



Implications of accreditation criteria when transforming a traditional nursing curriculum to a competency-based curriculum



Yvonne Botma ^{*,1}

School of Nursing, University of the Free State, P.O. Box 339, Bloemfontein 9300, South Africa

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ABSTRACT

Nurse educators in a resource-poor country have identified the need to change from content-driven curriculum to a competency-based curriculum. A rapid assessment was done to determine the standing of nursing education in the country. Structured interviews were conducted with educational and administrative staff as well as students at all six nursing schools in Lesotho. Programme design, human resources, teaching and learning, physical resources, and programme accreditation were addressed during the rapid assessment. The results were uniform due to the country being small and four nursing schools forming a consortium. A traditional content-driven three-year diploma programme that renders a single-qualified nurse is being offered. A five-year degree programme in nursing is being offered by the only university in the country. Nursing schools are resource-poor with limited or no external funding sources. Changing to and sustaining a competency-based curriculum will require extensive empowerment of nurse educators. Professional governing bodies should produce supporting rules and regulations.

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1. Introduction

Transforming nursing education in many developing countries in Africa is long overdue and is driven by a number of factors, for example the high HIV and TB prevalence. Due to the high burden of communicable diseases, the life expectancy at birth for the region is 54 years. Seventy-three per cent of the population in Lesotho lives in the mountainous rural areas (WHO, 2012). Furthermore, Lesotho is disproportionately affected by the combination of the shortage of health care workers, high maternal mortality (620 per 100,000 live births), and the communicable disease burden. It is calculated that an additional 2625 general and midwifery-trained professionals are needed to meet the aggregated nurse/midwifery density of 1.73 per 1000 population by 2015 (PEPFAR n.d.).

In 1979, primary health care as the strategy for health service provision was adopted. However, to date, nursing education remains hospital-oriented with the bulk of work-integrated learning occurring in hospitals and not in primary health care facilities. According to the World Health Organisation Country Cooperation Strategy 2008–2013 (WHO, 2009), Strategic Priority 4 aims to

strengthen the health system capacities and performance. A pertinent focus is to scale up the training of nurses, midwives, health technologists and community health care workers. Training of more and better-qualified nurses and midwives is being supported by the Nursing Education Partnership Initiative (NEPI). NEPI supports the goal of the USA President's Emergency Plan for AIDS Relief (PEPFAR) to strengthen the quality and capacity of nursing and midwifery education institutions and to support innovative nursing retention strategies in African countries (PEPFAR n.d.).

In line with the WHO Country Cooperation Strategy 2008–2013, plans to enhance the capacity of professional regulatory bodies and associations involved in improving the quality of education and practice in partnership with the national network of public health education institutes are being implemented. In 2004, the Lesotho Council on Higher Education (CHE) was established to monitor higher education and to maintain quality standards. However, the CHE faces many challenges, for example an unclear legal and policy framework, inadequate operationalisation, conflicting roles with regard to governance and limited resources to support development in higher education, to name but a few (Lesotho, 2010).

The Lesotho Nursing Council (LNC), as stated in the Nurses and Midwives Act No. 12 of 1998, advises the health training institutions in Lesotho on matters pertaining to the form of the qualification, issuing of duplicates and certified copies of qualifications, requirements, which institutions and candidates have to meet, and the conduct of examinations (Lesotho, Act No. 12 of 1998).

* Tel.: +27 51 401 3476.

E-mail address: Botmay@ufs.ac.za

¹ The author was appointed to conduct the rapid assessment of nursing in the country.

It is evident from the literature that globalisation plays a significant role in curriculum development and that uniform and comparable systems for external quality assurance in higher education become paramount. Although co-operation between countries and institutions is required to increase the mobility of students and staff, each region or country is influenced by its own culture and economic situation and should therefore have its own standards (Bureau of the Committee of Ministers of Education of the African Union, 2007; Hernes & Martin, 2008; Martin & Stella, 2007). Currently, there are no in-country guiding documents available in Lesotho.

The NEPI partnership with Lesotho was launched in August 2011, and offers an opportunity to benchmark nursing education with other countries. It provides a unique opportunity to focus on developing and improving quality in nursing education institutions in Lesotho. The nurse educator fraternity in Lesotho decided to address the health care needs of the Basotho through the development and implementation of a competency-based curriculum with the assistance of NEPI. This article reports on the rapid assessment of the current status of nursing education in Lesotho.

2. Literature review

In order to determine the aspects that should be addressed in the rapid situational analysis the researcher reviewed the criteria for accreditation of a programme in higher education locally and internationally. Accreditation refers to a process whereby organisations or programmes are recognised as meeting minimum acceptable criteria (Di Nauta, Omar, Schade, & Scheele, 2004; Hernes & Martin, 2008). These criteria are usually set by accreditation bodies such as councils of higher education or professional regulatory bodies, and published as guidelines or manuals. The WHO (2009) recommends that nursing or midwifery schools should be an integral part of a higher education institution that meets internal standards, recognised accreditation and/or governing body requirements. Furthermore, nursing schools should have criteria in place that meet accreditation standards for work-integrated learning, academic content, and demonstration of professional competencies. Relevant credible professional and academic bodies should recognise or accredit the schools and their programmes. Salmi and Hopper (2002) recommend that trends should be noted and compared with comparable institutions in the same segment of the tertiary education system when considering accreditation. Table 1 shows the criteria that are commonly applied by accreditation bodies and which were used during the

rapid assessment. Aspects that should be reviewed under each criterion are briefly expounded.

In addition to the aspects mentioned in Table 1, it is important to have regular reliable statistics on higher education as the lack thereof is a major obstacle in strategic reflection on higher education (Martin & Sauvageot, 2011).

2.1. Programme design

According to Fink (2003), a curriculum is designed down and implemented up. This implies that the highest regulatory authority should set the guiding instructions or regulations. Furthermore, the curriculum should be entrenched in a sound teaching and learning philosophy and learning theory (Goudreau et al., 2009) to guide the development of teaching and learning activities and the development of the student as a whole person. Pedagogical practices and mode of delivery should be noted (Salmi & Hopper, 2002). The Committee (2004) requires coherence, intellectual credibility and articulation in the programmes. The matter of articulation between programmes is supported by Kouptsov and Tatur (2001) who state that no education programme should lead to an educational dead-end.

2.2. Financial viability

When considering the financing aspects, the available revenues, government budget and additional resources should be noted. Tuition fees, student aid and unit costs should also be considered. Technology spending may escalate with the incorporation of e-learning and simulation (Salmi & Hopper, 2002). Criteria set by the WHO (2009) are that the budget allocation and control should meet programme, faculty, and student needs.

2.3. Outputs

Salmi and Hopper (2002) recommend that the throughput rate, overall employment rate of age cohort, research outputs of faculty and students, as well as community engagement should be evaluated.

2.4. Governance

According to the Council (2012), the institution should be managed effectively within the regulatory framework and have written policies with regard to (a) expected level of experience and quali-

Table 1
Aspects for accreditation in alphabetical order.

Aspects	Source								
	Kouptsov & Tatur (2001)	Salmi & Hopper (2002)	Di Nauta et al. (2004)	South Africa Higher Education Quality Committee (2004)	Stella (2005)	Bureau of the Committee of Ministers of Education of the African Union (2007)	WHO 2009b	British Accreditation Council (2012)	
Programme or curriculum/design	✓	✓	✓	✓	✓	✓	✓	✓	
Financial viability	✓	✓	✓	✓				✓	
Outputs/results/research/consultancy/extension Graduate abilities/employability/programme	✓	✓	✓		✓	✓		✓	
Governance/regulation/healthy practices/quality assurance	✓	✓	✓	✓	✓	✓		✓	
Human resources	✓	✓	✓	✓			✓	✓	
Infrastructure and learning resources	✓	✓	✓	✓	✓	✓	✓	✓	
Student support and progression		✓	✓	✓	✓			✓	
Teaching-learning and evaluation/assessment		✓	✓	✓	✓	✓	✓	✓	

fications of staff, (b) recording of and requirements regarding attendance and punctuality, and (c) administration of examinations and other means of assessment. Procedures should be in place to ensure the integrity of certification. Quality assurance/improvement policies and systems ought to address student enrolment, monitor student progression, obtain student feedback and have staff performance appraisal and development programmes, and guidelines on internal and external award. Entry requirements should be fair, and should allow equal access for disadvantaged students but the institution should also ensure that students accepted for enrolment meet the set criteria. Furthermore, statistics should be kept with regard to applications and enrolment in order to plan strategically (British Accreditation Council, 2012; Kouptsov & Tatur, 2001; South African Higher Education Quality Committee, 2004). Within the current economic climate, new management models are forged where resources are pooled and partnership strategies across national boundaries are developed (Stella, 2005).

2.5. Human resources

Aspects with regard to human resources that should be noted during a rapid assessment are the demographic information about faculty, student–teacher ratio, staff development opportunities, staff retentions and loss, and salary levels (British Accreditation Council, 2012; Salmi & Hopper, 2002). Stella (2005) notes that there is a trend globally toward capacity building in teaching and research in order to meet the challenges of the changing contexts. Furthermore, there should be support staff that would allow academics to do the job they have been appointed for (Committee, 2004).

2.6. Infrastructure

Adequate facilities for example classrooms, laboratories, quiet study areas and IT facilities should be available for teaching and learning. Students and staff need designated spaces for individualised and group pursuits (Council, 2012). Student support services should be available.

2.7. Student support programmes

Minimal student support refers to academic advice and counselling, provision for students with special needs and disabilities, and residential accommodation (Council, 2012).

2.8. Teaching and learning

The curriculum should be well planned and aligned with sufficient supporting learning material such as textbooks, audio-visual materials and other applicable study resources (British Accreditation Council, 2012; South African Higher Education Quality Committee, 2004).

3. Research design

A quantitative rapid assessment approach has been used to determine the baseline data in order to plan and implement a competency-based curriculum for nursing education in Lesotho. This approach was deemed appropriate because it is participatory and action-oriented (Schrimshaw & Gleason, 1992). A literature based interview schedule with 97 questions was developed. On account of logistical reasons, telephone interviews were conducted with people at the nursing school that was the furthest from the capital of Lesotho. The interviews focused on current programme design,

student recruitment and selection, staff qualifications, staff size, teaching and learning strategies, assessment, infrastructure, library resources, and programme administrative services. The content of the interview schedule was structured in such a way that each interviewer's section was appropriate for the sample stratum (educators, administrators, students) being interviewed. Interviewees from different sample strata were asked similar questions to triangulate data and to enhance the reliability of the information (Schrimshaw & Gleason, 1992). Interviews lasted about an hour per stratum.

3.1. Population and sample

Four of the six nursing schools in Lesotho are faith-based organisations and together they are called the Christian Health Association of Lesotho (CHAL). These four nursing schools are closely associated with a hospital with which they share facilities and resources. Another training school is at the National University of Lesotho (NUL), and the last one is the National Health Training College (NHTC). Data were gathered from all six nursing schools. Face-to-face structured interviews were conducted with nurse educators, administrative personnel, and students at the nursing schools. At each nursing school representatives from each of top management of the institution (1 per institution), head of the school, lecturers (2 per institution), and the students (4 per institution), as well as the human resource manager, librarian and examination coordinator were interviewed. In only one institution the representative from top management was not the head of the nursing school. A total of 61 people were interviewed.

3.2. Data gathering and analysis

The NEPI coordinator in Lesotho obtained permission from the Ministry of Health, informed the nursing schools of the proposed rapid assessment and obtained informed consent from stakeholders. Confidentiality was maintained and accumulated results are reported in order to protect individuals and employers. Interviewing arrangements were made that allowed three hours per institution. The researcher and the NEPI coordinator in Lesotho conducted all the interviews with the sample from the same stratum at each nursing school. Possible limitation of articulation by the representatives from the stratum was considered during allocation because the author was not conversant in SeSotho. Data were recorded on the form and captured on a computer the same day. The researcher did descriptive analysis by using a Microsoft Excel™ spreadsheet. Group interviews were conducted with the two lecturers as well as the students per institution. Therefore a maximum of six questionnaires per stratum was completed.

Reliability was enhanced by the fact that the same person gathered and recorded the data on specific questions. Content validity was enhanced by the comparison of aspect that should be assessed for accreditation of higher education programmes (See Table 1).

4. Results

The results across the nursing schools were homogenous because Lesotho is a small country and nursing education is controlled by the Ministry of Health and Welfare.

4.1. Programme design

None of the nursing schools had a written philosophy or guiding theory but they all adhered to the behavioural learning theories. Five of the six institutions offered a three-year hospital care-oriented, content-based, nursing diploma programme that yielded

single-qualified nurses. Only the NUL offered a degree programme with a dual qualification in general nursing and midwifery. Due to limited resources, not all the newly qualified nurses could be accommodated in the midwifery programme. The mode of delivery comprised face-to-face lectures. A small component of community health that focused on health promotion and prevention of disease was part of the current nursing programme. Articulation possibilities were limited because no post-graduate degrees in nursing were offered at the NUL. Some colleges offered diplomas in a number of speciality areas such as ophthalmic nursing, primary health care, and psychiatric mental health.

Nurse educators made an effort to oversee students during work-integrated learning but due to time constraints and workload, they were not always successful. Students were reliant on nurses working in the hospital ward who had not been appointed or trained to facilitate their learning in the clinical setting. Collaboration between the clinical and educational institutions was sporadic and informal.

4.2. Financial viability

At the time of the research, nearly all nursing students (99% of approximately 750 students) were funded through the National Manpower Development Secretariat (NMDS), which was often the sole source of income for the nursing schools in Lesotho. Self-paying students are seldom encountered. If expenditure exceeded the amount received from the NMDS, the amount was procured from the students. However, at the time of the research in 2012 this amount has never exceeded 1000 Maluti (USD150).

4.3. Programme administration

Student progress was monitored by the lecturer and hard copies of files were kept in a filing cabinet in the office of the principal. Informal agreements between the clinical facilities and nursing school existed regarding student placements for work-integrated learning. A memorandum of understanding existed between the NUL and affiliated (CHAL) institutions but no formal contracts exist between training institutions and health care facilities where students had to demonstrate their level of competence. No accreditation of clinical facilities or nursing schools was being done by a reliable professional body.

4.4. Human resources

The findings showed that all the nurse educators in Lesotho had a qualification in nursing education. Although 33.85% of them had a master's degree at the time of the research, no research articles had been published at that stage yet. Continuous professional development (CPD) opportunities were limited. Although a Continuous Professional Development Framework has been drafted ([Lesotho Nurses Association, 2012](#)), no activities had been implemented at the time of the research.

4.5. Infrastructure

Library resources, especially at the CHAL institutions, but also at the NUL and NHTC were limited and in some fields, such as nursing management and nursing education, non-existing. Nursing schools subscribed to a singular scientific nursing journal or none at all. At the time of the research, all school libraries, except at the NUL, closed at 16:00. Hence, students did not have access to academic sources after office hours. NEPI provided all six nursing schools with simulation and computer laboratories in the form of prefabricated buildings, which, at the time of the research, were furnished with state-of-the-art equipment.

4.6. Student support and recruitment

No marketing was done because there were numerous applicants of whom only a small percentage was selected according to specific criteria. All the nursing schools had a throughput rate of at least 95%. None of the schools had a formal student support system. All learning, emotional and social support was given by nurse educators. Students enrolled at the CHAL institutions, received free medical care and counselling at the associated hospital.

4.7. Teaching and learning

Students across the six nursing schools were of the opinion that they received ample theory but that nurses were not yet competent on completion of the programme. The students ascribed their incompetence to the limited support or often complete lack of support in the clinical component.

Formative and summative assessments of theory were done but both were only in the form of written tests. Examinations for the CHAL institutions were centrally coordinated and moderated. Computer software with security measures were used for recording results and progress throughout the programme.

5. Discussion

Changing the nursing programme to a competency-based curriculum will have a ripple effect in all the aspects included in the rapid assessment. By changing to a competency-based programme with a primary health care focus instead of having a content-based programme with a tertiary care focus will entail the following:

- the content of the programme needs to change in order to address the conditions primarily treated at primary health care level;
- the clinical facilities used for work-integrated learning need to shift from easily accessible tertiary care to more primary health care facilities – with all the logistical and financial implications;
- the educational institutions need to collaborate with the clinical institutions;
- the assessment methods have to be aligned with the expected competence; hence pen-and-paper assessment may not be the most appropriate assessment method;
- a competency-based curriculum requires teaching methods other than the traditional lecture method;
- depending on the competencies required, supportive material such as well-equipped libraries, computer laboratories and simulation laboratories may be necessary;
- creating opportunities for students to become competent either through simulation or through work-integrated learning; and
- more advanced book-keeping and management skills than that which was used by nursing schools may be required to keep track of students and performances which may require more non-academic staff.

In addition to the abovementioned challenges, human resources pose a three-pronged challenge, namely the capacity of nurse educators to adapt to the bombardment of change and to adopt and implement relevant strategies, the shortage of nurses and nurse educators, and the lack of support staff.

The first and foremost threat to the implementation of a competency-based curriculum is the paradigm shift from behaviourism to constructivism because a completely different skills set is required. [Cooper \(2007\)](#) found that, in spite of considerable support, deep understanding and integration of the associated constructivist learning theory into practice have not occurred in Queensland since an educational reform in 2000.

Furthermore, the newly established simulation and computer laboratories are placing an additional burden on the already overburdened nurse educators. Incorporating simulation into a curriculum is already a challenge by itself. Conversely, it may be the ideal situation to incorporate simulation into the curriculum and embed it into the planned teaching and learning activities. Additional staff will be required to assist during the running of a simulation and to develop computer skills of nurse educators, administrators, and students (Jansen, Berry, Brenner, Johnson, & Larson, 2010).

In addition to changing the pedagogy, nurse educators in Lesotho have to change the context and therefore relevant foundational knowledge of the programme to that of primary health care in order to teach in accordance with the national health policy. The nurse educators may not be competent to facilitate learning in primary health care facilities because they have only experience in hospital-based care. Work-integrated learning may be enhanced by appointing and training preceptors for the clinical settings (Brathwaite & Lemonde, 2011; Omansky, 2010). However, recruiting and training preceptors may be a challenge due to the shortage of nurses.

By redressing the personnel need for primary health care facilities, a gap is created in the tertiary health care facilities. The primary health care focus demands that work-integrated learning occur in primary health care facilities. Thus, many “student hands” will be removed from the workforce in hospitals, which will put further strain on tertiary health care. It is therefore important that all stakeholders have to commit that the health care needs of the country and the people trump specific organisational or individual interest (Tanner, 2008).

Financial sustainability of a competency-based primary health care curriculum is a challenge. Maintenance and upgrading of a computer and simulation laboratory are extremely expensive, even in a developed country. Without formal agreements in place this may become a problem between the nursing school and the associated hospital that is primarily responsible for the maintenance budget and related tasks. Logistics and expenses with regard to travel to primary health care facilities and nearby accommodation of students could limit successful implementation.

Quality assurance measures such as setting minimum standards for nurse training schools and health care institutions must become a priority. The WHO (2009) sets accreditation of nursing schools and the programmes that they offer as a minimum global standard for the initial education of professional nurses and midwives. Accreditation should be done by credible, relevant professional and academic bodies. Health care facilities where students will experience work-integrated learning have to be accredited to meet a certain minimum standard (Hernes & Martin, 2008).

A professional development plan should be developed and implemented to capacitate current and future nurse educators to facilitate learning in a competency-based curriculum. Nurse educators who are unfamiliar with the foundational theories and principles will revert back to that with which they are comfortable, namely lectures and content (Patterson, 2007). Techniques to engage students with learning material, appropriate assessment strategies, and the development of valid and reliable assessment tools that will discriminate between a competent and incompetent person should be included in the professional development programme. The mission, vision and objectives of the competency-based curriculum should be widely publicised and discussed at public forums to promote professional and public buy-in (Hiatt, 2006).

Formal agreements between nursing schools and health service providers and all other role-players with whom partnerships are formed should be drafted and signed. It is advisable that the roles and responsibilities of all partners be formalised (Stella, 2005).

It is critical that the CHE and LNC move parallel to and in synchronisation with the nursing fraternity in developing rules and

regulations in support of the competency-based curriculum at governing and regulatory level. Accreditation criteria should be developed and systems put in place to meet this requirement (WHO, 2009).

Nursing schools should start generating income to carry the cost of maintenance and upgrading and to expand the libraries. Ministries of Health see their primary responsibility as ensuring that equitable health care be provided to the nation, and rightly so; thus, when ministries of health are challenged to procure essential drugs or to upgrade a mannequin for nurse training purposes, the chances are that they will most likely procure the drugs. Training needs of nursing schools will therefore never be their number one responsibility even though they provide the bursaries for nursing students. Due to this duality of responsibility, it is recommended that training of nurses fall under the jurisdiction of higher education and not under health care.

Nurse educators may feel threatened by the shift towards primary health care because their traditional disciplinary prestige will be less valued and it may cause a loss of identity (Patterson, 2007). Nurse educators should thus be afforded the opportunity to obtain a qualification in primary health care nursing to create a new area of expertise for them.

Clinical preceptors should be appointed and trained to facilitate learning in the clinical settings. WHO (2009) guidelines state that clinical experts should teach the content and facilitate learning in the clinical practice area. Partnerships with other training schools and health care facilities will secure a variety of qualified people to be clinical supervisors and teachers.

Although the nurse educators in Lesotho are well trained their scholarship should be developed. At the moment, there are no incentives to produce research or any form of research outputs. It stands to reason that incentives should not be the only reason for scholarly activities and generation of new knowledge, but it is a strong motivation.

6. Conclusion

The nursing education system in Lesotho has been unresponsive to the change in health needs and changed health care delivery systems in the country up to now. The extraordinary high disease burden and disproportionate shortage of professional nurses necessitates radical changes in health care delivery and nursing education. Nursing education has to deliver professional nurses who will be competent to render optimal health care to the Basotho in primary health care facilities. A rapid assessment was done through structured interviews with different staff categories and students at all six nursing schools in Lesotho to determine the current standing of nursing education.

Nursing education was measured against criteria that are commonly used to evaluate tertiary educational institutions. Elements included in the interview schedule were programme design, human resources, teaching and learning, physical resources, and programme accreditation. A hospital-based content-driven curriculum was offered primarily through lectures. Only one of the six nursing schools offers a baccalaureate degree. No guiding philosophy or learning theory is used. All the nurse educators have a qualification in nursing education, and 38% of them have at least a master's degree; but no scientific articles have yet been published. Professional development opportunities are limited but a professional development programme framework has been developed and will be implemented in 2013/4. Students taking part in the research were generally satisfied with the theoretical component but were of the opinion that they needed more support in the clinical work place to become competent.

At the time of the research infrastructure was limited with very small out-dated libraries with access only during office hours. The

NEPI donated skills laboratories, computers, and state-of-the-art mannequins to each nursing school in 2012.

Although significant data were obtained and verified through source triangulation there were limitations to the study. The research aim was to get a bird's eye view of nursing education but documentation to support the claims made by the interviewees were not obtained. Even though the researcher could not converse in Sesotho all those she interviewed were fluent in English because English is the official language of Lesotho.

Factors that may influence the implementation and sustainability of a competency-based curriculum were identified and suggestions on how to address these factors were made. Crucial to the success of implementing a competency-based curriculum is the empowerment of all current and future nurse educators. A professional development plan needs to be designed and offered to ensure that all nurse educators are competent in all eight competencies as articulated by the National League for Nursing (NLN) (2005). Local, national and international partnerships between training institutions should be formed and formalised. Partnerships will expand the pool of experts and people to support nursing students in becoming competent. Furthermore, the professional and regulatory bodies should develop supporting rules, regulations, and minimum standards for accreditation of nursing schools and health care services.

Despite the challenges discussed in this article, the nurse educators in Lesotho are committed to their goal to improve the health of the Basotho through better nursing education in the form of competency-based nursing programmes.

Conflict of Interest

The author was the consultant for the funding globalization at the time the rapid assessment was done.

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International Journal of Africa Nursing Sciences (IJANS) is an international scientific journal published by Elsevier. The broad-based journal was founded on two key tenets, i.e. to publish the most exciting research with respect to the subjects of Nursing and Midwifery in Africa, and secondly, to advance the international understanding and development of nursing and midwifery in Africa, both as a profession and as an academic discipline. The fully refereed journal provides a forum for all aspects of nursing and midwifery sciences, especially new trends and advances. The scientific journal International Journal of Africa Nursing Sciences is included in the Scopus database. Publisher country is . The main subject areas of published articles are Nursing(all). We offer making basic requirements to academic papers compliance test using "Paper quality checking" service. Paper quality checking service is in demand among researchers who wish to make final improvements to their work before submitting it to the target journal. The experienced editors of ORES, who have published papers in cited journals, with the participation of foreign partners go through