identifies a need to build capacity of nursing tutors to carry out curriculum development (MTR 2008, p 25). The report suggests that each college should have the capacity to complete the revision of the training curriculum, and have the capacity to insert new learning and teaching methods in the appropriate courses

and topics of the curriculum. Hence the MTR also puts emphasize on the continuing need for staff development (for instance training in teaching and learning methods) and the need for adequate learning and teaching resources to strengthen the colleges in curriculum implementation.

The project plan for the second phase of the “Improved Health Training Programme in Malawian Nursing Colleges” (2009 – 2011) is following some of the recommendations from the MTR when suggesting to use the 2. phase of the project to:

- a) Fully equip clinical skills labs and to make computers, LCD and internet available for the colleges.
- b) Institutionalize clinical teaching in the colleges as well as continuing the efforts to implement PBL and other student active methods in the colleges.

In addition the plan suggests a particular training for selected college staff in “curriculum implementation and monitoring/evaluation” (NCA 2009, p 34). The total focus on curriculum implementation as such is hence accentuated in the “second generation” project-plan.

The current investigation focuses on curriculum implementation of the NMT-program and the planning and monitoring tools in the CHAM colleges to facilitate curriculum implementation. A group of four people consistent of two Malawians, Mrs. Rose Wasili, and Mr. George T. Mwenye-Phiri, and two Norwegians, Mrs. May Liss Kollstrom and Mrs. Bodil Tveit were asked to undertake the assessment with the following Terms of Reference (TOR):

### **1.1 Terms of Reference**

1. Develop a set of tools/questionnaires for assessing curriculum implementation in the different CHAM colleges.
2. Assess the curriculum implementation in all the CHAM colleges in Malawi, focusing on the capacity in each college to deliver all parts of the curriculum, and the problems, challenges and needs perceived by the colleges.
3. Assess the planning capacity as well as monitoring and evaluation routines in the colleges connected to curriculum implementation.

4. Compile a report with the obtained results. The report should have the needed confidentiality and protection of persons interviewed.
5. The report should also give clear recommendations to improve the quality of curriculum implementation in the nursing colleges.
6. The report could contribute to validation and adjustment of the planned interventions in the phase 2 of the network collaboration project.

As the discussions of the investigation task started, it became clear that a comprehensive and useful assessment of the curriculum implementation at the Colleges is a time consuming and demanding task. We determined that a site visit on each College would be required. Due to allocated time and resources available, this assessment will not go deeply into external frame factors that might influence the curriculum implementations like the health care system or infrastructure etc. It was decided that the main focus would be on internal frame factors and different key person's experiences of the curriculum implementation. Other approaches could have been very useful like observations of tutor-performance, student performance etc. (for example observation of classroom-teaching and clinical teaching), but it was found that such approaches would be even more time demanding and therefore not feasible in the time-span of this assessment. The chosen approach after some discussions was the following:

- Three days of literature reviews, preliminary discussions and development of data collection tools. Itinerary preparations.
- One day pre-test of tools.
- 9 days of travelling to visit all the CHAM/NMT colleges in the north, central and southern regions of Malawi to do interviews and data collection. Preliminary analyzes of the collected information started concurrently with the collection of data and the site visits.
- One week in Lilongwe to analyse the data, to write a draft report and to submit it to stakeholders.
- 2 weeks of discussions of the draft report with NCA and CHAM. Finalizing the report.

## **1.2 Curriculum development - current tendencies in nursing education**

There are several tendencies that influence current nursing education. One of the most important challenges on a global level is the enormous increase of knowledge and information



in the health care and medical field. Although this development challenges nursing education in several ways, one of the most obvious consequences is the requirement of “critical thinking skills” and “information literacy” amongst today’s and tomorrow’s nurses all over the world to be able to solve complex patient problems by using the best available knowledge (Keating 2002, Shorten et al 2001).

Unfortunately, nursing curricula have not always facilitated such competencies. As a result of the availability of new knowledge, many educators have experienced that the eagerness to include new themes and knowledge in the curriculum has resulted in overcrowded courses and, thus decreasing the time available for activities to develop students abilities in critical thinking, problem solving as well as clinical reasoning and decision-making. These skills are necessary for nurses to function in today’s complex health care environments (Dalley et al 2008).

The conventional nursing education has been teacher-centred with faculty often taking the role of “dispenser of knowledge”. The focus has mainly been on the transmission of content from the tutor, seen as the expert, to the student seen as more or less “empty barrels” or passive absorbers of knowledge (Dalley et al 2008). The last decades tendencies in nursing education has evolved a shift from this teacher centred education to a more student centred or learning-centred education (Biggs & Tang 2008, Billings & Halstead 2009). One of the most prominent consequences of a more learning-centred educational approach is that more emphasis is put on the outcomes/competencies of the education, rather than the content. This shift in focus helps faculty to decrease the content of the overloaded education and to make a distinction between essential content and non essential content in the courses.

Outcome and competence based curricula put emphasise on giving the student a basic knowledge of concepts, principles, models, theories and methods, so that they are able to structure knowledge. This does not mean that content is not important, but rather than aiming to give the students specific knowledge in all fields, the aim is to give the students in-depth knowledge in essential, selected fields. Emphasis is put on learning the students to exploit information sources and available literature critically, skills that are necessary to assure self regulated lifelong learning and continuous professional development in a changing society. Closely linked to these approaches is a student active teaching and learning methodology,

aiming to strengthen the students' independence, discretion, capacity of reflection and clinical reasoning.

### **1.3 The Malawi context**

In Malawi the nursing education is influenced by a health care system facing many challenges. Major problems are linked to the heavy disease-burden which is combined with a human resource crisis in the field of health care. The deficiency of adequate health care personnel is due to both an inadequate educational capacity and "brain drain" problems leading to a shortage of qualified nurses available for the public. The project "Improved Health Training Programme in Malawian Nursing Colleges" is trying to respond to this situation through capacity and competence building etc. (page 3).

The nursing education in the CHAM colleges constitutes in 2009 a considerable part of the education of nurses in Malawi. The program offered by 9 CHAM colleges is a 3 year education program leading to a Diploma in Nursing Midwifery Technician (NMT).

The NMT program is presented in a syllabus, elaborated by the Nurses and Midwives council of Malawi (NMCM), recently reviewed in February 2009<sup>1</sup>. The syllabus contains the general philosophy and programme objectives for the NMT-program, as well as rules, regulations and requirements for the current program. The syllabus also presents and suggests the specific objectives and content of all the 25 courses in the NMT program.

A core curriculum based on the syllabus has been developed (recently under review in Zomba, April 2009<sup>2</sup>) to guide the tutors in training NMT's. The core curriculum contains a more detailed description of course objectives, content, teaching and learning methods, assessment forms as well as prescribed/recommended literature for each course. The courses have been arranged following developed level objectives to assure progression in student learning "from simple to complex, and from known to unknown". The number of hours allocated to each course and each clinical field is defined.

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<sup>1</sup> Only minor changes were made mainly to incorporate new trends on Basic Emergency management of Obstetric and Neonatal Care (funded by JHPIEGO/ACCESS).

<sup>2</sup> The review was made by a group of all academic deans (principal tutors) from all the colleges giving a NMT-program, together with resource persons from MOH, NMCM, KCN, CHAM, and NCA.

Although the colleges have been encouraged to develop their own versions of the curriculum (local curriculum) only a few of them seem to have completed the work. The tendency has been that the core curriculum has served as a standard or “model curriculum” for the colleges and the local curricula have been more or less copies of the core curriculum. The impression from the ongoing review (Zomba, April 2009) is that the idea of having a standard curriculum for all NMT colleges has been adopted as a strategy, and that the colleges are encouraged only to make local/individual *introductions* to the core curriculum, according to the specific philosophies and values of the particular institution/college.

One of the most prominent features of the Syllabus and the core curriculum is the aim of assuring a *comprehensive* program, meaning that the students through a three year program shall be able to serve as nurses and midwives in all the various settings of nursing/midwifery in Malawi.

One interesting thing to notice is that the newly revised syllabus (2009) does not mention “critical thinking” capacities in the programme objectives, although in the 2006 version of the core curriculum this is one of the program objectives. The programme objectives from the syllabus though include objectives like “ability to demonstrate professional knowledge”, “ability to make decisions and appropriate judgement” as important competencies for graduates. The syllabus also suggests that a graduate shall be able to “participate in research activities”, “utilize research findings for evidence based care” as well as be “able to exploit available information technology” (IT).

#### **1.4 CHAM-curriculum policy**

The “CHAM-Colleges Training Policy” (2008) describes more specific some guiding standards for curriculum development in the CHAM-colleges:

- Each program shall have a curriculum developed by the college and approved by the regulatory body.
- The curriculum shall be revised at least every five years.
- New trends emerging in the health sector shall be approved by the regulatory body before incorporating them in the curriculum.
- Each curriculum should specify core and supporting courses.

- The principal shall ensure that students are aware of the core and supporting courses for their program (CHAM 2008).

CHAM has also developed some standards for curriculum implementation:

- Each college shall develop a master plan, annually indicating the implementation of the curriculum.
- The academic staff shall translate the curriculum into manageable learning units of instruction by preparing course outlines and lesson plans.
- The principal shall facilitate mobilisation of learning resources relevant to different programs.
- Tutors, assistant tutors and clinical instructors shall be responsible for instruction delivery at all levels of training.
- Interactive learning methods shall be promoted in all learning experiences to promote active learner participation (CHAM 2008).

### **1.5 Curriculum implementation - Research questions**

The following investigation will explore several areas linked to curriculum implementation in the NMT colleges (CHAM) in Malawi. The research questions guiding the investigation were as follows:

How do the colleges plan the curriculum implementations?

How is the implementation of the theoretical part of the curriculum?

How is the implementation of the clinical part of the curriculum?

What are the perceived needs for further staff training?

How do the colleges monitor/evaluate curriculum implementation?

The intention with the investigation is to identify possible problems and gaps connected to the implementation of the curriculum. Although we are well aware of that there often (always) is a gap between the *intended* curriculum and the *implemented* curriculum, it is crucial to get knowledge of these gaps and to continuously work to improve when problems and gaps are indicating a need for change.

## Chapter 2: Methodology

The group had the opportunity to do site visits to all the 9 CHAM Colleges in Malawi offering a Nurse Midwife Technician Diploma. NCA contacted the sites prior to the visits, and informed them about the purpose of the visits, requesting college management and selected staff and students to be available to the investigators.

The tools and instruments for investigation were elaborated as teamwork, based on the information we had before starting out. The tools were tested on the first sites visited, and were discussed and adjusted after the tests. Hence the tools used were not exactly the same on all the sites, although the aim of having a consistent and uniform approach was guiding us.

The methodological approach included the following sources of information:

- Interviews with college management, tutors, students and clinical staff.
- Observations on sites.
- Written documents (planning tools, course outlines etc.).

Based on the TORs listed in Chapter one, 4 areas were to be focused:

1. Curriculum implementation planning tools and systems.
2. Curriculum implementation from the point of view of students, tutors, preceptors (clinical staff) and college management.
3. The experienced/perceived needs, problems and challenges in curriculum implementations from the point of view of students, tutors, preceptors (clinical staff) and college-management.
4. Curriculum monitoring/evaluation tools and systems.

### 2.1 Sites Visited

During the needs assessment the following CHAM-Colleges were visited;

- Ekwendeni College of Nursing and Midwifery
- Holy Family College of Nursing and Midwifery
- Malamulo College of Health Sciences
- Mulanje Mission College of Nursing and Midwifery
- Nkhoma College of Nursing and Midwifery
- St John's College of Nursing and Midwifery
- St Joseph's College of Nursing and Midwifery
- St Luke's College of Nursing and Midwifery
- Trinity College of Nursing and Midwifery

## 2.2 Interviews

Interviews with selected informants constituted the main source of information. The interview guides/questionnaires developed included both quantitative and qualitative questions, although the main approach was qualitative. The interview-guides were semi-structured allowing the interviewer to explore and follow up on interesting answers or ideas coming up during the interviews.

The informants were selected strategically and consisted of tutors, student, hospital staff, and management (see list attached, Appendix 3).

Number of informants:

Category	Number
Principal	8
Tutor	19
Student	18
Hospital staff	10
Total number	55

Table 1: Number of informants

Before the interview started the respondent were informed of the purpose and the main content of the interview and of our obligation to assure the needed protection and confidentiality. After the information the respondents were asked to voluntarily give his/her consent on participating.

## 2.3 Analyses

Analyses of data started after each site visit, when the information in each interview were transcribed and synthesised (phase 1). After the finalisation of all the site visits, the totality of interviews, documents and notes from each site were analysed and a summary document from each site were made (phase 2). The 3rd phase of analysing consisted of looking at the colleges as a whole and posing some analytical questions to the whole material.

The findings presented in chapter 3 is based on the analyses of the material collected.

## **Chapter 3: Findings**

The findings are presented in 5 sections. The first section (3.1) concentrates on the systems for planning the curriculum implementation at the colleges. Section two (3.2) focus on the implementation of the theoretical parts of the curriculum, while section three (3.3) describes the findings on the implementation of the clinical parts of the curriculum. Section four (3.4) depicts on the perceived need for further training of the college staff, while section five (3.5) gives a short description of the findings concerning monitoring and evaluation systems available at the colleges.

The findings from the interviews are basically presented as group results, but some findings on planning/management/evaluation etc are presented with college specific information (see appendix 1).

### **3.1 Planning and management of curriculum implementations**

The most important planning tools for curriculum implementation in the CHAM colleges seem to be master-plans and course outlines.

#### **Master plans**

The master plan (at some places called the curriculum master plan or the academic calendar/plan) is normally depicted as a plan indicating the blocks of theoretical teaching and clinical placements for all the classes at the colleges (1st, 2nd and 3rd year). The plan also includes the dates when each block should start and end, expressed in months and weeks, and normally the examinations periods, review periods and holiday times. Only a few colleges had master plans showing assessment periods and specific clinical experiences each class should have at each clinical block, as well as the specific courses that should be taught during each theoretical block.

Normally the master plan was developed as a team work, developed by all tutors at the college, with the principal and dean taking the lead. The way each college communicated or informed of the master plan varied. In some places the master plan was in full view on the wall in the principal's office, at the tutor's offices, as well as on the student's notice board. In other colleges the plan was kept in tutor's files, and only visible in the principals office. Several students claimed that they had never seen the plan, and indicated that their training

programme was only communicated to them verbally, which made it difficult for them to get an overview and to plan their own studies.

All colleges had experienced deviations from the master plans and these were largely due to delayed funding/payment of student's fees. The experiences of not being able to follow the plan because of delayed funding were expressed as follows: "*it de-motivates us*", "*it disturbs my mind*", "*it brings uncertainty*". For the students having to postpone their graduation the frustration was present, although the impression was that the colleges tried to do their best to assure that the students completed and were given all the courses they were supposed to have. In addition to deviations caused by delayed funding, some colleges mentioned deviations caused by unavailability of teaching staff, leading to students being sent for unplanned clinical placements.

### **Course outlines**

All the respondents (100%) indicated that they use course outlines as an important planning tool for curriculum-implementation in their colleges. Some courses though, did not have them, in particular those where external tutors were involved. Most of the colleges (about 80%) made the course outlines available for the students, by giving them a copy each, but some colleges just communicated them verbally to the students at the beginning of each course. The students were very clear of the importance of having the course outlines ("*it helps us to plan our studies*" "*it helps in reading*"), and expressed frustration when they were not available or not complete ("*it confuses us*", "*we have to push them (tutors) to get copies*" "*sometimes the tutors change topics – and sometimes they inform us and sometimes not. It is difficult because we need to prepare ourselves*").

The tutors generally seem to feel competent or very competent when it comes to developing course outlines:



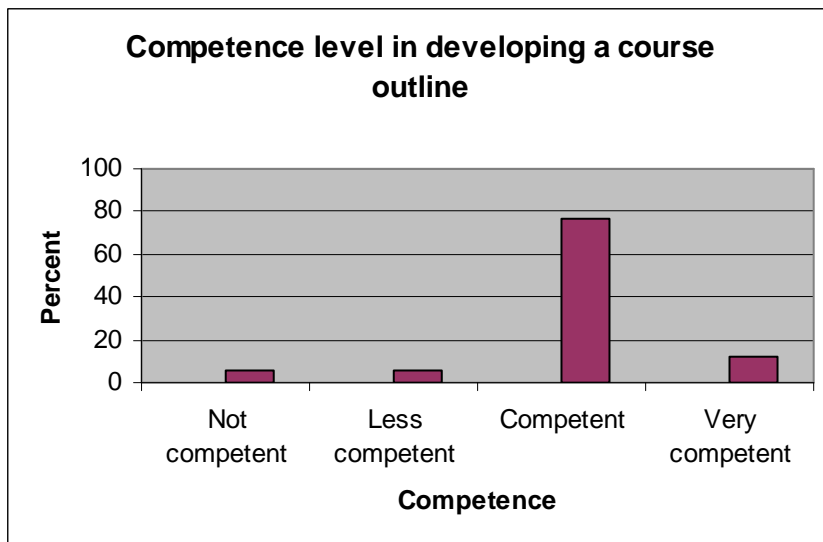


Figure 1: Competence level in developing course outlines (n = 19)

Almost 90 % of the tutors interviewed stated that they feel competent or very competent in developing course outlines. Only very few disclosed a lack of competence.

Copies of course outlines from the colleges were made available to the investigation team and analysed. The analyses indicated a quite interesting variation in the course outlines. In most of the colleges, important parts of the course outlines were more or less copies of the course descriptions in the core curriculum and syllabus documents, meaning that course descriptions, course objectives and prescribed/recommended texts, as well as modes of assessments were the same as those in the core curriculum or syllabus. Approximately 20 % of the course-outlines were regular photocopies from the curriculum.

Information like course requirements, competencies and skills, laboratory hours, teaching and learning methods and more specific modes of assessment, did normally not appear on the course outlines.

Although almost all the tutors stated that they felt competent in developing course outlines, the analysis of the course outlines above indicates that most of them do not invest so much in developing more specific and adapted courses, or “translate the curriculum into manageable learning units of instruction”, as the CHAM policy suggests that the tutors should do. Some of them mentioned that they sometimes add new topics to the course descriptions in the curriculum (“*new conditions force us to cover them though they may not appear in the*

course”). Others feel less free and seem to feel very restricted by the topics listed in the core curriculum.

Nevertheless there are some examples of tutors trying to translate the curriculum into more manageable and useful course-outlines:

*“The curriculum has too much information to an extent that students are not able to read it. We as tutors select the most important and give self- studies for the rest. We write this in the course outlines”* (tutor).

In most of the colleges the course coordinator is responsible for developing course outlines. In some colleges the Head of Departments is responsible. Other colleges discuss the course outlines in the faculty meeting and at one college they said that they sometimes send them to other colleges for moderation and feedback.

### **3.2 Implementation of the theoretical part of the curriculum**

According to the syllabus, theoretical courses cover about 1/3 of the NMT programme. Most tutors expressed that they find the course outlines (though often as copies from the core curriculum or syllabus) indispensable when it comes to planning the theoretical parts of the courses. They use the course outlines to prepare lessons, to do time tabling, to sequence the content etc. An overall tendency is though that many tutors seem to use the course outlines first and foremost as a checklist for the topics to be taught and the content to cover.

#### **Lesson plans**

Although all tutors seem to use course outlines, the situation seem to be more inadequate when it comes to lesson plans. Nearly all the tutors seemed to recognize the importance of a good lesson plan. They described it as follows: *“it guides me in what to teach”*, *“it’s very useful to control time”*. *“It helps one to cover the content.”* *“Lesson plans help me to know that the objective has been achieved”*. The lesson plans described by the tutors are supposed to contain more specific objectives for the lesson, as well as time allocated for each topic, teaching and learning methods (teacher activities and student activities) and learning material to use as well as evaluation of the lesson.

Some of the tutors were very clear in insisting that they use lesson plans; *"I use lesson plans always together with my teaching notes"*, said one tutor. But they are not always so sure when it comes to their colleagues: *"I always make lesson plans. I don't think that all the other tutors do"*, was a statement from one of the tutors. Some tutors admitted that they don't use lesson plans very often: *"I use them in particular when teaching complicated and longer topics"* or *"Experience make me not use a lesson plan sometimes"*. Others admitted that they rarely use them: *"I just depend on my teaching notes"*. *"I feel that it is duplication between notes and lesson plans"*. Some even admitted that it was *"laziness"* that kept them from developing lesson plans.

Even though many tutors neither develop lesson plans nor use them, almost all the tutors seem to feel either competent or very competent in *making* lesson plans:

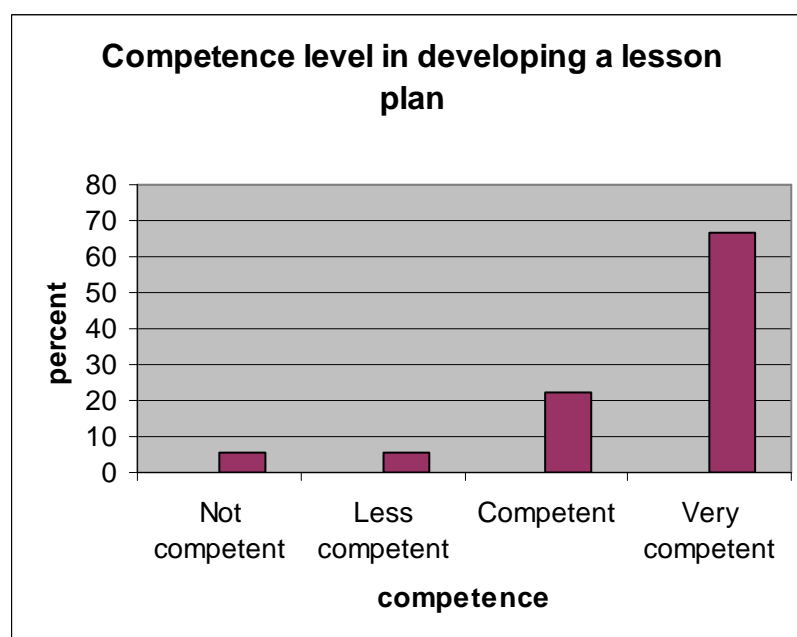


Figure 2: Competence level in developing lesson plans (n = 19)

## Content

Many faculty members from different colleges indicated that they felt that the programme was overloaded as compared to time available for delivery. It seems to be a common experience that the curriculum for the NMT is overcrowded when it comes to content listed and topics to cover. Giving the students a comprehensive programme to make them both competent nurses and skilled midwives in three years is not easy. Remarks like *"The curriculum is*

*overcrowded*”, “*There is too much content to cover*” were commonly expressed by both tutors and students.

Some tutors wish that the curriculum could guide them more in selecting content for the teaching: “*I feel that all colleges should have a standard of what to teach and which literature to use. In the curriculum, only the topics are listed*”, said one tutor. “*I wish there was a standard guiding us to ensure content of coverage areas*”, said another.

One way of dealing with too much content in too little time is to give less relevant topics as self studies. Yet many tutors seem to feel a deep fidelity towards the themes listed in the curriculum. “*We don’t skip themes. We have to cover it all*”. The tutors seem to think that they are in line with the students when deciding that all topics should be covered. According to the tutors many students don’t like when themes are skipped or given as self studies. One of the teachers expressed it as follows: “*It makes the students feel half baked and not getting enough information*”.

The problem of levelling the teaching, i.e. deciding the depth of the content and assuring that it is corresponding with the NMT level, is depicted as a challenge by many of the tutors:

*“I have problems in deciding the level of the content. This is a major problem. Some books don’t say exactly what to teach and some books are unlimited. You are not guided in how deep you shall go”.*

*“Sometimes it is difficult to know how deep you should go. Sometimes you find that you have been giving something too deep for the students. When you ask them, they don’t answer”.*

Sometimes the problem of finding the adequate level is linked to the fact that the tutors generally have a degree (normally BSc) and hence, a deeper understanding of the different themes than the students is supposed to have at the diploma level. Especially those who have not started at the diploma level themselves, tend to find it difficult:

*“I have difficulties to teach in such a low level we have here, especially in midwifery”.*

*“I’m a RN with a higher qualification. We tend to teach the way we where taught”.*

The curriculum is not very clear on “*where to start and where to stop*”, and some tutors remarked that the literature prescribed and recommended in the Syllabus and curriculum are

almost the same as the books they used at the RN and even BSc-level. All this is contributing to the experience that levelling of the content is a challenge.

### **Teaching and learning methods**

The network collaboration project “Improved Health Training Programme in Malawian Nursing Colleges”, has made considerable efforts to introduce new teaching and learning methods to the colleges. In particular methods for self directed learning and interactive learning methods have been promoted, to encourage the students to more actively participate and take a larger responsibility for their own learning.

The overall impression is though, that the teachers tend to “*teach as they were taught*”, and hence the most common and popular method of teaching is lectures. As a part of the lecture most tutors use some interactivity like “questions and answers” and “discussions”. A few tutors mentioned that they sometimes use “role plays” as a part of their teaching.

Only a few tutors mentioned Problem Based Learning (PBL) as one of their teaching and learning methods. Those mentioning PBL described it as a nice approach “*because it stimulates the students to be active*”. The overall impression is though that the experience with using Problem Based Learning is mixed. One tutor had tried PBL once and found it too difficult and that it was a lot of work. Although liking the method, the few mentioning PBL depicted it as a very time consuming activity: “*We don’t have the time to do it often*”. “*I also use PBL. The only problem is that it is time consuming*”, are statements indicating problems in implementing the method.

Quite a few tutors use approaches not so far from PBL, often linked to different forms of assignments, sometimes given as group-work. For instance the tutor might ask the students to go into groups, give them different topics (or sometimes a case), and then give them time to go to the library to find out of the topics. The same day or the day after the groups perform presentations in the classroom on what they have found. One of the tutors was enthusiastic when telling about his experiences: “*I gave two assignments which were marked and contributed to the mid term. The students got some questions and went to the library to find answers. They write very good assignments!*”

The impression from the interviews both with tutors and students indicates that there is a strong correlation between the use of student active methods and the student's tendency to read books and to use the college library to plunge deeper into nursing literature. Some tutors express a worry when it comes to the student's willingness to search for more information than what is given to them during the lessons.

*"My impression is that the students don't read very much. They depend on their notes. When I push them for assignments, they have to read". (tutor)*

*"Often when they have a case or assignment, they have to go to books, but when you give them a topic they rarely go to books."(tutor)*

Some of the students we interviewed stated clearly that their main source of information were the lectures and the classroom teaching. The library was not always frequently used. When asked about teaching and learning methods the student attitude seems to be quite unison: The students are used to lectures and seem to demand more lectures. Some students were very clear in their demand that the lectures should cover all topics.

*"We write down the lectures. Of course we go to the library, but mostly we depend on the information we get from the tutor."(student)*

The tutors seem to struggle with the expectations coming both from the student, but also from their own ideas of how student learn, when considering whether or not to introduce more student active methods:

*"Sometimes I feel like I'm giving them everything. It depends. Sometimes it seems as if you give them everything, it helps them in the understanding. And sometimes you feel that you are spoon feeding them. There is not much self directed learning."(tutor)*

Many tutors from different colleges share the impression that the students don't use the library as they are supposed to do. *"Probably because of this spoon-feeding system they depend very much on their notes, unless you tell them to go and look for books"*, said one of the tutors. As depicted above, some tutors seem to be aware of their responsibility to encourage or "push" students to read by introducing assignments and other student active methods. This is obviously not the attitude of all the tutors. Hints from some informants suggest though that it is not only the students who don't read very much. *"Some tutors are lazy, they just use their old notes"*, is the description from one of the principals. Although this might be the case with some tutors, this is not the overall impressions of what is happening.

## **Library resources**

According to both tutors and students the availability of books has improved lately. New and interesting books of a high quality level have arrived at the colleges. Although this was widely recognized and appreciated both by students and tutors, the availability of sufficient number of good books was still depicted as a problem.

*“There are few copies against a large number of students”, “New books are in tutors offices”, “Books are there, but not available”, “If they are away, the students have nothing”* are all statements describing the situation. Some places the situation is described even more dramatically; *“The tutors are fighting for books”* said one tutor, *“The students have to scramble for the same books”*, said one of the students.

Not all the books are very popular. One of the students expresses it as follows: *“Some books are not used, the books we use are not so many”*. The utterance might refer to the fact that a great number of library books are old books, but also that even some new books are not necessarily considered to be so relevant.

To deal with the problem of unavailability all the college libraries have organized a reserve shelf where the most relevant/prescribed books are available for short time loans.

## **Assessments**

The core curriculum suggest both continuous and summative (end of year) exams to assess the student performance in the theoretical parts of the education. The suggestion is that the continuous assessment shall contribute 40% and end of year shall contribute 60% to the final grade. The course outlines are supposed to describe the specific modes of assessment for each particular course. If the course outlines developed at the colleges had descriptions of modes of assessment at all, the percentage of continuous and end of year 40/60, was normally the only information written.

Only very few course outlines were more detailed on modes of assessment, describing how the continuous assessment would be done. Often the assessment was described quite general, as follows: mid-block exam 10%, end of block 30% and end of year 60%. The interviews depicted various assessment forms like quiz, multiple choice, assignments and oral tests in addition to written exams. The overall impression was though that the students sometimes

were poorly informed on the modes of assessments, and that the information they got was not always reliable. For instance the use of assignments as a part of the continuous assessment seemed to be quite varied. Sometimes student assignments were assessed and given marks. Sometimes these marks contribute to the continuous and sometimes not. When the course outlines very rarely had a more detailed description of modes of assessment, they were not always followed anyway. This indicates that the tutors tend to feel quite free to use a variety of assessments:

*They were not indicated on the course outlines, but I used quiz, end of term test, mid term test and group assignment (tutor).*

*In my last course I did group presentations, individual written assignment, mid theory exams, end of theory exam (tutor).*

As a result of this sometimes quite scarce information on modes of assessments, some students express that they feel uncertain and that the assessment system is not clear, in particular when it comes to the formative part (continuous).

*“Assessments are not described in the course outlines. They need to state in the course outlines when the tests are to be given. They should not come as a surprise.”(student)*

In some courses, at least at some of the colleges they don't have any continuous exam at all. The students complained about that because they felt that the continuous exams act as a warning on student performance and also as a helpful reminder of what to be covered. As one of them expressed: *“all courses should have formative assessment to give room for students to improve upon getting feedback continuously and not at the end”*

The students were concerned about the council examination at the end, which they considered very important. More than one student indicated that the exams given throughout the year did not necessarily correspond with the final exam. It would have been better if they were in line, according to the students.

Another suggestion from students was to have more exams upon finishing a course and then no end of year of the same course: *“It would have been better with exam at end of course instead of end of year”*.

Sometimes the exams seemed to come as a surprise to the students:



*“This end of year was a case study. The test was satisfactory, but the assessment could have been improved if they gave better information on how the case should be done. As now we can fail 2-3 times because we were not informed.”*

### **3.3 Implementation of the clinical part of the curriculum**

The clinical part includes about 2/3 of the NMT programme, according to the syllabus. All students are supposed to have 93 weeks of clinical experience in various fields (listed) with the minimum of 3720 hours. The syllabus has specific demands to the clinical facilities utilized for student experience, whether it is the community or the hospital.

#### **Planning, collaboration and supervision**

According to the syllabus, the colleges and the clinical area have a joint responsibility to assure the students clinical training. The collaboration between the colleges and the placement areas is therefore crucial. The impression from the investigation is that the colleges and the various clinical sites collaborate in different modes and ways. A very critical point of collaboration is linked to information flow. Sending students for clinical training demands a communication between the college and the clinical sites. According to most of the tutors, written information is normally sent to the sites prior to the placement. The most common is to send information of the number of students allocated, the period of stay and the objectives for the placement. Often the clinical duty rosters for the students are communicated and sometimes the colleges' routines for supervision.

The interviews with the hospital staff (preceptors) indicated that the information was not always very good. Some places the information of students coming to the wards was given only some days before the students arrived in the wards. One of the preceptors said that she often only got verbal information of the allocation of students and that she only rarely received the objectives for the particular placement in advance. The communication and collaboration with the tutors during the placement was not always very good either. Our impression is though that the information to placement sites far from the colleges, such as district clinics, community health centres and reference hospitals seem to be better, and to be given at an earlier stage than information to the mother hospital.

All the students say that they normally are well informed of what they are expected to learn in the different clinical placements. The information they refer to is normally only the objectives

for the actual placement. Approximately 50% of the students say that they were informed of who would be their supervisor from the college and from the clinical sites.

The objectives for the various clinical placements are normally developed by the tutors, although the impression is that they are often more or less copied from those in the core curriculum. Only one tutor (in our sample) asked the students to develop their own objectives, based on the curriculum objectives.

All the college tutors are supposed to supervise students in the clinical placements. In most colleges the tutor's supervising schedules (work plans) were elaborated and available. The way of organising the supervising and sharing the tasks varied from college to college. The most common however was that the tutors shared the responsibility for a certain group of students, meaning that the tutors were responsible for supervising all the students in all the different wards and departments in the (mother) hospital one day each or one week each.

One of the colleges had adopted a different system. To strengthen the clinical teaching they had decided to give each tutor the responsibility for the group of students in one specific department/ward throughout the whole placement. The tutors seem to be very satisfied with the way of dividing the tasks:

*"It is much better when we have shared the different wards. I get to know the students better and I know how I can guide them. And I get to know the nurses better. I feel more responsible." (tutor)*

In more remote clinical sites one teacher was supposed to stay with the students throughout the entire period.

Some tutors indicated that they were supposed to supervise each student for one or two hours per day. The overall impression is though, despite such ambitious estimations, that the presence of tutors in the clinical area and the time spent on supervising student are much more limited. There is a discrepancy between how often tutors say they were supervising students and how often students say they were supervised. Approximately 50% of the students said that the tutors very seldom come to the clinical sites. One student kept waiting for a tutor that never showed up: *"All the time I was there I never saw a tutor"*, she said. Another student had a similar frustrating experience, when preparing for assessment: *"We prepare and prepare but the tutor never comes"*, was her frustrated utterance. Some of the clinical preceptors

confirm that the tutors are rather scarce and hasty guests in the clinic: *“Preceptors are left alone for the clinical supervision. The tutors only come when there is a problem and during assessments”* (preceptor) *“Tutors rarely come to supervise students though the college and the hospital are closely attached”* (preceptor).

One of the tutors tried to explain why so many tutors seem to put so little emphasis on clinical teaching. She linked it to the training of tutors in Malawi:

*“Not all the tutors have training in clinical teaching. Those who are trained at Kamuzu (College of Nursing) are not trained. We run away from the clinic because we are afraid. Skills lab the same.”*

### **Clinical teaching and learning methods**

When (or if) the tutors come to the wards, the most common teaching and learning method seem to be demonstrations. The tutor gathers a group of student and demonstrates how to perform a nursing procedure/intervention, while the students are watching. Normally a patient, needing the particular intervention is involved. This method was mentioned by almost all tutors and preceptors involved in supervision of students. Many students seem to appreciate this method. The impression from our investigation is that they frequently asked for more demonstrations: *“Tutors should come and demonstrate every procedure”*, said one of the 2. year student. The experience, however, is not always corresponding with the expectations: *“Most of the time tutors don’t come and demonstrate”* was the utterance from another student. One of the preceptors reported a similar experience: *“Students are left alone in the ward. They get inadequate supervision from college. Another preceptor also complain about lack of supervision from the college: “Tutors only come for assessment or they don’t supervise students adequately”*. Many preceptors felt quite alone with the responsibility to teach students: *“Other clinical staff are unwilling to teach students”*, one of them said..

Although demonstrations are the most common mentioned method of clinical teaching, some examples show that there are exceptions. When it comes to clinical teaching methods used in community health practice, a broader repertoire of methods appears. The impression is that tutors tend to use approaches like case studies, assignments, group work and guiding, when they teach students. They also seem to relate to the clinical area in a different way. One tutor explained in details how careful she was to inform several local leaders and stakeholders (chief, local authorities etc) before the students were sent to the community to avoid

problems. She also mentioned the close collaboration she had with the community health nurse, which she considered indispensable for a good result.

Exemplary cases are not only linked to community health: At one of the colleges the collaboration between the college and the clinic were obviously very good. The information flow was fine and frequent and the preceptor cooperated with the college before, during and sometimes after the placement. The clinical staff was involved in supervision and assessment of students together with the tutors. The preceptor and the tutors were guiding the students in the elaboration of the nursing care plans, which the students were supposed to make for each patient. Sometimes the students were working in groups with “cases” by discussing and reflecting together with fellow students and the tutor. Both of the students we interviewed from the college in question stated that they had no problems or complaints concerning the clinical placement.

One important arena for clinical teaching and training is the skills lab. The project “Improved health training programme in Malawian Nursing Colleges” has a significant focus on the skills lab facilities, recognising how important they can be for clinical training. The skill labs at the colleges are still under construction or are being renovated, and most colleges reported that the equipment at the moment is scanty and the training facilities not very satisfactory. Nevertheless the skills labs are in use. The teaching methods in play in the skills lab, according to the tutors and the students seem to be very much limited to demonstrations and re-demonstrations. The students normally have access to the skills lab for independent practicing, but in most places they need to borrow a key and sign for responsibility to get access. In other places they have to get a tutor escorting them if they want to practice. One of the colleges experienced that most of the equipment was stolen by students; hence the college had been forced to be stricter. Many students said they would use the skills-lab more often if it had been better equipped.

### **Assessment**

All tutors and most of the preceptors we interviewed seemed to be involved in assessment of the student’s clinical practice. The assessment tools they use are mainly tools from the Nurses and Midwives Council of Malawi (NMCM), but some colleges have also developed their own tools. The student’s green-book or procedure manual is also in use in many colleges. Some tutors expressed that they were not satisfied with some of the tools from NMCM. They were

said to be too general with too much room for subjectivity, they were outdated or they lacked some areas. One tutor complained that there was no particular focus on professional conduct in most of the forms. Another tutor from one of the colleges who have developed their own tool is satisfied with the implementation of caring attitudes and professional comportment in the tool: *“We have an ethical part in them, on professional conduct”*, she said underlining the importance of assessing the students ethical performance and not only the technical part of the procedures.

The overall impression of the council’s assessment tools is that they are very much focused on assessing student performance of various nursing and midwifery procedures. Most of the college specific tools seem to be more or less in the same genre as the council’s tools, mainly focusing on the student psychomotor skills and ability to plan and perform certain procedures. In one college, however, they were testing out a quite different assessment tool. The tool, constructed by the college faculty, was a more overall assessment of the students’ total performance during the placement. Aspects of nursing like communication, ethos and professionalism, documentation, clinical reasoning, as well as specific competencies linked to the patient conditions are assessed.

At most of the colleges the students were usually informed of when the assessments were to take place since they often were the ones responsible for asking the tutor to come and assess them. However, some students and also some preceptors told about tutors who were just not coming even if they were called upon: *“Students can have a case for assessment but the tutors don’t come”*(preceptor).

With some exceptions (mentioned above) assessment procedures are generally more or less the same for all colleges, but the way they are conducted varies. Several students complained about their tutors and confessed that some of them hide when the tutor is coming. *“Tutors are feared and students run away. They hide when tutors visit in the ward”*, said one student. One of the tutors supports this statement and seems to be aware of what is happening: *“In my experience, when I go for assessment, the students think that I am going there to find faults in them. Some of them even run away”*, she said. According to some students, assessment was sometimes done through confidential report from staff to college, in particular in cases where there were problems. The students were asked to come and sign at the college. *“We are being*

*assessed continuously without knowing. This generates tension between tutors and students*”, were the complaint from one of the students.

NCMN is planning to administer an Objective Structured Clinical Examination (OSCE) to test the competencies among the students by the end of the NMT-programme. Some colleges are already implementing the OSCE, although quite a few tutors brought up the need for further training in how to perform the OSCE.

### **Learning environment**

The environment for the clinical teaching is for several reasons not always the best to assure optimal learning. In addition to the problems already mentioned, one frequently mentioned problem is the lack of availability of sufficient equipment. Sometimes this may menace the students’ security, when doing nursing procedures or giving care to patients: *“The working environment is neither safe for us nor for the patients. We have patients with HIV and hepatitis and we lack gloves and other protective wear and we don’t get vaccines for hepatitis”*, said one of the students. Lack of equipment makes it difficult to teach the students how to perform correctly in all situations. Often the students learn to use short cuts: *“You need clamps, you need delivery packs, you need scissors, gloves and they are not there. We have to improvise”* (student).

Another problem some students drew attention to was the nurse - student relationship. Several students complained of nurses who seem to lack both awareness and willingness to supervise and teach students. Sometimes they accused the nurses of even exploiting the students in the wards: *“Nurses takes advantages of students. Some of them leave everything to students, while others ignore us”*, was one statement. *“The nurses demoralize students. They don’t even answer questions”*, was another.

Sometimes the tutors were included in the critic. *“Attitudes of both staff and tutors should be improved”*, says one of the students. *“Tutors should stop punishing students”*, is another statement. *“Tutors are not good role models. They shout at us and have bad behaviour”*. The complaints are sometimes sent back to the students: *“Students have poor professional conduct which does not improve with counselling”* (preceptor).

Fortunately the picture is more complex and nuanced. When the students were asked if they had met any role models in the clinic, they all affirmed that they had. When asked to describe them they came up with an impressive list of positive characteristics. The nurses they describes as role models were *hard working, smart and punctual*. They were *self directed, gave proper handover, and were cooperative and responsible*. They were *committed to work, well educated and knowledgeable*. The way they performed their work, were appreciated by patients. They were *friendly with the patients, communicated well and cared for them in a holistic way*. May be most important though: *They were interested in students and willing to teach! They were helpful and gave demonstrations, even guided and corrected the students*.

### **Other challenges**

As mentioned above, one of the challenges in implementing the clinical part of the curriculum were said to be inadequate staffing of both tutors and nurses. Some hospital wards are often very crowded, with too many patients and a shortage of staff. Another quite opposite problem mentioned by some of the preceptors was linked to a particular situation in some of the CHAM hospitals. For several reasons some of the CHAM hospitals have seen a decrease in the number of patients coming to the hospital. Some hospitals and wards have very few patients, but at the same time they receive a lot of students. One preceptor said it like this: *“Sometimes there was only one patient in the ward. The students do not find the conditions they want”*. The tutors were also aware of the fact that a large number of students sometimes share few patients. Several tutors depicted this problem to create unsatisfactory learning conditions, *“Students scramble for cases”*, was the quite illustrative comment from one of the tutors.

As mentioned above, the syllabus has listed a quite specific and detailed list of required areas for student placements. These requirements are not easy to meet, and the colleges are forced to send the students to clinical sites far away from the colleges to fulfil the demands. This is very costly for the colleges due to student accommodation costs, and costly clinical supervision. Some of the students graduate without having all the experiences they should have had according to the syllabus.

### 3.4 Perceived needs for further training

The staff of tutors we met during the investigation consisted of many well qualified teachers/nurses with a long and important clinical experience as well as a long formal education in health related subjects. Almost all the tutors at the colleges have a BSc- degree. Most of them started out with a basic nursing qualification and have achieved several years of clinical experience in various fields before they continued doing their RN (for those who didn't have it), and eventually their BSc in Nursing Education, Community Health or Mental Health/Psychiatric Nursing. Some very few tutors have started teaching with only a Generic Bachelor's degree in nursing and only a very short clinical experience.

The tutors were asked to rate their areas of priority for training. The results of the rating were as follows:

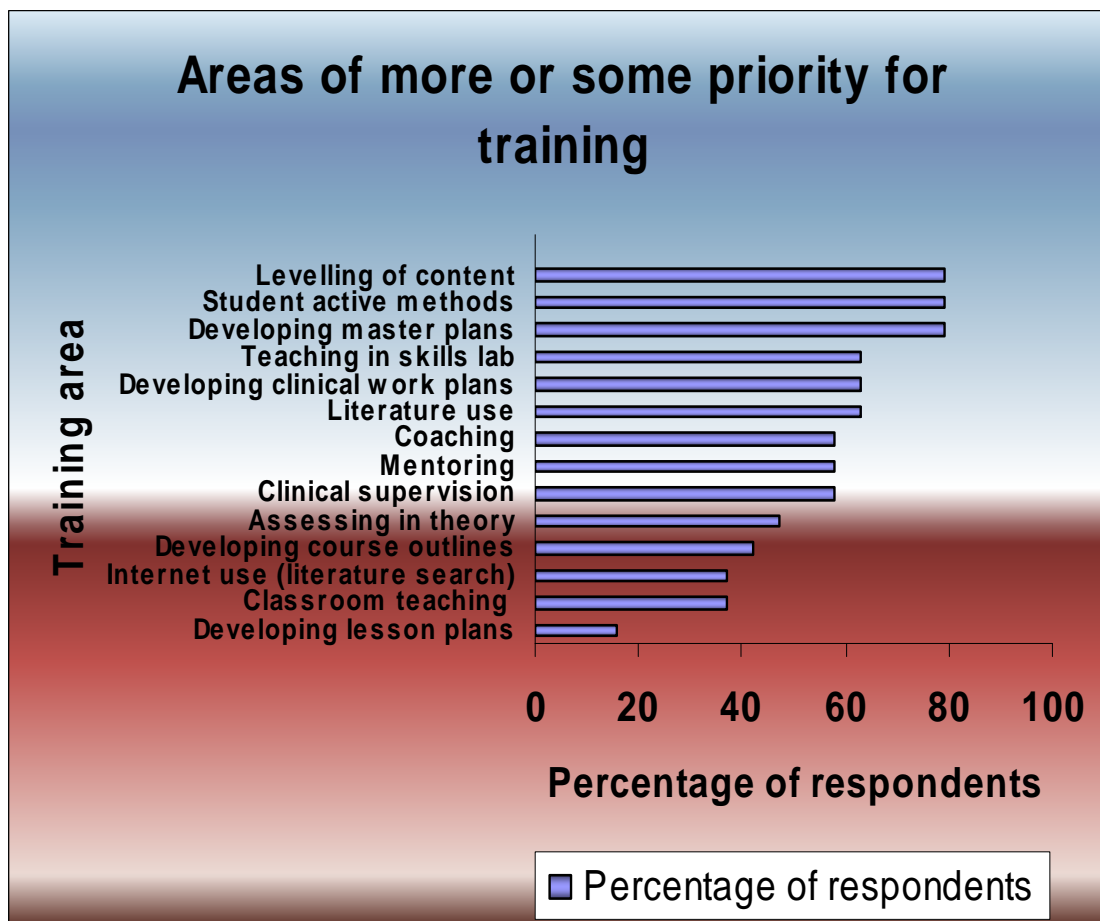


Figure 3 Priority of training tutors



It is interesting to notice that many of the tutors seem to give priority (some priority or more priority = 1 or 2) to pedagogical training like student active methods and use of literature/levelling of content. Teaching in the clinical area, included teaching in the skills lab, is considered important by over 50 % of the tutors. It is also interesting to note that although almost all the tutors considered that they were competent in making a course outline. More than 40% gave some priority to further training in developing course outlines.

About 40 % of the tutors gave priority to training in internet searching. When asked if they knew how to search for literature, most of the tutors responded that they had some experience and said that they knew how to search on the internet. Yet only a few of them claimed to be familiar with how to search in a research database. Most of them referred to “google”, when asked for knowledge of research databases. Five colleges do not have access to internet at the present time. Only two have regular access to research databases like HINARI (a WHO-initiative that gives access to a lot of medical- and nursing-journals in full text). The accessibility for students is generally not very good. When the internet is available, and the computers are working, some students have access, but they complain because they normally don't have *free* access. “*We have to pay to browse*” said one of the students.

The principals at the colleges as heads of institution were asked to depict what they perceived to be the most needed areas of training for their staff. The most frequently indicated areas for staff training according to the principals were clinical teaching, teaching methodology and training in curriculum development.

### **3.5 Quality assurance - evaluation and monitoring**

The master-plans available in the colleges (though in different forms and with various content, ref. 3.1), were mentioned by several principals as important tools facilitating the monitoring of the implementation of the curriculum. According to the principals, deviations were easier to see with a master-plan available, and actions could be taken. Most colleges had written course-outlines and in some of the colleges the principals had electronic copies of them and went through them for checking. Only very few of the colleges do regular or continuously review of the courses, most of them do the review only when new trends and major changes in the curriculum demands it.

Most of the colleges do not have any standard tools for quality assurance, monitoring and evaluation. Only one of them mentioned that they use standard tools (for course assessments and classroom observations/assessment of tutor on probation), and very few of them write regularly monitoring and evaluation reports. The NCMC do regular monitoring and evaluations visits to the colleges, normally twice a year. *“They come unannounced, and later they send a report”*, was the statement from one of the principals.

Several principals mentioned the exams as the most important source of information of the quality of the performed programme. When the students got good results in particular at the end of year exams and the Licensure exam conducted by the NCMC at the end of the three years, it is a feedback on the quality of what the college does.

Also college tutors tend to lean on the results of the exams to monitor the quality of the teaching. Very few of them do formal course evaluation, although quite a few of them mentioned that they ask students for oral feedback at the end of a course.

Many colleges have implemented a system for both internal and external moderation of exams, most of them during the most recent years. Some have not yet started, but have planned to do so very soon. The internal moderation is mostly taken care of by exam committees (3-4 persons), but in some colleges the whole faculty as a group (academic committee) are responsible for the moderation.

One of the colleges mentioned that they do performance appraisal of tutors on probation. Besides that, none of the colleges have started doing structured performance appraisal of the faculty, but most of them have the intention to start very soon. *“It’s a new thing, but we intend to start appraising staff”*, said one of the principals. The lack of training and tools available was depicted as the main hindrances to start. One of the principals expressed a fear that performance appraisal could de-motivate the tutors. Another problem was that some of the tutors are employed by the government; hence their files and documents are kept by their governmental employer, which makes it difficult for the principals to conduct the appraisal.

The principals expressed a need for training in the area of monitoring, evaluation and quality assurance, especially in its links to curriculum implementation.

## **Chapter 4: Discussion**

### **4.1 Planning tools – availability and quality**

The general impression of the planning systems/modes of planning in the CHAM colleges is that they differ from college to college. Although most colleges use master-plans and course-outlines as important tools, the tendency is that the content of the plans is not the same from college to college. In addition to the master-plans and the course outlines the colleges normally use three types of schedules in relation to the curriculum implementation, namely class schedule (time tables), clinical duty roster and tutors supervising schedule.

The lack of uniformity of planning tools like master-plans is not necessarily a problem. What is important though is that there exists an appropriate overall planning at all the colleges, which includes a certain minimum of information. In our opinion such plan should give an overview over when the specific theory courses and the specific clinical placements for each class are going to take place. It should also include dates (months and weeks) for exam periods and review periods as well as holiday times. The plan should be for a whole year, and include all classes at the college.

To facilitate planning and a proper understanding of the entire study program, it is of great importance that the master-plan is communicated very clearly (permanently in full view on notice boards) not only to all members of the staff but also to all the students at the college. When there are changes or deviations, this need to be communicated clearly. A master-plan with all necessary information will also assist in the collaboration with the clinical area. A good plan will make it a lot easier to communicate and plan for the placements in time.

The course outlines seem to have an important role in the implementation of the curriculum at all the colleges. Even if most of the colleges have course outlines for almost all the courses, there seem to be a way to go to assure the quality of those documents. Normally course outlines should be developed by the faculty members (course coordinator/head of department) and be submitted to the whole faculty for discussions and approval. Sometimes a curriculum committee could be a good instrument to assure the existence and quality of course outlines and to assure regular reviews, although in small colleges all faculty members may serve as the curriculum committee (Keating 2006, p 178).

The fact that most of the course outlines in the colleges, were more or less copies of the core curriculum, seem to be contradictory to the finding that most of the tutors (90%) feel competent/very competent in developing course outlines. In our opinion this suggests that there is a need to discuss and to work further with the college faculty to increase their capacity in developing adequate course outlines.

The course outlines are very important sources of information for students. The findings suggest that they are often the only information of the details in the curriculum that the students get. The fact that they some places are not available for the students can be a hindrance for the students when it comes to proper planning, preparations and performance of their studies. It is very important to address this problem to assure that steps are taken in all the colleges to make certain that the students are well informed.

#### **4.2 Theoretical courses – challenging areas**

Although methods for self directed learning and interactive learning methods have been promoted by the project “Improved Health Training Programme in Malawian Nursing Colleges”, the overall impression is though that the most common method of teaching in the colleges still is traditional lectures. Most tutors use some interactivity like “questions and answers”, “discussions” and sometimes “role plays” as a part of their lectures. It is though quite apparent that the approach is mainly teacher centred, focusing the teacher as transmitter of knowledge and the students as a passive absorber.

It is also the overall impression that students often are expecting the teachers to cover all (or most of) the topics by lectures. The depiction of the students wanting to be “spoon fed” by the tutors, or the metaphor of students feeling “half baked” if the teaching doesn’t cover all the topics, are underpinning such assumptions. The information that some students hardly open books and depend mostly on their notes from the lectures is rather worrying.

It is not only students who seem to be resistant to new approaches. Some tutors feel very loyal to the idea of having to cover all the topics, and find lectures most effective in doing so. Certain tutors point to the fact (described by Goodlad as early as in 1984) that teacher tend to teach the way they were taught, meaning that they stick to lectures and, what Billings & Halstead call, “outdated teaching and learning methods” (Billings & Halstead 2009). The problem is that even though content is important, students’ ability to learn is hindered if too

much information is presented to them in lectures, and not linked to other learning activities. Students will normally learn material better if they need it to solve problems (Dalley et al 2008).

Fortunately the above descriptions are not the whole picture. When analyzing the material some very promising examples appeared. Although very few tutors seem to use PBL to a large extent, some tutors seem to have good experiences in using student active methods in a broader sense. The approach of giving the students assignments and ask them to gather information on a specific topic or a certain problem and then come back to the class and present, seems to encourage the student to go to the library and search for literature and reflect on the problems on their own.

### **Planning and levelling**

To be able to use more student active methods in a proper way, good planning tools are indispensable. Although all tutors seem to use course outlines, even though the quality of them differs, the situation is more inadequate when it comes to lesson plans. Nearly all the tutors seem to recognize the importance of a good lesson plan, but only few tutors seem to use them regularly. Most of them are depending on their teaching notes, which probably is not good enough (especially if they are old).

The problem of finding the right and adequate level of the teaching is depicted as a challenge by many of the tutors. Some tutors are very clear when saying that the content of program is too demanding and inclusive. They even suggest that the difference between the level of the NMT diploma and the RN level is not always very evident. The academic level of the literature prescribed and recommended in the syllabus and the core curriculum seem to be quite high and demanding. The need for a profound discussion and analyse of the levelling of literature and courses seem to be necessary. Another problem linked to literature is connected with the tendency of copying course outlines (included the lists of literature directly from the syllabus or the core curriculum) without adapting it to local contexts. At some colleges the prescribed and recommended literature in the course outline was not even available in the library collection.

### **Assessment**

When it comes to assessment of the theoretical parts of the courses the lack of clear information to the students seems obvious. The information written in the course outlines are

very general, and the lack of more precise information makes the student feel uncertain. The impression is that testing and assessments, in particular the continuous part of it, appears a bit haphazard.

The way students are assessed are very important and are often very much linked to the way students work and spend their time studying. If changes are made in a program whether it is learning objectives, content or teaching methods, it is very important that the assessments are changed correspondingly (Biggs 2007).

In our opinion further work to build up tutors capacities in developing good course outlines can address and should concentrate on many of the problems discussed above.

#### **4.3 Clinical experiences – the need for a broader approach to clinical teaching**

There is no question that experiences gained through clinical courses are a crucial part of the curriculum. In the NMT programme the clinical part constitutes around 2/3 of the program. The requirements of various areas of clinical training to be covered noted in the syllabus are quite vast (Syllabus 2009 p 85 – 89). Almost all the colleges have experienced challenges in their attempts to provide clinical experience in specific settings. The efforts made and resources spent to fulfil the students need for clinical experience and the requirements are noticeable.

The overall impression from the findings is still that there is a way to go to really exploit and make the most of the resources used in implementing the clinical parts of the curriculum. Quite a few informants pointed to the lack of focus on clinical teaching in their teacher training at Kamuzu College of Nursing, and admitted that they felt unconfident and lacked knowledge of clinical teaching.

Although there are some good exceptions and model cases in the material, there seem to be a common need to strengthen the collaboration between the colleges and the clinical sites. In particular the colleges' collaboration with their mother hospital seems to be somehow scanty. One step in the right direction is the creation of joint committees for collaboration. It is very important though that these committees engage in pedagogical discussions and focus on how to strengthen the students' clinical experiences.

## **Supervision**

All the college tutors are supposed to guide or supervise students in the clinical fields and most of them do. However, the time spent with students varies, and the investigation displays a discrepancy between how often the tutors say they are in the clinical and what students say. Some tutors indicated that they were supposed to supervise each student for two hours per day. When looking at the number of students and the amount of weeks of clinical training, this might seem a bit over ambitious. No nursing educational program has the luxury of unlimited time for clinical teaching. It is also evident that the amount of time the tutors spend in the ward is not always the most important. The tutor's understanding of her role, approaches to clinical teaching, selection of teaching and learning activities, use of evaluation process and relationship with students and others in the clinical environment is what is most important for the quality of the clinical supervision, hence it will influence how much time the tutors need to spend in the clinical environment.

According to the findings, the teaching and learning methods used in the clinical area seem to be very traditional. Demonstrations and re-demonstrations are frequently used methods. The concept of "supervision" seems to connote mainly to approaches such as demonstrations and assessment of nursing procedures. In current clinical teaching methodology these approaches are considered to have obvious limitations (Keating 2006, Biggs 2007). The need for a broader scope of methods in the clinical area, including more self directed learning methodology, is evident. Interesting approaches to consider can be "guided learning groups" where the students can work together, present cases and get feedback. Guided learning groups can be used to make the students collaborate in developing care plans, work on cases, have guided discussions in actual themes, share "stories" of students' personal experience with clinical topics and ethical dilemmas etc. All these are valued and well tested methods in contemporary nursing education. Learning groups encourages students to organise their thinking by comparing ideas and discuss their interpretation of clinical situations with each other, and to express, and hence give form, to their understanding of a subject. All these are activities which might contribute to the development of clinical reasoning and critical thinking skills.

Guided learning groups have the advantage of making it easier to include and encourage a more holistic approach to nursing. For instance, use of guided learning groups can facilitate the efforts of turning the focus away from procedures and diseases and toward the individual

experiencing it, which has always been stated as a focus for nursing education, although nursing education often has failed to do so. The benefit of including more affective learning, and not just focus on cognitive and psychomotor domains, can contribute to development of important professional qualities and attitudes that can influence the quality of the care patients receive.

Other possible benefits of guided clinical learning groups can be the acquisitions of skills in critical thinking and clinical reasoning. It can also help the students to organize and interpret information. For instance the guided learning group can be a very good place to introduce the student to current research (articles). Learning groups provides a shared learning experience and enhance collaboration skills.

### **Assessment**

Assessment is an integral part of the clinical educational process with the intention of assuring student quality, but also to continually provide feedback about strengths and weaknesses in students' performance. All tutors and most of the preceptors were involved in student assessment in one way or another. The assessment strategy in use was mainly linked to standard assessment tools either developed by NMCM or developed by the college staff. The tools, however, seems to focus mainly on students ability to plan and perform different procedures. Some tutors disclosed that they were not satisfied with some of the tools from NMCM since they were too general and lacked other areas such as focus on professional conduct, ethics etc. As mentioned before; there is a strong correlation between what the students are focusing and the way they are assessed is obvious. If the education wants to strengthen the ethical comporment and professional conduct of the student, it is very important to include such areas in the assessment.

In one college they are testing out a new tool with the intention to capture a more overall assessment of student's total performance. The intention is to include not only the student technical procedural performance, but also other important aspects of nursing competence like communication, ethos and professionalism, documentation, clinical reasoning etc. Although the work on developing this form was still not accomplished, this constitutes a very promising initiative and indicates a new direction in approaching clinical assessment in the nursing colleges in Malawi.



The system of clinical (and theoretical) assessments in the NMT colleges is s complicated and difficult to overview. The differences between the colleges are considerable. It is in our opinion very important to go deeper in to it, and to explore further on what is going on in the colleges. The aim should be to get a more transparent system where all interested parties (including the students) are well informed on how and when they are going to be assessed.

Some of the students confessed that they hide or run away when tutor is coming and one tutor said that when she go for assessment the students think she is coming to find faults in them. It is well known that clinical experiences and being assessed can be stressful for many students. It is also evident that the learning environment or climate is of outmost importance for student's positive learning experiences and that anxiety can contribute to decreased learning. Tutors and preceptors can create a climate of mutual trust and respect that supports learning and student growth. When students feel supported, they ask questions and seek answers without fear of being thought of as dumb or incompetent. The responsibility for creating and maintaining a good learning environment are mutual, but teachers have the ultimate responsibility to establish this climate. Fortunately all students had experienced some good role models in the clinical settings. Role modelling is an important and almost inevitably learning strategy in the clinical environment. Learning takes place constantly from observing role models delivering care (Keating 2006).

## **Chapter 5: Conclusion - the need for a reconsideration of the curriculum**

This investigation of curriculum implementation in the CHAM/NMT colleges in Malawi has drawn attention to problems and gaps. While focusing on problems it is important not to be misled to overlook the strengths and resources in the colleges. This investigation has revealed that the NMT colleges are progressing and developing fast. It also showed managers and tutors with an eagerness and willingness to take responsibility, well aware of their need to continue the struggle to improve and to engage in necessary changes. However, the focus of this investigation has been on the problems. The findings and discussion (Chapter 3 and 4) have identified many challenges which are crucial to address to assure a successful implementation of the curriculum.

The need for further work to increase the management competency in elaboration of adequate planning tools and monitoring/evaluation systems is apparent. Such tools are indispensable to be able to continually assess the programme, correct errors as they occur and continuously improve the quality of the planning.

Another important area is the need to continue the efforts to equip the colleges with sufficient teaching and learning resources such as library resources, skills labs etc.

The most important and difficult challenge is though linked to more pedagogical and didactic problems. This investigation of curriculum implementation in the CHAM/NMT colleges in Malawi has drawn a picture of an education programme built on quite traditional and somehow old-fashioned pillars. The implementation of the theoretical part of the courses is characterized by overcrowded courses and teachers doing their best to transmit all the content, mainly by lectures, to students trying hard to write down what the teachers teach. The implementation of the clinical part of the courses is characterized by a somehow poor organisation and quite limited didactic approaches (mainly demonstrations and assessment of procedures).

The problems of curriculum implementation are most probably corresponding with a lack of competence and a need for more knowledge within the group of tutors in the NMT colleges. However, it is also very important to regard the problems as very closely linked to the NMT

syllabus and the core curriculum itself. The syllabus (and the core curriculum) tends to promote a program focused on the delivery of a great number of topics and a very broad and comprehensive content. It also tends to focus more on the teacher as a transmitter of knowledge than on the student as a learner. Comparing this to current tendencies in nursing education the need to reconsider the NMT syllabus and core curriculum is quite evident.

In the new millennium, with an increasingly amount of new knowledge available through internet (although not yet available everywhere), health care environment will increasingly demand nurses to be “information literate” professionals and able to solve complex patient problems by using the best available knowledge (Shorten et al 2001). Even nurses with a NMT-diploma level need to be able to recognize when information is needed and have the ability to locate, evaluate and use new knowledge effectively. A modern educational program should put emphasis on development of critical thinking skills and commitment to life long learning, because such skills may prepare students to deal with the complex and ambiguous aspects of a rapidly changing health care system. The need to have a curriculum more focused on developing such skills is obvious.

Curriculum work is a very important and demanding task at the core of all educational activity. Curriculum development can never be considered complete; it is a continuous work involving professional regulatory bodies and national authorities and leaders as well as college faculty and management. A dynamic and ongoing discussion of questions related to curriculum, involving all parts concerned, is crucial to be able to create an educational programme responding to the demands and needs of today’s and tomorrow’s Malawian health care environment.

## Chapter 6: Recommendations

1. Staff (management) training in how to develop, use and communicate appropriate curriculum master plans.
2. Train faculty (academic deans) in contemporary curriculum thinking and promote changes from a teacher centred and content based to a students centred and outcome/competency based curriculum.
3. Staff training in developing course outlines. The training needs to focus on all parts of the curriculum like outcomes, content, learning activities, assessment and literature. The need for “curriculum committees” at each college to assure quality of course outlines should be considered.
4. Continue to train tutors in student active and self directed and interactive teaching and learning methods with a broader scope than PBL.
5. Raise discussions in the academic committees about levelling of content and how to select appropriate literature.
6. Focus on clinical teaching:
  - Training of tutors in student active clinical teaching methods such as guided learning groups, use of cases, peer assessments, guiding, search for information, use of skills labs etc.
  - Training of tutors in clinical assessment competency/development of assessment tools, including methods and tools corresponding to more overall objectives (outcomes) like ethical competence, clinical reasoning, communication and collaboration skills etc.
  - Raise discussions on learning environments in joint committees (lack of equipment, attitudes towards students, role models, security).
  - Develop and arrange courses for clinical preceptors.
7. Assist the colleges/train management in developing and institutionalizing adequate monitoring/evaluation systems.
8. Review and adjust/modify Phase 2 project plan for the “Improved Health Training Education in Malawian Nursing Colleges”, according to the recommendations of this report.
9. Review and adjust/modify the CHAM training policy according to the recommendations of this report.

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## Appendix 1 - College specific information<sup>3</sup>

Indicator	Nursing College								
	Ekwendeni	Holy Family	Mulanje Mission	Malamulo	Nkhoma	St. Lukes	Trinity	St. Johns	St. Josephs
Masterplan	●	●	●	●	○	●	●	●	●
Strategic plan	●	●	●	●	●	●	●		●
Annual implementation plan <sup>4</sup>									
Course outline for all courses	○	●	●	●	●	●	○	●	●
Curriculum committee		●					●		
Academic committee	●	●	●	●	●	●		●	●
Student committee	●	●	●	●	●	●	●	●	●
Joint college/hospital committee <sup>5</sup>	●		●	●		●	●	●	●
Ethical committee				●		●			
Masterplan for monitoring and evaluation	●		●		●				
Performance appraisal tool			●			●			●
Regular performance appraisal			●			●			
Regular review of course outlines	●		●		●	●			
Examination committee	●	●	●	●	●	●	●	●	●
Internal moderation		●	●	●	●	●	●	●	●
External moderation		●	●	●	●	●	●	●	●
Faculty doing research		●							●
Reserve shelf for important books	●	●	●	●	●	●	●	●	●
Access to internet	●		●	●		●		●	○
Access to data bases for research	●			●				●	

○ partly available

● available

<sup>3</sup> Some of the information in the table might be uncertain. The information needs to be verified before important steps are taken. Check the following footnotes.

<sup>4</sup> Some colleges have this included in other tools like strategic plans, annual budgets etc.

<sup>5</sup> In many of the CHAM colleges the principal is member of the management committee of the hospital, which may be considered a joint committee, although the committee in question is supposed to be concerned about clinical training for students only.

## Appendix 2 - Sites visited



### Appendix 3 – list of participants

PLACE	DATE	INTERVIEWEE	INTERVIEWERS
<b>St. Luke's College of Nursing</b>	April 24 <sup>th</sup>	Principal Tutor 1 Tutor 2 Student 1 Student 2 Head of Clinical Matron Preceptor	Mwenye-Phiri/Tveit Tveit/Mwenye-Phiri Kollstrom/Wasili Tveit/Mwenye-Phiri Kollstrom/Wasili Wasili/Kollstrom Mwenye-Phiri/Tveit Kollstrom/Wasili
<b>Nkhoma College of Nursing</b>	April 28 <sup>th</sup>	Principal Tutor 1 Tutor 2 Student 1 Student 2 Sister in Charge	Tveit Mwenye-Phiri/Kollstrom Mwenye-Phiri/Kollstrom Kollstrom/ Mwenye-Phiri Tveit Tveit
<b>Ekwendeni College of Nursing</b>	April 29 <sup>th</sup>	Principal Tutor 1 Tutor 2 Student 1 Student 2 Preceptor	Mwenye-Phiri/Kollstrom Tveit Mwenye-Phiri Kollstrom Tveit Mwenye-Phiri/Kollstrom
<b>St. John's College of Nursing</b>	April 30 <sup>th</sup>	Principal Tutor 1 Tutor 2 Student 1 Student 2 Preceptor	Tveit Mwenye-Phiri Tveit Kollstrom Kollstrom Mwenye-Phiri
<b>St. Joseph's College of Nursing</b>	May 05 <sup>th</sup>	Tutor 1 Tutor 2 Student 1 Student 2 Preceptor	Mwenye-Phiri Tveit Kollstrom Mwenye- Phiri Kollstrom
<b>Holy Family College of Nursing</b>	May 06 <sup>th</sup>	Principal Tutor 1 Tutor 2 Student 1 Student 2 Preceptor	Mwenye-Phiri Mwenye-Phiri Tveit Kollstrom Wasili Wasili
<b>Mulanje College of Nursing</b>	May 07 <sup>th</sup>	Principal Tutor 1 Tutor 2 Student 1 Student 2 Preceptor	Mwenye-Phiri Mwenye- Phiri Tveit Kollstrom Wasili Wasili
<b>Malamulo College of Nursing</b>	May 07 <sup>th</sup>	Dean Tutor 1 Tutor 2 Student 1 Student 2 Preceptor	Mwenye-Phiri Mwenye-Phiri Tveit Kollstrom Wasili Wasili
<b>Trinity College of Nursing</b>	May 08 <sup>th</sup>	Preceptor Tutor 1 Tutor 2 Student 1 Student 2 Preceptor	Mwenye-Phiri Mwenye-Phiri Tveit Kollstrom Wasili Wasili



## **Appendix 4 - interviewguides**

### **INTERVIEWGUIDE - PRINCIPAL**

**Name of institution:**

**Name(s) of interviewer(s):**

**Date of interview:**

Number of students 2009:

Number of tutors:

Number of clinical instructors:

How many clinical sites do you for clinical placements in your college?

#### **Master plan**

- If this college have a master-plan – what is the content?
- How do you use the master-plan?
- How important is the master-plan to you as the head of this institution?
- Who developed it?
- When was it made?
- Is it available for the tutors?
- Do you consider it to be a good plan?

#### **Course-outline**

- If you use course outlines - who develop them?
- If any - which challenges do you see in implementing the curriculum?
- Has there been any deviations from the curriculum lately (major/minor)
- How do you deal with the deviations?
- How did they affect your work as a principal?

#### **Clinical studies**

- If any - which challenges regarding the clinical part of the education do you experience?
- Do you have any suggestions for improving the clinical part of the education?

#### **Quality assurance of curriculum implementation -Monitoring and evaluation.**

- Do you have any monitoring tools in place for quality assurance-what kind of tools?
- If any- what kind of standard evaluation tools for quality assurance do you have in place?
- Do you prepare monitoring and evaluation reports to the MCNM?
- Do you have regular reviews/evaluation of the courses in the curriculum?
- Do you have any suggestions for improvement?

#### **Other managing tools**

- Do you have managing tools for economy?
- Do you have other sources for funding except for the student fees?
- Do you have a strategic plan?
- Do you have annual implementing plans?
- Do you have any problems implementing the plans?
- Do you perceive any particular training needs of staff members?

## INTERVIEWGUIDE: TUTOR

**Name of Institution:**

**Name(s) of Interviewer(s):**

**Date of Interview:**

### RESPONDENT DETAIL

	R2. YEARS OF TEACHING EXPERIENCCE	R3. TEACHING COURSE (s):
R4. HIGHEST LEVEL OF EDUCATION:	R5. AREA OF SPECIALISATION:	R6. NURSING CADRE:
R7. GENDER: 1. Male 2. Female	DEPARTMENT ( <i>If applicable</i> )	

## A PLANNING TOOLS

### 1 MASTER PLAN

- If you use a master-plan- can you please explain how the master-plan works for you as a planning tool. What works and what might not work?

### 2. COURSE OUTLINES

- If you use course outlines in the courses you teach - can you please tell about the content in the course outlines and how you use them.
- During your most recent theoretical course, which teaching and learning methods did you use?
- If the course was assessed -how was it done?
- How do you regard the benefits of using course outlines?
- What's the challenges when using course outlines?
- If you have experienced any deviation from course outlines- how did it affect the implementation of the curriculum?

### 3. LESSON PLAN

- If you use lesson plans for the courses you teach – what functions will you say that they have?
- If any- what kind of challenges do you have with levelling of content?
- If any - What challenges do you face in teaching based on a lesson plan?

## B RESOURCES

- If you are using the skills lab- can you please tell about the teaching and learning methods that you are using?
- How do the students use the skills lab?
- If any-which challenges do you face using the skills lab?
- If you have access to internet- how do you use it?
- What do you think of the adequacy of the library recourses for faculty and for students?

## C CLINICAL PLACEMENT

- What kind of planning tools do you use for students clinical placement?
- How do you collaborate with clinical staff?
- When you supervise students in the clinical area-
- How many students do you supervise?
- How often do you supervise students?
- Which teaching and learning methods do you use?
- If participating – in which way do the clinical staff participate in the assessments of the students?
- What kind of assessment tools do you use?

In which areas of curriculum implementation do you think that you need training? Please prioritize?

**Note:** 1= More priority, 2= some priority 3= Less priority 4= No priority

	<b>Priority</b>			
Developing a curriculum master plan	1	2	3	4
Developing a course outline	1	2	3	4
Developing a lesson plan	1	2	3	4
Assessing students in theory	1	2	3	4
Assessing students practically	1	2	3	4
Classroom teaching	1	2	3	4
Coaching,	1	2	3	4
Mentoring	1	2	3	4
Guiding	1	2	3	4
Teaching methodology	1	2	3	4
Internet use (literature search)	1	2	3	4
Teaching in the skills lab	1	2	3	4
Counselling students	1	2	3	4
Developing clinical work plans	1	2	3	4
Supervision	1	2	3	4
Levelling/depth of content	1	2	3	4
Use of literature	1	2	3	4
Student active methods	1	2	3	4

Do you have any comments or things to add?

## **INTERVIEW GUIDE - STUDENT**

**Name of Institution**

**Name of interviewer(s):**

**Date of interview:**

### **1 MASTER-PLAN/STUDY PROGRAM**

- What do you think of the information you get from the college regarding your 3 years of study?
- If your college have a master plan and a cum rotation plan – how do you use them?
- If deviation from the study program – can you please tell about them and how they possibly affected your studies.

### **2 COURSE OUTLINE**

- If the tutors provide you with course outlines – how useful do you think they are?
- If you have experienced deviation from course outlines- what were they?
- If you got a course outline for the last course you were taken- was the assessment of the course described?
- How were you assessed in that particular course? (tests, assignments etc)
- Were you satisfied with the way you were assessed?
- What could be improved in the assessment?

### **3 LITERATURE/WORKLOAD**

- What do you think of the literature prescribed for each course?
- How do you find out what to read?
- Do you manage to read all the literature?
- What do you think of the accessibility to literature?
- How do you find the level of the content in the books? (Deep/shallow, easy/difficult to understand, language)
- What do you think of the workload for you as a student?
- If needed - do you have any suggestions on how to improve your theoretical studies?

### **4 CLINICAL PLACEMENT**

- How well are you informed about what you are supposed to learn in the clinical placement?
- Do you get any written information?
- Where did you go the previous time you went for placement?
- Were you informed of who would be your supervisors from the college and the clinical site?
- If you were supervised – what kind of methods were used?

- How often did you get supervision?
- Did you know when you were to be assessed in that particular practical placement?
- How were you assessed?
- How often were you assessed?
- What do you think of the objectives for the particular placement
- If you are working in groups together with fellow students – what do you do in those groups?
- If you experienced any positive role models in the clinic – how will you describe them?
- Have you had all the types of placement you should, according to the program
- What were in your opinion the main challenges in the placement?
- Do you have any suggestions on how to improve your clinical studies?

#### **D SKILLS LAB**

- How do you use the skills lab/practical room?
- Do you sometimes use it independently together with other students?
- Do you have any problems/hindrances in using the skills-slab/practical room?
- Do you have any suggestions on how to improve?

## INTERVIEW GUIDE

### TOOL: PRECEPTOR

Name of Institution

Name of interviewer(s):

Date of interview:

### RESPONDENT DETAILS

R1. RESPONDENTS ID:	R2. YEARS OF EXPERIENCE:	
R4. HIGHEST LEVEL OF EDUCATION:	R5. AREA OF SPECIALISATION	R6. NURSING CADRE:
R7. GENDER:	DEPARTMENT ( <i>If applicable</i> )	

- How do you collaborate with the college before- during and after the student's clinical practice?
- What kind of information about student's placement do you receive from the college?
- What do you think of the number of students allocated to your ward?
- What kind of teaching and learning methods do you use when supervising the students?
- If you participate in student's assessment – how do you participate?
- Are the students clinical objectives achievable in the clinical placement?
- If any- what's the challenges that you face in dealing with students in clinical placement?
- Do you have any suggestions of how to improve the clinical studies for students?