Reflecting on the learning experiences of student nurses in rural Uganda

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This paper reports on the first author Wanda Lovett’s experiences of working as a community nurse tutor in rural Uganda. Previously I worked in England as a health visitor and gained a range of experience within the context of public health nursing. The cultural setting in Uganda is very different to England, but I was able to draw on my experience of a range of cultures; my parents are from Eastern Europe, and I worked in Pakistan and Nepal for four years. However, this current tutor role is the first time that my work has had a substantial educational focus and this article reflects on some of the challenges encountered in practice. It will focus on the roles of tutors and mentors in managing the learning environment and facilitating learning in this context. It is widely acknowledged that mentors have an important role in translating theory to practice (Morton-Cooper and Palmer, 2000), but here in Uganda this is not evident in practice.

Background
The public health challenges in Uganda are enormous, including an infant mortality rate of 137 per 1000 (Ministry of Health Uganda (MHU), 2010). It is suggested that 75% of the disease burden in Uganda is preventable; for example, national latrine coverage is only 62%, with only 14% of the population washing their hands (MHU, 2010). The Government of Uganda is trying to address some of the health problems by putting an emphasis on training multi-skilled (holistic) nurses. These nurses are expected to provide health promotion and preventive, curative and rehabilitative services within the minimum healthcare package, which includes immunization, environmental health, school health, epidemic prevention and nutrition. Once trained, the majority of the nurses will be working in community health centres in rural areas (MHU, 2010). As tutors, therefore, we need to ensure that the education provided for our nurses fully equips them to meet the health needs of the rural areas that they will be serving.

The School of Nursing is situated within a 250-bed hospital in Uganda, serving a rural population of approximately 200,000. It is in a mountainous region with very little electricity and poorly maintained roads connecting villages, trading centres and markets. There are 140 students, in three sets, who undertake the nationally recognised Comprehensive Enrolled Nursing Course, over two and a half years (Ministry of Education Uganda, 2009). The school has an excellent reputation and has been very successful, with increased student numbers and a 100% pass rate at final exams. We often hear comments that the nurses’ training is excellent and that students are taught well and encouraged to learn. The school meets all of the deadlines imposed by central authorities and, to its great credit, manages to keep within its budget.

There are major differences in the nature of nurse education programmes in the UK and Uganda. In the UK, nurse education programmes are situated within Higher Education Institutions and emphasise both academic ability and clinical competence (Nursing and Midwifery Council (NMC), 2004). There are many positive aspects to the current training. Attendance on wards and in the classroom is excellent, and it is rare for students not to attend without good reason. The students pride themselves on their appearance, despite having only one, or at best two, uniforms. Although nurse training in Uganda resembles the apprenticeship model (which may not be the best approach to prepare nurses for their complex roles), students are easily motivated by an enthusiastic tutor. There is also a commitment to learning by both students and staff, with opportunities eagerly taken up. This makes teaching in this context both an honour and a pleasure.

ABSTRACT
This article presents the first author, Wanda Lovett’s experiences of pre-qualifying nurse education in rural Uganda, with a particular focus on promoting effective learning within community placements. The culture and context of health care and of nurse education are very different in this area when compared to the UK. Additionally there are a number of challenges associated with the mentorship of nursing students in practice, both in relation to facilitating learning and to the assessment of competence. This article describes the author’s experiences of developing a more appropriate approach that reflects adult-centred learning, to promote the level of thinking that students will need to meet the demands of their roles once qualified.

KEY WORDS
Nurse training • Mentorship • Rural Uganda • Community Placements • Mentorship • Andragogy
Mentorship

In the UK, mentorship is an important feature of pre-registration student nurses’ education programmes and this was strengthened with the introduction of the Standards to Support Learning and Assessment in Practice (NMC, 2008). The literature describes a range of functions within the mentorship role including adviser, coach, counsellor, guide/networker, role model, sponsor, teacher, and resource facilitator (Morton-Cooper and Palmer, 2000). Chow and Suen (2001) reported that mentors are expected to fulfil the five roles of assisting, befriending, guiding, advising and counselling, and found that students viewed the roles of assisting and guiding as the most important.

The role of the mentor is vital, both in terms of promoting learning and in the assessment of that learning. Wilkes (2006), in her literature review of the student-mentor relationship, found that the skills, qualities and attitudes of the mentor can optimise learning. The assessment of learning has become increasingly important within the mentor’s role in recent years, to ensure competence at the point of registration in order to assure public protection (Duffy, 2004; NMC, 2008). Indeed, in the UK, mentorship is closely supervised and controlled within a structured framework of standards for the knowledge and skills required, and it is a requirement that every student has a named mentor to support and assess each practice placement and to sign off proficiency at the end of the programme (NMC, 2008). In contrast, in Uganda, student nurses are not formally allocated to mentors although they may find a nurse who acts in such a role, nor are they set objectives for each of their placements. Mentorship training is not a requirement as it is in the UK, and although there are examples of good practice, there is minimal quality assurance of this process.

Students look for inspiration from exemplary nurses, and it is argued that modelling excellence contributes positively to the education of nurses (Perry, 2009). It is important that people who teach care practice what they preach (Wilkes, 2006), but from personal experience clinical skills (for example, hand-washing and giving injections) are not always performed correctly by qualified staff. These are examples of negative role models and students may then adopt incorrect clinical practice; habits may then be formed which are very difficult to break and are considered to be the norm of practice. It is therefore vital that a community tutor develops the learning environment to promote positive role modelling for students.

The community aspect of the nurses’ training comprises two weeks completing a community diagnosis (survey) and a four week placement in a community health centre. In addition, students attend community
clinics in rehabilitation, antenatal care, immunizations and HIV/AIDS as part of the hospital outreach programme. However, the severe lack of resources and the challenges of the terrain mean that the community aspect of the course is physically very demanding. Yet the students never complain. There are also challenges in relation to the learning environment and the facilitation and assessment of learning, with no formal mentorship role or learning objectives. However, despite the lack of formal training, some practitioners here in Uganda take teaching and assessment very seriously. For example, one midwife was keen to inform me that some of the students placed at her health centre needed a lot more experience before they could be considered ‘fit for practice’.

It is difficult for tutors to make regular visits to the centres which are distant from the hospital and are difficult and costly to access due to poor transportation and roads. I hope that providing mentorship training and establishing a support group for enthusiastic practitioners will improve their ability to support our students in practice. However, practitioners attending training require payment; most require monetary facilitation, but others accept sacks of sugar which is then distributed. The School of Nursing is constantly struggling to keep within its budget and finds these costs difficult to meet. We therefore need to find creative ways to address these challenges and, within my role as community tutor, I have been supporting a number of motivated nurses and midwives to develop their mentorship roles.

**Facilitating learning in practice**

**Managing the learning environment**

There are many theories of how we learn, and teachers need to be able to apply these to a range of educational contexts, to design teaching and learning activities which take the principles of learning into account (Dunn, 2002). Biggs (2003) discusses deep and surface approaches to learning and, according to this view, students have less need for memorising and reproducing facts (a surface approach to learning) than for developing understanding and being able to relate new experience to existing knowledge. This encourages critical thinking and evaluation (a deep approach to learning), which encourages students to make a real effort to connect with and understand what they are learning. Benner (1984) views this deep and surface learning as part of a continuum, with a movement from novice to expert in five steps. Curriculum and assessment should reflect this, so that teaching and assessment of competency should be progressive, placing building blocks onto subsequent learning. This does not finish after training. It is a lifelong process and is something I am more than aware of as I continue with my training in my new role as tutor.

Reflecting on the education of student nurses here in Uganda, it appears that the system currently promotes a surface approach to knowledge, what Knowles (1990) would called pedagogy. This is reflected in the style of teaching, with the teacher as expert dictating information and students writing it down. This includes learning to cope with course requirements; treating the course as unrelated aspects of knowledge; memorising facts and carrying out procedures routinely. In my experience, this leads to students experiencing difficulty in making sense of new ideas, and studying without reflecting on either purpose or strategy. Additionally, this approach does not take into account students’ individual learning styles and it encourages learning based not on understanding, but rather on passing exams (Coffield et al, 2004).

It is important to acknowledge that we are educating nurses to enrolled level, rather than diploma or degree (although such training is available elsewhere in Uganda). It could be argued, therefore, that deep learning and critical thinking skills should not be expected. However, once qualified, these nurses are expected to meet the diverse health needs of remote rural areas; the deeper their understanding the more able they will be to face the complexities of health needs. I am, therefore, committed to developing a more adult-centred approach within my teaching to prepare them for these complex roles.

An example of the surface approach is that, currently,
aspects of community training may be seen as separate experiences and I am keen to integrate these into a holistic approach. For example, if nurses are asked about refuse or waste management, pollution or vector control they are able to state the theory: but at the site, wards and health centres, this is not translated into practice. I intend to promote experiential learning from community placements (Kolb, 1984) and to implement a model of progressive level of expertise (Benner, 1984). For example, it is important that before first year students complete the community diagnosis (survey) part of their training, they have sufficient knowledge of the relevant theory (immunisation, communicable diseases, management of childhood illnesses, nutrition, vector control, malnutrition and family planning). This will enable them to develop skills to meet the health needs of the communities they are visiting, in preparation for their roles once qualified. I have already introduced learning objectives for the students within their community experience and I encourage reflection and feedback on their experience. Reflection is said to be a valuable strategy to promote professional education, particularly to promote learning from experience (Schon, 1987), although we need to prepare the tutors and mentors to facilitate reflection in their students (Gidman, 2007). Personally, I have found reflection useful to help students to link the theory to the practice in community settings.

Variety in teaching methods

Another change that I have introduced is what Knowles (1990) would call a more andragogical style of teaching to encourage a deeper level of learning. Andragogy is the facilitation of learning which draws in a variety of learning methods such as group work, role play, workshops, seminars, tutorial groups, buzz groups and discussions. In reality, pedagogy and andragogy are two ends of the spectrum, and strategies can be used along the whole spectrum to increase learning opportunities for students (Coffield et al, 2004). This helps to engage students with the process of learning and to apply theory to their practice experiences. For example, I introduced role play when teaching communication skills, self assessment questionnaires to facilitate learning about self esteem, and group work to enable students to understand Belbin (1998) and team roles.

I also encourage students to learn from a range of professionals during their community experience. For example, learning about refuse and environment management is facilitated by the environmental health officer, who teaches the theory in the school and applies this during a visit to the practice setting. In addition, physiotherapists and occupational therapists from the rehabilitation ward teach the students about disability. Despite the paucity of evidence to support inter-professional learning (Royal College of Nursing, 2007), students reported that they
learned a lot from these approaches.

There are a number of challenges in introducing new teaching strategies, with limited library resources, unreliable Internet availability and large class sizes. It is also evident that there is a need to develop the culture of both the hospital and the School of Nursing to enable a more adult-focused approach to nurse education. This may be difficult both for tutors and students who have come through the very didactic educational system. The Ugandan Nurse Tutors Training course now also promotes a more andragogical approach and it is vital that we prepare both students and staff for this new approach to learning.

Conclusion

There are many positive features to the School of Nursing, not least of which is the dedication of the staff and students to the learning process and the pleasure of teaching them. The students have an ability to joyfully withstand some of the poor conditions they are both living in and training in, especially in the community, and despite meagre resources are able to take pride in their appearance, attendance and in their achievements. There are also challenges in the education of nurses to prepare them for their roles in community nursing. These relate to the culture of Ugandan nurse education which is currently pedagogic and didactic, the fragmented nature of community experience and the lack of mentorship during practice placements.

Reflecting on student learning in this context has enabled me to suggest ways to improve the facilitation of learning. It would be useful to establish a forum for all relevant teaching and practice staff to develop a cohesive framework for the community aspects of the nurse training programme. This will include developing appropriate learning outcomes and competencies for each stage of training and a robust supervision and assessment strategy. This is a major undertaking because it requires a culture shift from teacher-centred didactic approaches to student-centred andragogical approaches to learning. It is also important to ensure that community experience occurs at the appropriate time within the education programme. We need to ensure that students are sufficiently prepared to benefit from experiential learning opportunities and to facilitate reflection on, and evaluation of, experience immediately after community placements. The preparation and support of teaching and practice staff is vital to enable them to act as positive role models and effective mentors for students in the community setting.

Whilst it is recognised that change in this context will be very difficult, there are several drivers to support it. These drivers include the changes to nurse tutor preparation and the implementation of a continuing professional development programme for nurse tutors and senior nurses, in collaboration with a UK university and hospital. Nurse training in the UK took about 30 years to get to where is it now; the impetus for change being driven by government, professional bodies and numerous stakeholders, with a plethora of documentation, standards and guidelines. Here in Uganda there is less impetus for change and the challenges are great; the health needs of the population are also great, and demand the best trained nurses that we can deliver.


KEY POINTS

- Mentors have an important role in translating theory to practice, but in Uganda this is not evident in nurse training.
- The Government of Uganda is trying to address some of the country’s health problems by putting emphasis on training multi-skilled (holistic) nurses.
- The culture of Ugandan nurse education is currently pedagogic and didactic, with a fragmented community experience and lack of mentorship during practice placements.
- Working as a nurse tutor, the author has introduced learning objectives for the students within their community experience, and encourages reflection and feedback on their experience.
- The Ugandan Nurse Tutors Training course now promotes a more andragogical approach, and it is vital that we prepare both students and staff for this new approach to learning.