

**SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA, LEGON**

**MANDATORY CONTINUING PROFESSIONAL DEVELOPMENT PROGRAMME
(MCPDP) IN KADUNA STATE, NIGERIA: PERSPECTIVES OF NURSES**



**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
AWARD OF MSC DEGREE NURSING.**

JULY, 2015

DECLARATION

This is to certify that this thesis is the result of research undertaken by Barry Baidy Afoi towards the award of the Master of Science in nursing degree in the School of Nursing, University of Ghana

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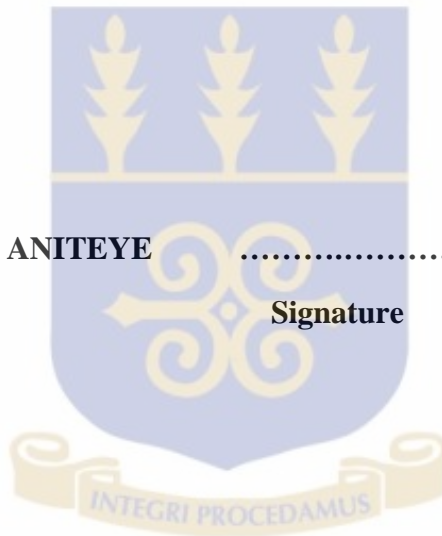
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ABSTRACT

This study was carried out in Kaduna State, Nigeria to explore the perspectives of nurses about the Mandatory Continuing Professional Development Programme (MCPDP). The study used an exploratory descriptive qualitative design to explore and describe the perceptions of registered nurses and midwives in Kaduna State about mandatory continuing professional development programme. Since not much research has been done in Nigeria to elucidate the perspectives of nurses about the various dimensions of MCPDP, the qualitative design was best suited to delve into the phenomenon and throw more light on it. The target population was all nurses who had attended MCPDP in Kaduna State. Purposive sampling was used to recruit participants in this study. Ten (10) nurses and midwives were interviewed to reach data saturation. Data were collected using face to face interviews and transcribed verbatim. The data were analysed using content analysis. The major finding of the study indicated that nurses generally held good perspectives about the MCPDP and the rationale for its introduction. The major challenges confronting participants was identified as poor programme accessibility, funding, administrative barriers and shortage of nurses. Findings also revealed that, there are shortcomings in the practicum and some aspects of content and delivery of the programme. Further evaluation of the MCPDP programme with a view to addressing the identified pitfalls is necessary. It is recommended that the Nursing and Midwifery Council of Nigeria, the Ministry of Health, Kaduna State and the State Implementation committee must collaborate to resolve the challenges within their mandates and capacities at each level.

DEDICATION

This thesis is dedicated to God Almighty the maker of all things visible and invisible. I also dedicate this work to my lovely parents Mr and Mrs Patrick Ayuba Afoi, my siblings and my fiancée, Tama. I dedicate this work to you in appreciation of your encouragements and for funding my studies in Ghana.



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TABLE OF CONTENTS

Content	Page
DECLARATION	i
ABSTRACT.....	ii
DEDICATION.....	iii
ACKNOWLEDGEMENTS.....	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES	x
CHAPTER ONE	1
INTRODUCTION.....	1
1.1 Background to the study	1
1.2 Problem Statement	5
1.3 Purpose of the study	7
1.4 Objectives of the study.	7
1.5 Research Questions.	8
1.6 Significance of the study:	8
1.7 Operational definition of terms.....	9
CHAPTER TWO.....	10
LITERATURE REVIEW	10
2.1 Perceptions of nurses towards MCPDP.....	11
2.2 Attitudes of nurses towards MCPDP	14
2.3 Impact of MCPDP on patients' care.	15
2.4 Barriers to MCPDP participation	16

2.4.1 MCPDP related barriers	16
2.4.2 Workplace related barriers.....	18
2.4.3 Person (Nurse) related barriers.....	19
2.5 Summary of literature review	21
CHAPTER THREE.....	22
METHODOLOGY	22
3.1 Study design.....	22
3.2 Study setting.....	22
3.3 Study population.....	23
3.3.1 Inclusion criteria:.....	23
3.3.2 Exclusion criteria:	24
3.4 Sampling method and sample size.....	24
3.4.1 Recruitment of participants.....	25
3.5 Pilot test of interview guide	26
3.6 Data collection tool and procedure.....	26
3.7 Data Analysis.....	27
3.8 Methodological Rigour.....	28
3.9 Ethical Considerations.....	29
CHAPTER FOUR	32
FINDINGS.....	32
4.1 Socio demographic characteristics of participants.....	32
4.2 Organization of Themes.....	33
4.2.1 MCPDP programme planning and organization.....	34

4.2.2 Rationale for MCPDP.....	35
4.2.3 Publicity of MCPDP	37
4.2.4 Course content	38
4.2.5 Role of NMCN in MCPDP	41
4.3.Factors influencing MCPDP participation	43
4.3.1 Reasons why nurses attend MCPDP.....	43
4.3.2 Positive factors.	45
4.3.3 Negative factors.....	47
4.3.4 Other factors.....	48
4.4 Perceptions of MCPDP	50
4.4.1 Merits of MCPDP.....	50
4.4.2 Demerits of MCPDP.....	52
4.4.3 Expectations from MCPDP.....	53
4.5. Nurses' attitudes towards MCPDP.....	55
4.5.1 Pre- and post- MCPDP attitudes	56
4.5.2 Mixed feelings about MCPDP.....	57
4. 6 Impact of MCPDP.....	58
4.6.1 Effects of programme on nurses.....	58
4.6.2 Effects of programme on practice	61
4.6.3 Effects of programme on patients	63
4.7 Challenges of MCPDP.....	64
4.7.1 Programme accessibility.....	64
4.7.2 Funding for MCPDP.....	66
4.7.3 Administrative barriers	68
4.7.4 Shortage of nurses.	69

4.8 Strategies for improving participation in MCPDP	70
4.8.1 Needs assessment for MCPDP	71
4.8.2 Sensitization of stakeholders of MCPDP	72
4.8.3 Enforcement of regulation.....	73
CHAPTER FIVE.....	77
DISCUSSION OF FINDINGS	77
5.1 Socio demographic characteristics of participants	77
5.2 MCPDP programme planning and organization	78
5.3 Factors influencing MCPDP participation	84
5.4 Perceptions of MCPDP	88
5.5 Demerits of MCPDP	90
5.6 Nurses attitudes towards MCPDP	92
5.7 Impact of MCPDP	94
5.8 Challenges of MCPDP.....	96
5.8.1 Funding for MCPDP	97
5.8.2 Administrative barriers	98
5.9 Shortage of nurses	99
5.10 Strategies for improving participation in MCPDP.....	99
CHAPTER SIX	103
SUMMARY, IMPLICATIONS, CONCLUSION AND RECOMMENDATIONS.....	103
6.1 Summary	103
6.2 Implications.....	104
6.3 Limitation	106

6.4 Conclusion.....	106
6.5 Recommendations	107
REFERENCES.....	110
APPENDICES.....	116

LIST OF TABLES

Table 1.1: Distribution of Nurses' attendance at MCPDP 2011 – 20146

Table 4.1: Major themes and their corresponding sub-themes..33

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Mandatory Continuing Professional Development Programme (MCPDP) is the planned educational activities intended to build upon the educational and experiential basis of the professional nurse for the maintenance, enhancement and extension of knowledge, expertise and competence of health professionals following graduation from training (Lucy, Johnson & Long 2012).

The United Kingdom Central Council (UKCC) introduced reforms in nurses' post registration education in line with changes that led to movement of more nursing programmes into the university. These reforms were aimed at ensuring quality care for patients. The reforms have led to nurses being required to identify their own educational needs. Having identified their own needs, post registration education programmes were developed to meet their needs. MCPDP is compulsory as defined in the UKCC code of ethics (Lucy et al., 2012). Similarly, in Australia there are trained clinical nurse educators whose roles are to provide continuing education for nurse practitioners, and all nurses are expected to receive training through continuing education (Govranos & Newton, 2014). In 2008, the Malaysian Nurses' Board made continuing education mandatory, and every year, nurses were required to participate in a minimum number of hours of education and training. The board believes that mandating compliance reinforces the message that health care is dynamic and that nurses must update their knowledge and skills to keep pace with global changes. There is an expectation that nurse professionals maintain currency, irrespective of external pressures (Chong, Sellick, Francis, & Abdullah, 2011). In the USA, various states make continuing education mandatory for nurses to acknowledge that continuous renewal of knowledge is a necessary condition for assuring competence. For

them, MCPDP is the means to assure the public in various states of the continuing competency for practice of the professional nurse. In Texas, participation in twenty contact hours of continuing education programmes is required by the board of nurse examiners for the State of Texas (Sovie, 2011).

In Africa, the Lesotho Nursing Council (LNC) developed a successful national CPD programme in 2010. The LNC is the first health professional organization among the health team members to do so, and the LNC has been requested to provide technical assistance to the Lesotho Medical, Dental, and Pharmacy Council in developing their CPD programme. Similarly, in June 2010, the Nurses and Midwives Council of Malawi (NMCM) launched a mandatory CPD programme for all nurses and midwives practising in Malawi. The majority of Southern Africa, Eastern Africa and Central Africa member countries run mandatory CPD for professional nurses. All nurses' regulatory bodies, however, recognized that meeting the requirements of the CPD programme was still presenting a challenge for some nurses and midwives. In Western Africa, personal communication with a zonal officer of one of the regional offices of the Nursing and Midwifery Council of Ghana, indicated that nurses require CPD for relicensure every 2 years. A study conducted in....to.... recommended that in many sub-Saharan African countries, there is a need to further develop CPD models and establish legal frameworks, policies, and structures to support CPD. (Gitonga & Muriuki, 2014; Moetsana-Poka, Lehana, Lebaka, & McCarthy, 2014; Richards, 2007; Volunteers overcoming poverty, 2013).

In Nigeria, MCPDP was initiated by the Nursing and Midwifery Council of Nigeria (NMCN). It is in line with the Council's regulatory function for the training and practice of nursing in Nigeria (Nursing and midwifery council of Nigeria, 2012). Similar to other Nurses' regulatory bodies, it was introduced because the Council is concerned

with improving the quality of nursing care in Nigeria. A number of reasons heralded the introduction of this programme. It was observed that the majority of nurses do not regularly read professional books (Garba, 2011). Other reasons included the changing disease patterns, new technologies in health care, new approaches to care, new drugs, changing client demographics, increasing awareness, changing needs of patients, as well as the need for quality assurance in nursing care (Garba, 2011). The need to promote professionalism in nursing such as licensing, promotion and good conduct as well as the need to make nurses up to date in nursing care in particular and health care in general, were other reasons for introducing the programme. (Chagiel, 2014; Garba, 2011; Garba, Ladan, Sani, Ajayi, & Kure, 2011; Lawal, Anyebe, & Sani, 2014).

The objectives of the MCPDP include updating the knowledge of nurses in order to assist them appreciate the advancements in nursing practice and the dynamics of change in the profession. It also affords the opportunity to supplement the national training of nurses and expansion of their knowledge. Thirdly, it ensures the continued relevance of nurses in the health care team (Chong et al., 2011; Garba, 2011). Furthermore, the MCPDP was to help nurses maintain continuity in professional education and practice, maintain standards in nursing care, meet the needs of the employers and the consumers of nursing care in particular and health care in general.

It was expected that MCPDP when introduced, would significantly correct the deficiencies and weaknesses affecting the quality of nursing care, and promote good leadership in nursing that will meet the new challenges (Garba, 2011; Nsemio, John, Etifit, Mgbekem, & Oyira, 2013).

To achieve the above objectives of the MCPDP, the Nursing Council set up a central committee in February 2008, to design and develop the medical-surgical nursing modules and to draw up the strategies for implementation. The modules were developed in

two volumes with each volume made up of two modules i.e. Volume one was made up of modules 1 and 2, while volume two was made up of modules 3 and 4. Each of the volumes was quantified to cover 45 hours and equated to carry three (3) credit units. Some topics in volume one were repeated in volume two because of their importance (Garba, 2011).

Training of trainers' workshop for the states and teaching hospital facilitators first took place at the University of Ibadan in March, 2010. In February 2013, a second training of the trainers' workshop took place to appraise the progress of the MCPDP. New modules in midwifery, mental health and medical surgical nursing were introduced. Specialized professional bodies within nursing were expected to submit modules to the central committee for evaluation and allocation of credit units.

The implementation is organized in central, zonal, and state levels. It is compulsory for all nurses and midwives to participate in the two volumes within three years before licenses are renewed. All nurses in government and private services including those retired, who want to renew their licenses and engage in nursing activities, are expected to participate. Nurses are expected to pay for the programme, as it is a personal professional development and a continuous programme. The programme is made up of taught courses and clinical experience in the wards. (Garba, 2011). Barriers to participation are therefore likely and may arise from the packaging of the programme in terms of organization and content, method of delivery of knowledge and coverage for the various specialty nurses attending the same programme with non-specialist nurses. The perceptions nurses have, the attitudes they show and factors influencing nurses participation will determine the aim for which MCPDP was introduced. This study therefore explored nurses' and midwives' perceptions on MCPDP, their attitudes towards the programme, the impact they think the programme has had so far on nursing practice and the barriers that hinder their participation in the programme.

1.2 Problem Statement

Although scanty literature on continuing professional education/development (CPE/CPD) for nurses exist, many studies have shown that in many countries of the world, CPD is now mandatory and a requirement to maintain professional registration (Gould, Drey, & Berridge, 2007; Lucy et al., 2012). Continuing professional development is very important for nurses globally. There is rapid progress in the medical science today with expanding specializations. The expectation from nurses is quite high with an increasing demand for accountability as well. Nurses therefore need to provide high quality care for individuals, groups and the community at large. To achieve this, nurses need scientific knowledge to improve their clinical reasoning and decision making skills regarding what care to provide to patients/clients. The NMC Nigeria adopted what is this? in 2010. The MCPDP in Nigeria is uniformly implemented. It is the only certificate required for relicensure. Each nurse is expected to earn six (6) credit units within 3 years before relicensure. Between 2010 and 2014, medico-surgical, midwifery and mental health modules were developed and have been in use since then. More specialized groups are expected to make submissions of their modules for quantification and allocation of credit units. Studies in Malaysia showed evidence of absenteeism despite the Malaysian nursing board's adoption of continuing education as mandatory. (Chong et al., 2011) The report further showed that prior to legislation, participation in CPD was higher (Chong et al., 2011; Lai, 2006; Nia et al., 2014). This suggests that making MCPDP mandatory does not ensure nurses' commitment to participation.

Most studies have shown that nurses have a positive attitude towards CPD but barriers affect commitment and participation (Chong et al., 2011; Gitonga & Muriuki, 2014; Gould et al., 2007; Nsemu et al., 2013; Ross, Barr, & Stevens, 2013; World Health Organization, 2010). In Calabar, Nigeria, it was found in a study that nurses have positive

attitudes towards MCPDP and they perceive the programme as valuable and worthwhile hence they participate but not without challenges, as seen in other parts of the world (Chong et al., 2011; Gould et al., 2007; Nsemo et al., 2013; World Health Organization, 2010).

TABLE 1.1 shows the attendance of nurses at the workshop in Kaduna state between 2011 and 2014. The table shows the fluctuating participation of Nurses at the MCPDP. In 2011 when it started, the maiden edition witnessed a relatively poor participation; the 2nd and 4th workshops had higher participation. The 3rd however, failed due to poor participation. By 2012, the participation fluctuated with the highest participation being 335 nurses and midwives. The 9th MCPDP held in the same year, 2012 had significantly low nurse participation (27). In 2014, the same trend of fluctuation was seen. The programme is organized as many times as may be required but in Kaduna state, six (6) slots are planned annually and two are held in each of, the three senatorial districts in the state. The programme lasts for 5 days. It is expected to train a minimum of fifty (50) nurses and a maximum of one hundred (100) nurses at a time. Not all the 6 slots are held each year in Kaduna State, yet some sessions were low while others were overwhelming with nurses and midwives in attendance. Various reasons may be responsible for this fluctuating attendance. Anecdotal evidence suggests that nurses rush for the MCPDP when relicensure becomes necessary.

Table 1.1: Distribution of Nurses' attendance at MCPDP 2011 – 2014

SN	Year	No. of Participants
1	2011	299
2	2012	707
3	2013	477
4	2014	272
	Total	1755

(Source: State Implementation Committee MCPDP, 2011)

The researcher, a member of the state implementation committee of MCPDP in Kaduna State, Nigeria, has had the opportunity to interact with many participants and the ensuing comments emerged:

“I only came for the programme because my license is expired”,

“I have to be on permanent night duty to attend this programme”,

“I am a theatre nurse this module is not relevant to me”,

“the registration fee is too much”.

These comments are indicative of the various barriers that nurse participants face in attending the MCPDP. The comments contributed in arousing the researcher's interest to undertake a study to unveil the barriers that affect Kaduna State nurses commitment and participation in MCPDP. Therefore, a study that elicits nurses' perception and barriers to nurses' participation in the newly introduced programme in Kaduna State was deemed worthwhile.

1.3 Purpose of the study

The purpose of this study was to elicit and describe perceptions of registered nurses and midwives in Kaduna State about mandatory continuing professional development programme.

1.4 Objectives of the study.

The specific objectives of the study were to:

1. Identify how registered nurses in Kaduna State view mandatory continuing professional development programme.
2. Determine nurses' views on the impact of the programme on quality of nursing care in Kaduna state.
3. Determine the attitudes of Nurses towards the MCPD programme in Kaduna State.
4. Identify barriers to mandatory continuing professional development programme experienced by registered nurses in Kaduna State.

1.5 Research Questions.

1. How do registered nurses in Kaduna State view mandatory continuing professional development programme?
2. What is the nurses' view on the impact of the programme on quality of nursing care in Kaduna State?
3. What are the attitudes of Nurses towards the MCPD programme in Kaduna State?
4. What barriers do registered nurses in Kaduna State experience when participating in mandatory continuing professional development programme?

1.6 Significance of the study:

The findings of the study when communicated will serve as a basis for understanding the feelings of Kaduna State nurses towards the programme and the barriers to their participation in the programme. Also, health care organizations could benefit as the findings will provide an insight that could lead to additional support structures to overcome identified barriers to MCPDP participation. The finding and recommendations could contribute to making MCPDP more accessible, and ensuring that relevance to clinical practice is maintained.

1.7 Operational definition of terms.

Perceptions: in this study, perceptions refer to what nurses' think about the MCPDP which they have experienced.

Barriers: refer to those factors (physical, attitudinal and structural) which prevent the registered nurse from participating in MCPDP.

Mandatory continuing professional development programme (MCPDP) in this study means Continuing professional education or (CPE), continuing professional development (CPD).

CHAPTER TWO

LITERATURE REVIEW

This chapter outlines the literature included in the study. The review provided the researcher with baseline information to conduct the study. This agrees with Burns and Grove (2011), who documented that literature review provides the researcher with knowledge on what is known and what is not yet known about a phenomenon. The literature review further identifies the depth of literature on the perception of MCPDP among nurses in Nigeria. According to Burns & Grove (2011), literature review allows for identification of gaps in the knowledge base. The review also provided the researcher with various methodologies, data analysis strategies and previous research findings globally which were useful for discussion for discussion purposes in comparison with the researcher's findings.

Various databases and Google Scholar were utilized to search for items related to the topic MCPDP. The databases included: Taylor and Francis, CINAHL, MEDLINE, Africa-wide information, Willey online, sage journals, Health source: Nursing/academic edition, eBooks collection (EBSCOhost) and Science Direct. Articles used from the databases were restricted from 2009 to date. Articles from Nigeria had no date restrictions owing to the dearth of literature on MCPDP in Nigeria. Journals from Google Scholar were restricted from 2000 to date, owing to the scarcity of literature on MCPDP. Also, some few old studies became necessary to use because of the relevance of their findings to this study. Various search terms were used to search for relevant information on MCPDP globally. Some of these terms included: Perceptions, views, perspectives, continuing, professional, development, nurses, midwives, attitudes, barriers, impact, education, care and Nigeria. Books, conference paper presentations, reports and personal communications were also used to obtain information relevant to the study.

2.1 Perceptions of nurses towards MCPDP.

Globally, many studies have reported nurses' perceptions on MCPDP and its perceived impact on practice (Gould et al., 2007; Govranos & Newton, 2014; Nsemio et al., 2013). In Australia, various studies observed that respondents perceived CPD as business since it is only in the form of workshops and conferences and the role of CPD is not clearly defined so professionals are not mostly used to facilitate MCPDP clinically. This makes it difficult to achieve improved patient outcomes and maintain competency and currency. Nurses also perceived CPD as part of the work while the majority saw it as separate from the workplace. Other nurses also viewed the MCPDP as a requirement for relicensure. Furthermore, nurses believe that there is no link between CPD and the ward context. The relevance of the content of MCPDP is also questioned by nurses as seen in the study findings of some authors (Gould et al., 2007). Similarly, studies in Australia also viewed the MCPDP as requiring a framework to facilitate an education that allows nurses to express their choice in topics for CPD (Gould et al., 2007; Govranos & Newton, 2014; Lucy et al., 2012; Thomas, 2012). The authors used both qualitative and quantitative approaches and got similar findings. However, Lucy et al. (2012), made an intensive and extensive analysis of previous research findings but failed to mention the methodologies used in the studies as well as their strengths and weaknesses.

The findings of some UK based studies revealed that nurses perceive CPD as important to bridge the gap between theory and practice as well as enhance career development. The methods of delivery of the course content were heavily criticized. They observed that the delivery methods did not consider what was to be taught and that the content was not sufficiently related to practice and the methods of assessment were also not appropriate to meet practitioners' needs. They also noted that MCPDP does not consider self-learning (Gould et al., 2007). Respondents perceived that nursing is

becoming overly academic rather than clinical and nurses attend more and more training without improving clinical awareness, thereby making nursing unattractive (Gould et al., 2007). The findings of the UK based studies also showed that respondents perceived that managers hinder the implementation of new knowledge and expertise acquired. (Drey, Gould, and Allan, 2009; Gould et al., 2007). Although relatively large samples were used for these studies, a qualitative mix method approach would have clarified the respondents' context of "inappropriate assessment methods" and "making nursing unattractive". How managers hinder the use and practice of new skills acquired was not exactly explained in the study. It is possible that the training needs of junior, senior and novice nurses were not considered hence a qualitative approach to this study would have given the authors a clearer picture. In Canada, CPD was perceived as important for practice and the respondents also perceived the programme as not based on learning needs. The majority of respondents preferred online CPD for reasons of distance and accessibility and a few others preferred short conferences, seminars and classroom lecture methods (Baxter et al., 2013).

In China, respondents also saw CPD as necessary and as being clinical and hospital based, comprising clinical teaching rounds, seminars, academic meetings and case discussions lasting five days or less (Ni et al., 2014). Respondents in studies in Greece, viewed CPD as a process of lifelong learning to meet clients' needs with better health outcomes while achieving job retention (Yfantis, Tiniakou, & Yfanti, 2010). In a study in Las Vegas, respondents favoured both online and face to face learning for CPD (Landers, McWhorter, Young, Hickman, & Schuerman, 2010). Respondents in a study in Scotland perceived CPD as important for nurses and whether it was mandatory or not, they were still going to attend. The nurses noted that expectations were met using both face to face and e-learning. This was because nurses and facilitators were highly motivated; facilitators

were highly skilled and continued to provide skilled support beyond the workshop/seminar time (Stout, 2013).

The majority of the studies in Canada, China, and Las Vegas used the quantitative approach except for that of Scotland which combined qualitative and quantitative approaches. All the studies showed a poor response rate of the questionnaires. Unlike the findings of the studies in Canada and China, the respondents in Scotland appeared to be satisfied with CPD. In South Africa, physiotherapists perceived that CPD should be mandatory while others preferred self-learning, hence CPD was meaningless to them (Maharaj, 2013). The study was largely female dominated and comprised mainly of physiotherapists with no other therapists. Therefore the responses may reflect the views of female physiotherapists only. In Ghana, Aiga (2006), reported in his study that Ghanaian health workers participate in MCPDP mainly for maintaining professional competence and skills development.

In Nigeria, not much work has been done on MCPDP. The only study revealed that nurses perceived MCPDP as invaluable for all nurses, but all nurses observed that MCPDP does not meet their expectations because the programme seemed fragmented. Other workshops are not recognized for relicensure except the CPD organized by the Nursing and Midwifery Council of Nigeria. Other CPDs do not earn credit points. Respondents also wondered why e-learning was not being used for those who cannot leave their immediate environment. Also, nurses were not satisfied with the content and resource persons used in the programme. Their learning needs are also not considered as there is usually a limited practical demonstration and limited time for questions (Nsemo et al., 2013). Many research reports show that nurses agree that MCPDP plays an important role in enhancing service provision and maintaining safety for patients and nurses. It also bridges the gap between theory and practice as well as career development. It is valuable

and worthwhile and a consequential guarantee that the public will receive the best possible health outcomes. (Baxter et al., 2013; Chong et al., 2011; Govranos & Newton, 2014; Ni et al., 2014; Nsemo et al., 2013; Yfantis et al., 2010).

2.2 Attitudes of nurses towards MCPDP

There is little information available on nurses' attitudes towards mandatory professional development programme.

In a study in the federal republic of Ireland, Timmins (2008), reported that cardiovascular nurses showed a positive attitude towards continuing professional education. The nurses said that continuing education is essential if nursing is to develop as a profession. Out 195 participants, the researcher recorded a response rate of 52% of the self-report questionnaires and 94% of the participants were females. The findings of this study therefore cannot be generalised as representing the opinion of nurses in Ireland. The findings can only be generalised as the attitude of female nurses within the setting the study was carried out. A qualitative approach to this study would have also added more insight to the attitudes of nurses in the study setting.

Also, in his study Naicker (2006), examined the attitudes of perioperative nurses towards continuing education and professional development using a mix of quantitative and qualitative methods. He found that nurses displayed a positive attitude towards continuing education and professional development as well as mandatory continuing education and professional development. Factors that were perceived as motivators for participation in continuing education and professional development included funded courses, study leave and courses related to current speciality. The mixed method approach, which is the use of both quantitative and qualitative methods is commendable for this study. The findings suggest that motivation influences positive attitudes towards MCPDP participation.

In another study involving dental therapists and dental nurses, the participants' attitudes towards CPD was positive but the nurses had challenges accessing CPD that met their needs (Mercer, Bailey, & Cook, 2007).

Jordanian and Australian nurses were reported to have positive attitudes toward continuing education. There were no statistically significant differences in nurses' attitudes towards continuing education according to age or gender among Jordanian nurses (Fahey & Monaghan, 2005; Jaradeh & Hamdeh, 2010).

2.3 Impact of MCPDP on patients' care.

Although a few studies have been done on MCPDP, the studies focused on barriers to participation in MCPDP, there is paucity of studies that evaluated impact but a few have reported that participants perceived there is no commensurate improvements in patients' outcomes, while others suggested studies to establish the impact of CPD (Kem & Baker, 2013; Philips, Piza, & Ingham, 2012). Some studies suggest that workshops and conferences improve knowledge and practice behaviours of the attendee (Latter, Maben, Myall, & Young, 2007; Nia et al., 2014). Reasons advanced for lack of improvements in patients' outcomes included poor delivery methods as lectures are delivered outside the practice area and so lack clinical demonstration. Also, the course content lacks evidence based knowledge in improving patients' outcome, (Lucy et al., 2012). For other authors (Govranos & Newton, 2014; James & Francis, 2011), it is difficult to know the impact of quality care on patients since there is no monitoring to ensure that knowledge gained is used in practice. It is also believed that self-learning is not encouraged at MCPCP so the programme means different things to different people. (Govranos & Newton, 2014; James & Francis, 2011; Nsemo et al., 2013). Similarly, there is no empirical evidence to show MCPDP improves clinical skills and professional practice since 3 decades ago (Thomas,

2012). Studies also found that managers are perceived to be the gate keepers in implementing new knowledge and expertise acquired, but managers hinder nurses from implementing new knowledge as the right environment to implement the care is seldom provided. A study found 91% respondents saying they were not supported to apply knowledge (Gould et al., 2007; James and Francis, 2011). Lack of commitment to work and poor motivation also was reported to prevent change in practice behaviour hence an improvement in practice should not be expected. However, James and Francis (2011), in their study found that the prognosis for MCPDP is yet to be made clear. What is made clear is the fact that it is a requirement by the profession for nurses to maintain competence in their practice and a consequential guarantee that the public will receive the best possible health outcomes (James & Francis, 2011).

2.4 Barriers to MCPDP participation

2.4.1 MCPDP related Barriers

Neglect of perceived learning needs: among the findings of studies reviewed, authors reported that the learning needs of CPD participants were neglected (Baxter et al., 2013; Gould et al., 2007; Govranos & Newton, 2014). The findings revealed that the contents of MCPDP are not based on needs assessment. Organisers of the MCPDP do not consider that nursing has different cadres of the nurse specialist; the update a nurse anaesthetist will require will be different from that which an orthopaedic nurse will require. Similarly, skilled, experienced nurses and novice nurses may not benefit from the same continuing education modules. (Baxter et al., 2013; Gould et al., 2007; Govranos & Newton, 2014). It is noteworthy that the quantitative and qualitative studies by these authors elicited the same findings. This indicates that the lack of needs assessment is a real barrier to nurses' participation.

Teaching methods at CPD programmes: the methods used to deliver content at CPD programmes was reported by some authors, the programme is run by e-learning and by face to face lectures (Khatony, Nayery, Ahmadi, Haghani, & Vehvilainen-Julkunen, 2009; Phadtare, 2009). There are merits and demerits of each of the approaches. Phadtare (2009), criticized face to face lectures as being inflexible, boring and not applicable to real life demands, a position (Khatony et al. (2009), supported that the traditional didactic approach to learning is not student centred. E-learning has also received some criticism that there are several barriers such as accessibility to computers. Biggs and Tang (2007) and Fry, Ketteridge, and Marshall (2009), reported that the learning processes of an individual plays a vital role in the efficacy of education and must be considered when providing programmes of learning.

Scheduling of MCPD Programme: Researchers have reported MCPDP programmes scheduling as barriers to participation (Chong et al., 2011; Nsemo et al., 2013). MCPDP programmes are organized outside the hospital facilities, within the facility and mostly in urban centres. Participants in China prefer MCPDP within the facilities, citing distance and cost of transport as reasons (Ni et al., 2014). Studies have shown that participation is higher when MCPDP is scheduled at the time of need by the participants. Nsemo et al. (2013), found in Nigeria that participants prefer MCPDP when organised outside the facility, citing distractions at the workplace during programme as reason.

It is commendable that Chong et al. (2011), in their study of what influences Malaysian nurses to participate in CPD programme, used a larger sample for the study, but the sample was drawn from a spread of only 4 out of the 13 states in Australia.

Distance as a challenge to CPD participation: Tuckett, Parker, and Robert (2010), found that distance is a problem to attending MCPDP among nurses in the rural area. Update programmes are mostly held in urban centres (Maharaj, 2013; Nsemo et al., 2013).

The reasons why update programmes mostly held in urban centres were not stated by these authors but it possible that the facilities that may be required may not be readily available in the rural area. It is important to find out whether the hospitals in the rural areas can accommodate the programme in terms of accommodation, auditorium/conference hall facilities, equipment and power supply among other requirements for hosting the programme.

Unrealistic requirements for relicensure: requirements that were not realistic was another challenge reported in CPD programmes requirements for relicensure. In a study in china where CPE was made compulsory, the author reported that a disconnection between policy formation, implementation and evaluation was evident. The credit units' requirement to satisfy relicensure were initially unrealistic and so many nurses could not meet the demands. The requirements however were modified due to the failure by most nurses to achieve the required credit units required for relicensure (Xiao, 2010).

Negative experiences of participants at CPD programmes: Studies also reported nurses' negative experiences in previous MCPDP workshops attended (Chong et al., 2011; Ni et al., 2014). Some of the negative experiences included lack of order in the classroom and the use of inexperienced teachers to deliver content of CPD (Ni et al., 2014).

2.4.2 Workplace related Barriers.

Busy work schedule as a challenge to CPD participation: Globally, many studies reported nurses could be on duty when a Mandatory CPD will be holding. Sometimes, the nurse manager will not be willing to release a nurse, perhaps because there is no nurse to cover up her duty. Some authors have also reported that the wards could be too busy for the nurse to run between the venue for the programme and the ward. The result at best is a distracted participant who loses the gains of the continuing education (Chong et al., 2011;

Gould et al., 2007; Ni et al., 2014; Nsemo et al., 2013; Yfantis et al., 2010). These results stem from studies carried out across the globe. There are different modes of programme implementation of MCPDP in these countries and work schedules, staff strength and types of health services provided by each facility may vary. The manner in which the credit units are earned may also differ thus caution must be applied in the interpretation and comparisons of findings of studies on MCPDP.

Nurse Manager's attitude: Findings of studies show that nurses do not have the managers' support to go for MCPDP and some managers make unfavourable policies to hinder the nurse from participation (Baxter et al., 2013; Gould et al., 2007; Maharaj, 2013; Nsemo et al., 2013; Stout, 2013). Others do not provide the right environment and support to implement knowledge and skills acquired from CPD. Managers were said to be reluctant in allowing their subordinates to go for updates for fear that the subordinate may gain new knowledge that is superior to that of the manager (Gould et al., 2007). Some managers however provide funding and support for CPD training and implementing skills and knowledge (Maharaj, 2013; Stout, 2013).

Shortage of nurses affects participation: This increases pressure on the few nurse practitioners thereby making it difficult to attend MCPDP within or even outside the hospital environment. The practice of new skills acquired therefore was difficult to be seen or appreciated by clients. (Maharaj, 2013; Singchungchai, Kritcharoen, & Limchai-arungreung, 2009).

2.4.3 Person (Nurse) related barriers

Cost of MCPDP: Findings of research also revealed cost as a barrier to nurses' participation in MCPDP (Chong et al., 2011; Gould et al., 2007; Nsemo et al., 2013). In relation to studies by Hegney, Tuckett, Parker, & Robert (2010), the cost of attending MCPDP was mentioned as a barrier among nurses in the rural area. This is because nurses

from the rural areas would have to spend on transportation and accommodation in addition to the registration fee for the programme. There is a feeling among nurses that managers should be responsible for sponsoring CPD since the hospital management benefits more from the knowledge but managers feel otherwise (Gould et al., Maharaj, 2013; Nsemo et al., 2013). Managers and regulatory bodies expect nurses to pay for their updates, especially as budgetary constraints affect allocation of funds for MCPDP (Garba, 2011; Singchungchai et al., 2009). Where budgetary allocation is done, financial backing and subsequent release of the fund is not timely therefore affecting the smooth running of MCPDP. Some respondents also suggested that passing the financial burden solely onto practitioners is likely to back fire and reduce the quality of MCPDP as well as skill reduction among practitioners (Thomas, 2012).

Distance from venues of CPD programmes: studies reported that distance affects those in the rural areas more as CPD centres are mostly urban based. Distance incurs other costs automatically in terms of expenses. Managers are more reluctant in releasing nurses when the CPE is to be held a distance from the facility (Gould et al., 2007; Hegney et al., 2010; Ni et al., 2014; Nsemo et al., 2013; Singchungchai et al., 2009).

Time as a challenge to CPD participation: a study reported use of personal time of participants for attending CPD workshop as a challenge. The participants in the study felt that the hospitals which are the direct beneficiaries of updates should be giving approved study leave to nurses who want to go for updates. Nurses, they suggested should not use their personal leave for updates (Gould et al., 2007).

Domestic work affects CPD participation: Gould et al. (2007) and Nsemo et al. (2013), found that the demands of undertaking MCPDP with home and domestic commitments, including arranging child care, combined with the distance to MCPDP centres were significant barriers. The use of personal time such as work leave rather than study leave

was seen as unfair and affects time for domestic work. Nurses who were older than 33 years and above participated more than those who were 20 to 32 years (Nsemo et al., 2013). The reason for this could be that those in the younger age bracket are in their active reproductive age. They are likely to be taking care of younger children than the former whose children may be able to care for themselves (Gould et al., 2007).

These studies were done using mixed methods that could have confirmed the qualitative and quantitative responses by clients. It afforded the studies the leverage to test for relationships quantitatively. The findings, however, could have been generalized if the sample size was larger.

2.5 Summary of literature review

This chapter reviewed literature on the perception of nurses about MCPDP, the perceived impact of MCPDP on patients' outcomes and the barriers that affect nurses' participation in MCPDP. The studies reviewed showed that both qualitative and quantitative methods were used to obtain the views of CPD participants. The mode of operations of the CPD programmes differed among countries. Paucity of Studies on MCPDP in West Africa including Nigeria was noted. Only one study was accessed by the researcher on CPD in Nigeria. No study on CPD for nurses and midwives was found in the northern part of Nigeria. This study set out to obtain the perspectives of nurses towards MCPDP in a state in the northern part of Nigeria.

CHAPTER THREE

METHODOLOGY

This chapter presents the study design, study setting and study population. The sampling method, inclusion and exclusion criteria, sample size determination and recruitment of the participants are also presented. The chapter also covers the data collection process and management, pilot testing of interview guide, methodological rigour and ethical considerations.

3.1 Study design

This study used an exploratory descriptive qualitative design to explore and describe the perceptions of registered nurses and midwives in Kaduna State about mandatory continuing professional development programme. This design is appropriate for research work where little is known about the phenomenon being studied. It allows new insights or ideas to be generated thus helping to formulate a more precise problem (Mustapha, 2011). Since not much research has been done in Nigeria to elucidate the perspectives of nurses about the various dimensions of MCPDP, the qualitative design was best suited to delve into the phenomenon and throw more light on it.

3.2 Study setting

Kaduna state is one of the oldest states in the northern region of Nigeria. It is centrally located in the northern part of Nigeria. Geographically, it is located on latitude 10° 30'11" north of the equator and 7° 30'11" east of the Greenwich meridian. Kaduna State is bounded by Katsina and Kano States to the east, Bauchi to the southwest, Niger and Zamfara to the west and Abuja and Nasarawa state to the south (Afoi, Emmanuel, Garba, Gimba, & Afuwai, 2012). Kaduna State has a total area space of approximately

48,473.2 square kilometres with a total population of 6,113,503 and an annual increase rate of 3%. It has a population density of 131.7/km. The state is the 4th most populated state in Nigeria and represents a major focus and centre for political and economic activities in the nation. It is made up of multi religious and multi ethnic population (National Population Commission, 2009). Politically, the state is divided into 3 senatorial zones i.e. the northern, central and southern senatorial zones. There are 4 tertiary health institutions (hospitals) owned by the federal government located in Kaduna State. Three of the hospitals are teaching hospitals namely: Ahmadu Bello university teaching hospital Zaria, National eye centre Kaduna and National ear care centre Kaduna. The 4th is Federal neuropsychiatric hospital. Kaduna state has 29 secondary health facilities with about 1,305 nurses. The comprehensive and primary health care clinics make up the rest of the state owned health facilities in the state. Also, there are over 300 private clinics all over the state (Afoi et al., 2012).

3.3 Study population

The Study population refers to the total number of elements from which the sample is selected (Babbie, & Mouton, 2011). The study population was all nurses and midwives practising in Kaduna state who have attended MCPDP. It covered nurses in the 4 federal government hospitals, the 29 general hospitals in Kaduna State, the comprehensive and primary health centres and private hospitals. The total number of nurses were 1,705 (Afoi et al., 2012).

3.3.1 Inclusion criteria

The inclusion criteria for this study were nurses who have participated in MCPDP programme organized by Kaduna State implementation committee and nurses who have

worked for at least 3years post qualification. This period would have allowed them to obtain adequate experience in relation to most of the challenges and issues surrounding continuing education practice policy in their facility. Also, nurses who work in any of the federal, State, comprehensive/primary health care centres, or private hospitals within any of the 3 senatorial zones in Kaduna State were qualified to participate. Only nurses who were willing to participate in the study were recruited.

3.3.2 Exclusion criteria:

Nurses who have never participated in MCPDP were excluded from the study. Nurses who have not practised nursing since the commencement of MCPDP in Kaduna State were not included in the study. Nurses who do not practise are not likely to appreciate the issues surrounding MCPDP as it relates to the practice environment. Nurses who declined to participate in the study were not included in the study.

3.4 Sampling method and Sample size.

Sampling is the process through which a group of people, an event, place, institution or any other element is selected to allow for the conduct of research (Grove, Burns, & Gray, 2013). Purposive sampling was used to select hospitals and nurses in those hospitals who had gone through MCPDP and met the inclusion criteria. The nurses were selected to reflect each of the centres in the 3 zones where MCPDP is organized within the state. This is because they provided information based on their unique experiences in previous MCPD Programmes attended in their zones, thus meeting the study objectives.

Sample size is the number of participants who have consented to be recruited for a study (Grove et al., 2013). The sample size for this study was not predetermined, but was reached through data saturation. Data saturation is reported at the point where no new

information or theme is obtained during data collection. (Marshal, Carbon, Poddar, & Fontenot, 2013). This approach enabled the researcher to have enough participants to provide information to achieve the study objectives.

3.4.1 Recruitment of participants

The recruitment of participants was done after due ethical clearance was obtained from the Institutional review board of the Noguchi Memorial Institute for Medical Research. The researcher, being a member of the state implementation committee had access to the list of participants in the 3 zones where MCPDP is held since the inception of the programme. Thirty one (31) participants were contacted through their mobile phones. The 31 called were based on the addresses on the list of participants to cover urban and rural based nurses, nurses in the private sector and nurses in the public sector taking the federal state and local government health institutions into consideration. Eighteen (18) out of 31 accepted to participate in the study. Only 11 participants out of 18 gave appointments with dates, venues and time. The rest 7 never gave dates until the data collection period ended. One (1) out of the 11 declined to participate citing personal reasons. Ten (10) Participants were interviewed after which no new information was emerging so the researcher stopped the interview. The 10 participants were made up of a member of the state implementation committee of MCPDP, (the organizers/facilitators of the programme) 2 resource persons (faculty members), and 1 ex-member of the state implementation committee of MCPDP. The 6 other members were made up of nurses and midwives who met the inclusion criteria for the study. The researcher discussed the purpose of the research in detail with participants and requested their consent to participate in the study. The participants were then given the consent form to indicate their

willingness to participate in the study. A meeting was then scheduled with each of the participants and the date, time and venue for the interview was determined.

3.5 Pilot test of interview guide

The researcher conducted a pilot test of the interview guide using two (2) nurses in Kaduna State who share similar characteristics but did not form part of the research participants. The pilot testing of the interview guide aimed at determining whether the proposed interview guide could collect data that would answer the research questions, identify potential problems in following the research procedure, identify local politics or problems that may affect the research process; and provided a platform for the researcher to build on his skills as a novice qualitative researcher (Van Teijlingen, & Hundley, 2002). In this study, the pilot testing was done and questions which were redundant were deleted. Questions that were ambiguous were clarified to facilitate data collection in the main study.

3.6 Data collection tool and procedure

A semi-structured interview guide was used to conduct the interview. Semi structured interview is used to collect data from participants through a set of open ended questions asked in a specific order. Since little is known about the phenomenon under study, this tool was used to capture data from participants in the form of feelings, thoughts and insights. The tool enabled the researcher to elicit more information from the participants. The researcher using the semi structured interview had the flexibility to probe and obtain in-depth information about the MCPDP being studied (Mayan, 2001). Given these inherent attributes of the semi structured interview, the researcher elicited information about MCPDP that adequately helped to achieve the study objectives.

On the day of the scheduled interview, the researcher met the interviewee at the venue and time agreed upon. The researcher after welcoming the participant and making him or her comfortable enquired whether the participant still wanted to participate in the study. Following this, use of the recorder was explained and permission sought. Using the topic guide, the interview commenced with general questions followed by specific ones. Use of probing questions was applied for purposes of clarification until all sections of the guide were exhausted. The shortest interview lasted 40 minutes while the longest lasted 49 minutes. At the end of each interview, the researcher thanked and gave refreshment to each participant and gave transport fare to those who travelled by any means to the scheduled venue of the interview.

3.7 Data Analysis.

Data was analysed using content analysis as described by (Mustapha, (2011). This technique is inductive as the categories and themes will emerge out of the data rather than being imposed prior to the collection and analysis of the data (Patton, 2002). The analysis began at the commencement of the interviews and continued throughout the data gathering process. Data collection and data analysis was done concurrently to help shape the data collection. Immediately after the end of each interview, the researcher played and listened to each interview many times to familiarize himself with the data. The researcher then transcribed each interview verbatim. Each transcript was read and re-read for purposes of familiarization. Emerging themes were written down and grouped based on patterns or relationships amongst them. A hierarchy of themes and sub-themes was created. Following this, each transcript was coded using the identified themes and sub-themes. Using a computer, similar themes were copied and placed in one file in line with the

objectives of the study. The findings were written using the themes and sub-themes with some quotations provided as evidence.

3.8 Methodological Rigour

Rigour refers to trustworthiness. Rigour in qualitative study should satisfy the following criteria: credibility, transferability, dependability, and confirmability. Rigour refers to the steps taken to ensure that the research findings are trustworthy (Lincoln & Guba, 1985; Polit, Hungler, & Beck, 2001).

In this study, **credibility** was achieved by taking the verbatim transcribed interview data back to each participant to agree or disagree with the content of the transcript. None of the participants made changes in their narrations. This agrees with Jackson & Stevenson (2000), who recommended that research findings be taken back to the participants to give them the chance to agree or disagree with the researcher's data. During the interview, the researcher also repeated some phrases and words mentioned by the participants so that they could clarify what they meant.

Transferability in qualitative research refers to the extent to which the reader is able to transfer the findings of the study to other similar settings (Lincoln & Guba, 1985; Polit & Beck, 2004). In this study, direct quotes from participants and thick descriptions of the settings in which the MCPDP was being studied was made available to allow for transferability to similar contexts.

Dependability, refers to audit trail which is the systematic collection and documentation of the decisions, choices and insights trail that was used by the researcher such as use of field notes, coding process, use of diaries and journals. It also refers to data stability over time and conditions (Lincoln & Guba, 1985; Polit et al., 2001). In this study, pilot testing of the interview guide was done noting all critique and implementing

those agreed on by researcher and his supervisor. The audit trail enables another researcher to clearly follow the decision trail used by the investigator in a study so that replication of the study with similar groups in a similar context will yield similar findings (Mayan, 2001; Polit & Beck, 2004).

Confirmability refers to the objectivity of the data such that two or more independent people will agree with data relevance of meaning (Polit et al., 2001). In this study, the researcher was mindful of his attitude towards and knowledge about MCPDP in order not to impose them on the participants' data. The researcher's feelings, ideas and personal views were separated from those of the participants. A well-documented audit trail was kept to allow following confirmation of findings. Upon transcription, reviews of the relevance and meaning of the data were made by an expert in Ahmadu Bello University Zaria, Nigeria and the two research supervisors in Ghana.

3.9 Ethical Considerations.

The requirements of the Helsinki Declaration (World Medical Association, 2013) was applied throughout the study. These include submission of the research proposal to the Noguchi institutional review board for ethical clearance for the research. Ethical principles that were observed throughout the study are outlined below.

Autonomy: Each participant was given the information sheet and informed consent for voluntary participation in the study and the opportunity to ask questions or seek clarification after reading the information sheet. The participants were informed of the right to withdraw from the study at any time and to share only information that they are comfortable to share. The participants were requested to choose the date, (within the time frame for data collection) time and venue for the interview session. The researcher sought for permission to use an audio-recorder and to take field notes from observations. The

information sheet was given to each participant to read at home in a relaxed atmosphere to make an informed decision to participate in the study.

Confidentiality: Participants information were stored under pseudonyms while data was transferred to the researcher's personal computer, which was passworded, in order to limit access to the data to him alone. The interviews were listened to with the aid of headphones to prevent it from being heard by a third party. Consent forms were kept under lock and key until after the write-up of the research. Also, information was reported in such a way that it will not be traced to any particular participant.

Beneficence and non-maleficence: Participants were informed that there are no direct benefits to them by participating in the study and that the indirect benefits of the study included generating data that could be used to review policy statements and guidelines that will help improve MCPDP in Kaduna State. Participants were assured that interview questions were phrased with minimal potential for psychological harm to occur. Also, participants were informed of the right to withhold any information that they were not comfortable in sharing. Each participant was taken through a debriefing session by the researcher after the interview to ease any apprehension that may result from the interview. Participants were assured that the information they will share with the researcher will not be used to jeopardize their job or career in the future.

Justice: Selection of participants was based on inclusion and exclusion criteria which were explained during the recruitment meeting. The participants were treated in the same way, regardless of age, culture, rank or beliefs. The concerns of participants and agreements that were made with them prior to commencement of the interview were treated with respect. The participants' culture and belief system were respected as well. Participants were not interviewed over issues that they do not want divulged.

Risks: Participants were assured that any foreseen risk for participating in the study will be addressed accordingly; for instance participants' apprehension during interview due to fear of the unknown. The participants were assured that the data collected was for research purposes only and would not be used to penalize them.

CHAPTER FOUR

FINDINGS

This chapter presents the findings of the study. The socio-demographic characteristics of the participants are first presented and followed by other findings. Seven major themes and 23 sub-themes are presented with supporting verbatim quotations from the interview transcripts. The real names of the participants are replaced with pseudonyms.

4.1 Socio demographic characteristics of participants.

Appendix I is a table that presents a summary of the socio demographic characteristics of the ten (10) participants for this study. The participants were drawn from all the three (3) MCPDP zones in Kaduna State. The youngest participant was twenty six (26) years old and the oldest was fifty six (56) years old. Six (6) out of the ten (10) participants were males while four (4) were females. The majority (8) of participants were married; two were single. The table also shows that six (6) of the participants worked in the Kaduna State government health facilities, one (1) worked in the local government health facility while two (2) worked in private health facilities. Five (5) participants had two (2) qualifications. Each of them had the general nursing qualification and another qualification in one specialty area. Four (4) participants had a single qualification each; three (3) of them had the general nursing qualification while one (1) had only the basic midwifery qualification. Five (5) of the respondents had a first degree in nursing. Participants' years of post-qualification experience ranged from 3 years to 34 years. Even though one of the participants had retired from active government service he was still practising nursing. Apart from two (2) participants who attended their most recent MCPDP update in 2012 and 2013 respectively, the remaining eight (8) participants attended at different times in 2014.

4.2 Organization of Themes.

Seven (7) major themes emerged from this data with twenty three (23) subthemes. The codes from the transcripts were collated and common issues were grouped into sub-categories. The common issues in each sub-category were further grouped into categories and given a theme that accommodates them all. The categories were then grouped according to their interrelatedness and collapsed into themes. The themes became the major themes (7), while the categories became the sub-themes (23) under each main theme. The details are presented below:

Table 4.1: Major themes and their corresponding sub-themes.

Major Themes	Sub-themes
1. MCPDP programme planning and organization	<ul style="list-style-type: none"> • Rationale for MCPDP • Publicity of MCPDP • Course content of MCPDP • Role of NMCN in MCPDP
2. Factors influencing MCPDP participation	<ul style="list-style-type: none"> • Reasons why nurses attend MCPDP • Positive factors • Negative factors • Other factors
3. Perceptions of MCPDP	<ul style="list-style-type: none"> • Merits of MCPDP • Demerits of MCPDP • Expectations from MCPDP
4. Nurses' attitudes towards MCPDP Programme	<ul style="list-style-type: none"> • Pre and post programme attendance attitudes • Mixed feelings about MCPDP
5. Impact of MCPDP	<ul style="list-style-type: none"> • Effects of programme on nurses • Effects of programme on practice • Effects of programme on patients' care
6. Challenges of MCPDP	<ul style="list-style-type: none"> • Programme accessibility • Funding for MCPDP • Administrative barriers • Shortage of nurses
7. Strategies for improving MCPDP participation	<ul style="list-style-type: none"> • Needs assessment for MCPDP • Sensitization of MCPDP stake holders • Enforcement of regulations.

4.2.1 MCPDP programme planning and organization

This major theme had four (4) sub-themes namely; rationale for MCPDP, publicity of MCPDP, course content of MCPDP and the role of NMCN in MCPDP. The participants scored the organizers of the programme as being above average and commended them on the spread of the programme across the year as well as its timing. Other areas participants appreciated were the venues of the programme particularly its centrality in the various zones. The resource persons were commended on the quality of their presentations. The participants furthermore praised the interactive behaviour of the organizers especially how they related to them, stressing that they were friendly and approachable during the programme. Over all, the planning of the programme and its organization was observed by participants as being well done. In their view, the spread and conduct of the programme in about three (3) to (4) times a year, gives nurses the advantage of making variable choices. If a nurse misses the programme in one zone, there is the chance that the person can attend the programme in another zone at a more convenient time during the year. A participant expressed:

“Well it is usually organized about 3 to 4 times in a year ... nurses I have interacted with, said it is good because if you miss one you will not miss the other because if they are not able to attend in the 1st quota, may be in the 2nd quota they will be able to attend”.

Tijani, age 53 years

The venue for the programme was said to be serene and comfortable by another participant:

“Yes the venue was good...the atmosphere was serene. I will say the organizers actually; tried ... the venue was good and comfortable”.

Ahmed, age 38 years

Participants also commended the organizers of the MCPDP workshops in terms of its planning and organization. Nihad had this to say:

“No, no, no, the organizers were very ok. We had a close relationship with the organizers; it was more of an interactive forum. Where you have questions or clarifications you are allowed to ask. They were accessible to us during the programme”.

Nihad, age 31years

Even though some participants commended the programme planning and organization and scored the organizers above average, they were dissatisfied about the feeding and mentioned it as an area that needed to be improved upon:

“... The organization is good though there are things we need to improve. So far Kaduna State MCPDP stands out of the many states in Nigeria. They were rated I think second or third in the last biennial review train the trainer workshop that was held at Ibadan. Their level of organization earned them that position because things are put in place... They appreciate the efforts of the organizers and what is put in so far”.

Ahmed, age 38yrs

In the same vein, Zira a resource person also commended the MCPDP programme in the state. He said the venue and timely presence of faculty members needed to be improved upon.

“Well we have issues that have to do with the venues... sometimes you hear apologies about some of the resource persons not being present at a time when they are needed most during the programme... So despite the fact that the organization is ok there is room for improvement”.

Zira, age 32 years

4.2.2 Rationale for MCPDP.

The participants advanced reasons for the introduction of the MCPDP for nurses and midwives. A participant said it was meant to enhance their professional competence as nurses and provides an avenue for nurses to update their knowledge in current practices.

“Ok I think the essence is to equip us nurses and also to correct some of our errors within the practice, how we handle things in the hospital settings, how we practice and the new things that research conducted has proven so that we can do away with some obsolete practices”.

Mitchell, age 26 years

Another participant in this study who believed that the introduction of the programme is to standardize the nursing profession expressed:

“Yes for professional development and also to standardize the nursing practice. It is very good for professional development. Personally, I think MCPDP is good for professional development and for improving the nursing practice we render to our patients”.

Tijani, age 53 years

A participant added that the rationale for MCPDP is to provide an avenue for the review of challenges nurses face in practice. The programme brings nurses from different facilities together to share their experiences during the course of practice. MCPDP was also said to be for the purpose of formulating research questions with a view to finding answers to common problems confronting nurses that are attributed to human health dynamics:

... it is meant also to provide a forum where professional nurses come together to revisit what they know and what is new because human beings are dynamic so they change as well. What was obtainable during the Nightingale era is different from what is obtainable now. The way clients appreciated your care in the past may not be the same today. Clients may even demand their rights from you, so you must key into the new changes. This is achieved only when we come together; hear from nurses the current trends of responses of patients in various facilities; that may push us to find out through research recurring problems from the various facilities to be able to render in the long run effective nursing services”.

Ahmed, age 38years

A participant described the rationale for MCPDP as a programme that is uniquely for nurses and run by nurses. To him the MCPDP provided the first opportunity for him to attend a post qualification workshop since graduation from school. He expressed:

“I didn't attend any programme after school so MCPDP was the first contact outside my working place that I made. In other words, I am trying to say that

nurses now have a place, they have somewhere they will go for seminars, seminars that are organized by them and controlled by nurses as well”.

Zuma, age 35 years

4.2.3 Publicity of MCPDP

The participants had different views on the publicity of MCPDP. Some participants commended the organizers but suggested that there is need for improvement. Ahmed observed that the organizers use different means to reach the participants including the use of mass “short message service” (SMS) through the participants’ mobile phones:

“... Even though we cannot have 100% accuracy to some extent the publicity goes round. We use the radio media occasionally but we use mass text messages to reach participants in different health facilities. Also, the facilities are visited to distribute invitation letters, posters and sometimes use that privilege to sensitize nurses. I think it’s a good effort though those that handle the publicity are few and unable to go round the facilities. To ease the task of publicity, there are people in the 3 senatorial zones of the state that are used for mobilizing participants within their zones whenever the programme is held in any of the zones. This is aimed at sensitizing nurses and midwives in each zone who may want to attend the MCPDP at the hosting zone to do so”.

Ahmed, age 38 years.

Another participant Hawa, in the public sector indicated that she heard about the MCPDP while a student in school but never heard about it again until her license expired. This led her to make enquiries about what it takes to renew a license and the MCPDP was mentioned to her as the first step of the requirements for relicensure:

“No, initially I heard it from school which I just... I was not taught about it. I think I also over heard it from colleagues; some mates from school that there is a programme now in nursing which you have to do, that it’s a new training which you have to attend a workshop before your license will be renewed. Then after that I didn’t hear about it again until when I started work and my license got expired, that was when my colleagues told me about it”.

Hawa said she finally attended the MCPDP when she got to know about it in her place of work through a circular and posters posted around her ward and the hospital where she worked:

“Ok before I finally attended the April programme I actually saw the circular. There were also posters all over the hospital. I think they were there before then

but I did not pay attention to them. Also, in December 2013, I think there was one that took place in college of nursing close to us here which I did not attend, but I heard about it and also saw the posters around inviting us for the programme”.

Hawa, age 31 years

Some participants interviewed from the private sector said the publicity for MCPDP was poor in the private health facilities and that when they eventually get to hear about the workshop it was difficult to plan to participate. Ahmadu did not know about the MCPDP programme until he went to renew his license:

“Ok, actually, since we are in the private sector, majority of us did not know about this MCPDP until I went to renew my license; that was sometime in 2012 when I learnt about MCPDP; that it is taking place in the state or in the whole country... that was how I began to ask about it and I participated at least 2 or 3 times since the time I learnt about MCPDP”.

Ahmadu, age 53 years

Nihad from the private sector also spoke about the poor publicity of the MCPDP. She believed her colleagues in other private hospitals might not have heard about it:

“Well, I think the publicity is not encouraging because I got to know about the programme because I was in the environment where the programme was being held. I never heard about this MCPDP until I came to this private health facility. There are some other nurses and some of my colleagues who work with smaller private hospitals, whom I presume or I guess don't know about this programme”.

Nihad, age 31 years

4.2.4 Course content

The participants said that the course content of MCPDP is rich and meets approved standards. The delivery of the courses by resource persons was said to be good. However, all the participants had their reservations about one thing or the other. Zira complained that the resource persons sometimes did not arrive on time to deliver their lectures:

“Ah! Well the presentation is quite good, it’s very ok since they use their projectors and their teaching aids efficiently. To an extent, most of the participants follow and the presentations are always interactive in nature. Most times the resource persons come to interact with the participants and it helps them to really go along with the presentations. To me, the resource persons are doing their best. Just that my actual problem is the issue of having them to come before time; but the presentations are good. They offer a soft copy of all the materials that are presented”.

Zira, age 32 years

According to Nihad the presenters do well except that the timing in terms of when to present what topic was not favourable to them. The participant felt that topics which should be presented early were usually presented at times when participants were tired.

“The organization was ok, but the issue was timing. Most of all the important topics related to nursing practice were presented at times when most of us were exhausted. You will just try to absorb everything but the understanding may not be there”.

Nihad, age 31 years

Another participant shared the same view on the timing of presentations. In her view, certain topics which should be presented at more favourable times such as in the morning were presented in the afternoons:

“...you find out that some vital courses are taught later in the day than morning hours when people are quite fresh and agile for the day. I feel in arrangement of courses to be taught, practical courses should be done later in the day while theory should be done in the morning hours of the day”.

Hawa, age 31 years

Many participants who spoke about the presenters at MCPDP held the same view on the presenters doing well but needing to improve on the aspect of time management. Nihad noted that the time constraints faculty members faced was due to late commencement of the programme:

“... The presenters (faculty) have good presentations but one thing I will like to tell you is that they have time constraints because of the failure to follow the stipulated take off and start off time for the workshop. You are supposed to start 10am ok? But you are not able to start at 10, you start at 10:30am... 30 minutes is gone. So you will see that the presenters are rushing because they don't want to delay people. The people or the participants are so eager because one thing they have not realized for example, you say you are closing at 4pm and you have about 3 topics to cover, you are now at 1pm and you have 3 topics and each topic is 2hours or 1hour 30minutes; they will shout no, no, no, no but they won't remember that the programme did not start on time, and they want to close on time, so the presenters are ok except for the challenge of time”.

Nihad, age 31years

Mitchell said some of the resource persons handled the topics well but others bored them and she added that the qualification of the resource persons was a source of encouragement to them. The qualifications according to her, ranged from Bachelor of Nursing Science (BNSc.) to PhD:

“We had different presenters that came, some of the presenters really dealt well and really passed the information well and some of them succeeded in making us sleep off. Some of them were BNSc. holders. They have gone for their masters; some of them were PhD holders so it was a good challenge for us who had RM/RN qualification only”.

Mitchell, age 26years

On the delivery of the content of the programme, while a participant showed satisfaction with the quality of the resource persons, he stressed that the content of nursing management of disease conditions was being deemphasized:

“I had one problem, the problem was about nursing management to be precise because we are nurses and that is where I think nurses key in very well. They gave a skeletal view of it. Overall I had no problem because they had good presentations”.

Zuma, age 35 years

The practicum was another aspect of the course content the participants complained about during the data collection. Some participants said the practical content of the MCPDP is mostly done in the form of demonstrations instead of going to the clinical site and carrying out the actual practical as expected:

“...we need to do more on that aspect because most times we hardly have time to go to the clinic because of the bulky materials we have to cover. I think it's only a few times we normally go to the actual or the real hospital setting to undertake the clinical experience. Most times it's more like in the form of demonstration and then final presentations by the participants”.

Zira, age 32years

Another participant said that the participants during their programme could not go to the hospital to have real live experiences:

“... The practical sessions didn't really go well because there were issues that came up. We couldn't go to the clinical area, so there was no practical on patients in the ward”.

Mitchell, age 26 years.

4.2.5 Role of NMCN in MCPDP

The MCPDP is a brain child of the NMCN thus the guidelines for its implementation were developed by this regulatory body. Participants felt that the programme which lasts five (5) working days is not enough to cover the content to the understanding of the participants. One of the participants noted:

“If it's possible instead of making it 5 days it should be extended to 10 days or there about, or perhaps 7 or let's say six days because you cannot add Sunday. If it's possible, it should be made two weeks. The aim of this programme is to impart knowledge because most of us have this as one of the ways to get information to update ourselves about medical and nursing practice”.

Nihad, age 31 years

Some participants had dissenting views about the duration of the programme. Ahmadu said that the programme should rather be less than 5 days:

“Well, actually if I had a say I would have compressed it (duration of the programme) to 3 days, complete 3days not 5 days”.

Ahadu, age 53years

The NMCN is responsible for setting the criteria for the selection of resource persons to transfer knowledge to participants and keep them updated. A participant expressed that the selection of resource persons should be by merit and in line with the NMCN guide lines.

She added though that resource persons do their best to give the best to participants:

“Yes what I think or I have observed or what I may want to say here is when topics are shared, the facilitators (organizers) should ensure that the people handling those topics are really people that can deliver it and not based on familiarity with the person that is given the topic to handle, whether or not he knows how to handle it. That is what I have observed otherwise I don't think there are many challenges. The presenters really put in their best to ensure that MCPDP is a success”.

Rochelle, age 46 years

Explaining further, the participant said that the qualifications of the resource persons as outlined in the NMC guidelines spells out that the faculty member must have a first degree and be able to handle the specialty well, drawing from his/her experience in practice:

“... If I remember I think the qualification of the resource persons at a time I think has to be first degree holders so that they can deliver and really deliver what they have been given. Another thing is the specialty of the topic, you find out that a psychiatric nurse is handling a midwifery aspect. I think a midwife who has gone through the training and is practising it with the qualifications should be able to handle that aspect or something like that”.

Rochelle, age 46 years

Also, the NMCN requires that a nurse must earn 6 credit units before relicensure every 3 years. These credit units must specifically be earned at MCPDP update workshops but some of the participants do not seem to understand this. A participant wondered what will happen to the many certificates they get from other professional update courses and whether the credit units of the MCPDP are real or not:

“One other thing the nursing and midwifery council should... I don't know the importance... they just said you should attend and that 1 hour something is calculated; I don't know if they are actually doing it. Because when you know you are learning something it's going to help you build up your morale. We as nurses

sometimes are left to wonder where we are; are we lost? We pile certificates where do we go? I am talking about the value and relevance of certificates”.

Obama, age 56 years.

On regulation of the number of participants on the day for registration, a participant believed that if the 100 maximum number of participants per workshop session is exceeded, the programme may become rowdy leading to distractions.

“There should be a limit to the number of participants per workshop to avoid a rowdy environment. If you are taking one hundred (100) people, the moment somebody comes making one hundred and one (101) don't register him. You can take his/her registration fee against next MCPDP”.

Ahmadu, age 53 years

4.3. Factors influencing MCPDP participation

The factors that influenced the participation of nurses in MCPDP were one of the major themes identified in the findings of this study. Out of these were 4 sub-themes which included reasons why nurses attend MCPDP, positive, negative and other factors. These factors influenced the participation of nurses. The ensuing section shows how the interplay of positive and negative factors direct nurses actions towards the MCPDP. Other factors that were neither positive nor negative also exerted their toll on the nurses' decisions as far as attending MCPDP was concerned.

4.3.1 Reasons why they attend MCPDP

The main reason for attending MCPDP in Kaduna as indicated by the participants in this study was for renewal of their licenses. This remains a policy that has generated so much controversy among nurse participants of the programme. MCPDP was initially resisted meanwhile participation was not a choice, as the NMCN made it compulsory. Here are some expressions from some participants:

"I did the MCPDP because they said it was compulsory and I had needed to renew my license".

Nihad, age 31 years

"...That I cannot renew my license until I attend the MCPDP training programme and have a certificate. That is what I will take to the nursing and midwifery council office and I will get my license renewed".

Hawa, age 31 years

"Yes for now, it is compulsory because as I said initially nurses were not seeing the need to embrace it so it was made compulsory to bring out every nurse to attend".

Rochelle, age 46 years

Other participants indicated that they attended because it was compulsory and that they would not have spent money to attend the programme:

"Yes, because if not for the renewal of license many of us would not have attended. We would not have paid money to attend".

Mitchell, age 26 years

"Yes actually I went there because it is mandatory for you to renew your license. So I felt I should go and do it to renew my license, not really that I wanted going there to add up knowledge, no I only went there because my license was going to expire and without the certificate I won't be able to renew my license".

Mitchell, age 26 years

"Sometimes you hear so many complaints about attaching it to license and most of them I observed are coming just to renew their licenses but all in all it's doing fine and they are participating well"

Zira, age 32 years

This compulsory nature of the programme generated a lot of mixed feelings. There were nurses supporting it on one side and others raising concerns on the other side:

"...actually in the state presently it's compulsory and I think they should still maintain the standard of it being compulsory. If it is not made compulsory people will say there is no need for me to spend my money unnecessarily despite the fact that MCPDP educates and improve my knowledge. We will somehow feel relaxed, that there is no need to go and spend money. You will procrastinate until you don't do it at all".

Rochelle, age 31years.

Zuma supported the idea that the MCPDP should be compulsory but added that nurses should be sponsored for the programme. The participant observed:

“Yes and no. Yes, because it is educative it brings you... it refreshes your knowledge for somebody who understands. No, in the sense that some people are complaining that they are not sponsored, it is not easy for them”.

Zuma, age 35 years

Another participant also felt that the programme should be compulsory but on condition that one should have the liberty to attend the MCPDP in his own specialty area or the area where one is currently practising for its maximum benefits. He believed the participant will be more comfortable spending money to get his preference.

“Personally, yes it should be made compulsory but I feel if it should be made compulsory, it should be more on your area of specialty or where you are practising. You will be enriched more and you will go back and practise it. But when you learn from where you are not practising you may not use it properly so the person who is compelled to do it, when it comes to practice, he will benefit more than learning something that you will not use. I attended the one on midwifery but I don't practise within the midwifery domain”.

Obama, age 56 years

4.3.2 Positive factors.

Among the factors that influenced the nurses' participation in MCPDP were some positive factors. Some participants expressed that although they feel participating in workshops is necessary it should not be strictly MCPDP:

“The compulsion about relicensure is that you must update your knowledge. I attend our annual specialty workshops so MCPDP should not be the only workshop to attend and be updated for relicensure any good workshop you attend keeps you updated it may not be necessarily MCPDP. What is important is that you should be updating your knowledge”.

Obama, age 56 years

A participant said that most nurses, including herself did not feel there was any need to go for MCPDP. She felt MCPDP was just about renewal of license but when she eventually attended the programme, she was compelled to attend more because she found it educative and enriching:

“Actually before my being involved in MCPDP I was actually somehow relaxed or I didn't feel there was the need for me to attend the MCPDP and that is quite common with the nurses in the practical area because I have not heard my colleagues yearn or desire to go for MCPDP. For many it's about getting licenses renewed. Now after the first MCPDP I attended, I wish to attend more of it because it was quite educative. I learnt much about it and it's something I am sure if I have opportunity to attend I will go without hesitation”.

Hawa, age 31 years

For these participants what they learnt, the experiences they had and the package of the programme were positive factors that made them want to continue to attend MCPDP. Specifically, Nihad was encouraged by the package of the programme:

“I saw the programme, I saw the package I saw how enlightening the programme is, there are some things that we were doing before now that we don't know that it's no longer obtainable in recent practice. Without all this type of update courses available, there is no way we would have known that those practices have been abolished”.

Nihad, age 31 years

Another participant said he learnt things that have vividly remained in his mind:

“What I learnt about the administration of cephtriazone and chloramphenicol (parenteral antibiotics) is vividly in my mind. So whatever it is you will learn something new in MCPDP that will motivate you to continue to participate. Like I told you earlier I have attended MCPDP 3 to 4 times since I learnt about it”.

Ahmadu, age 53 years

For Obama, MCPDP provided a platform for him to attend a programme in another specialty while maintaining updates in the workshops organized by the ophthalmic nurses' specialty body:

“The one I attended like I said earlier is midwifery module because there is no ophthalmic module but for my personal use I feel it was nice and I work in the society. I can be challenged anytime, since the community doesn't know the

difference between one specialist nurse and another, they think we know everything. So they can come and confront you with their health problems. Even within your family they expect that you know everything about health and so you can attend to them”.

Obama, age 56 years

4.3.3 Negative factors

Participants' responses showed that the participation in MCPDP programmes could be discouraging considering some challenges that may affect their participation in the programme. The negative factors centre on the readiness of the nurses to get early notices, register and participate in the programme. One of the participants said he learnt of the programme a few weeks to the date of commencement and had to look for money to register and participate in the programme:

“It is discouraging because I learnt of it some few weeks to the time so I had to quickly look for money and register, but my colleagues complained because it comes at a time when they usually don't have money to pay for registration and probably accommodation or whatever. So they may want to attend but when they don't have money and since there is no sponsorship, they have to forfeit it that period”.

Obama, age 56 years

Similarly, the short notice could also result in making it difficult for those who can register but have not made arrangements to leave work for one week to attend the workshop. The only option that participants may have sometimes is to plan to attend the workshop during their off duty periods or annual leave holiday periods or else one attends late and risks losing one's certificate of attendance at the end of the programme:

“...Nursing is a team profession. They have to plan to be either on their annual leave within that time or off duty because it's a one week programme and if you are not off... I remember some of my colleagues that had to go and register their presence at their place of work before they come to the programme, at the end they come late. That made them not to get their certificates after the programme so it was a problem for them and it was something they had grudges about”.

Obama, age 56 years

The duration of the programme, as pointed out by Ahmadu is also a discouraging factor for the elderly and private sector nurses. The participant said the five (5) days is strenuous for the elderly and keeps the private sector participants away from their facility for too long. He had this to say:

"...the nature of our nurses; some are aged. It's really strenuous for them to have a whole week studying on a programme. You will have to consider those in the private sector. Those that have retired years back. You have to allow the level of their understanding, if you compress or give them so much they end up not learning anything, those coming from the private sector. Sometimes you find he is attending a programme but they are calling him that his attention is needed in the office to take one decision or the other, so his mind is divided".

Ahadu, age 53 years

Another participant pointed out to distractions that occur during the programme owing to nurses being on duty at the time of organization of the programme. It is difficult for some participants who have to go for certain duties in the hospital to stay to the end of the programme:

"Yes because I found out that some people actually left before closing time, in fact there are people that were there, they will come in the morning, they are on evening shift they have to go to the ward so they leave during the programme to go and prepare for their duty. It is quite stressful and discourages nurses from attending the programme".

Mitchell, age 26 years

4.3.4 Other factors

These are factors of interest in relation to attending MCPDP. They are neither directly positive nor negative factors. They are largely factors that are more individualistic or within groups that emerge during participating in the MCPDP. A participant observed that the combination of all cadres of nurses in the same programme makes some young nurses uncomfortable:

“I have also come to realize that the younger ones, from interaction do not want it that way. They always feel they are young and current so the older ones that are still thinking of the old methods will be lumped up together but I don't think the separation would meet the learning needs because it is all about interaction”.

Rochelle, age 46 years

One of the participants also noted that the heads of organizations can either be discouraging or encouraging based on certain things they do or say about the programme:

“Heads of organizations have roles to play. That is by encouraging people. When you discourage those who are the lazy type, they will take your discouragement and sit down. So either ways, it will affect participation”.

Ahmadu, age 53 years

Also, for female nurses with young children, a participant observed that this could discourage them from participating owing to family responsibilities and distractions especially when the programme is organized in her locality. The participant noted:

“Like our female counterparts, most of them will have difficulty in attending freely when it is being organized in their own locality because they will have to contend with taking care of the home front; that is the children and other household needs”.

Tijani, age 53 years

Another participant believed that family issues should not constrain participation in update programmes. Zira thinks individual differences exist though, some of which may affect participation.

“If it has to do with professional development, family should not be a hindrance to our professional updates. Although we have individual differences and matrimonial differences... some family problems if not properly handled, may be a hindrance to professional development... nurses should attend to their family needs and responsibilities without letting them hinder their professional responsibilities...marriage is not an obstacle to the attendance of MCPDP, it shouldn't be”.

Zira, age 32 years

4.4 Perceptions of MCPDP

In this section, three (3) sub-themes emerged from the above major theme. These were: Merits of MCPDP, demerits of MCPDP and expectations from MCPDP. The participants' views showed that the MCPDP is a welcome programme in the state and to the profession of nursing. However, there were also mixed feelings from the participants about the programme. While their expectations were met in some aspects, others were yet to be met.

4.4.1 Merits of MCPDP

In this study, participants expressed their views about MCPDP. Among these views were how good or positive the MCPDP programme has been to them and the profession. Hawa expressed how good and commendable the programme is; she appreciated the organizers of the programme and hoped that it will be sustained.

“My view, I will actually say the idea of the MCPDP programme is very good and its initiation is quite commendable. It is quite educative. It has actually brought enlightenment to the nursing profession and the nurses entirely. It is a good one and I hope it will keep on and will actually bring about change to the profession in general... I think the programme is quite on the positive side, actually MCPDP is a good programme I really appreciate the initiators of this programme into the nursing profession it's actually a good one which will bring changes and enlighten nurses more”.

Hawa, age 31 years

Obama also liked the programme and spoke about its benefits but had a few reservations:

“Well it's a good programme. It kind of reawakens one professionally when you attend. The one I attended, in fact I was highly enriched in what I learnt, and only that I have my reservations on some aspects”.

Obama, age 56 years

In relation to the merits of the MCPDP, Zuma commended the organizers and urged them to continue the good work they have started. He described the programme as bringing new

frontiers to nursing, adding that the programme should be sustained as the impact of the programme was gradually being felt:

“Yes, I would say kudos to the organizers of the MCPDP and I pray they continue the good work they have started. It’s actually a forum where new things are learnt where new frontiers are brought to the front. I want to say MCPDP is one of the programmes to be continued and the impact is gradually being felt in the communities, hospitals, so they should continue with the MCPDP”.

Zuma, age 35 years

Rochelle said besides being good, the programme is an avenue to meet experienced people; citing one of those trained for Ebola prevention in Lagos:

“MCPDP is good because you meet a lot of people with experience, different experience like the one I had, the nurse was one of the people that was (during this Ebola case) selected to go to Lagos for training as well as select staff from his hospital that will participate in the fight for Ebola. The programme gave me an opportunity to meet somebody who was part of the current fight in the country so it added to my knowledge”.

Rochelle, age 26 years

Another participant indicated that the programme has been rewarding to Kaduna State, government, the organizers of the programme themselves as well as the participants:

“Well the MCPDP programme in Kaduna state has been very successful and rewarding to the facilitators (organizers), the state government and also the participants who were trained in so many modules...”

Tijani, age 53 years

The programme is such that all nurses can participate in any module irrespective of one’s specialty. A participant opined that MCPDP is now advanced enough to include specialty modules to meet the needs of nurses who desire them:

“No I think the way it had started is ok but having grown up to this level, I think it will be more beneficial if they are shared into specialty fields so that each specialty is treated and those in that specialty will choose to go there because it will benefit them more that way”.

Rochelle, age 26 years

Participants also reported that the programme is beneficial to all categories of nurses since topics such as nursing ethics, nursing research, foundations of nursing and medical and surgical nursing among others, are delivered at the programme. A participant who was an ophthalmic nurse specifically expressed his satisfaction having attended a midwifery MCPDP module. In his view, even though he did not think that the midwifery module will meet his personal needs, he was satisfied with the knowledge gained. The participant however recommended that the learning needs of the individual nurse must be considered in relation to professional development.

4.4.2 Demerits of MCPDP

MCPDP also had its demerits. Participants expressed their views of the demerits of MCPDP. The practice of what one has learnt at MCPDP may not be possible owing to one's current unit of practice. A participant who worked in the labour ward said she learnt about the "nursing process" but was not putting it to practice:

"It depends on where you work; what you were taught in MCPDP you may not have the opportunity of practicing it directly in your unit. But I remember the other colleague called me one time and said I should come let's practice the nursing process we were taught. So for me I don't directly practice the nursing process which I was taught".

Hawa, age 31 years.

The participants also complained that the programme is too loaded to be covered in one week. According to them, the programme lasts from 8am to 5pm. In their view, if the programme is made less loaded, it will be more beneficial. Other participants felt that the timing is normal for the credit units allotted to the programme stressing that it is typical of nursing to have long hours transferring knowledge in the conventional universities and nursing training colleges. A participant noted that the complaints associated with long hours of learning may be due to the fact that nurses have for long not been engaged in rigorous learning sessions such as the one characteristic of the MCPDP:

“The programme is too choked up for a week, you find out that you go by 8am and close sometimes 6 or 5pm. So I feel it's so choked up, if they can reduce the workload for that programme for each workshop, I feel it will be more beneficial”.

Hawa, age 21 years.

Participants had divergent opinions about MCPDP being organized under one umbrella for all specialties. Some felt that the status quo is better, others felt that the programme should provide modules in every specialty. According to participants, the latter status quo is good for a start but suggested that the MCPDP can now develop modules for different specialties. The participants noted that the current use of a single curriculum for all nursing programmes does not meet the learning needs of all nursing specialties.

Participants in this study revealed that nurses also see the MCPDP programme as a burden on them and an avenue to make money from nurses:

“ This very MCPDP programme, it's been seen as a burden on the nurses and most of the nurses are just looking at it that it's a way of earning money and nothing else”.

Zira, age 32 years

Another demerit of the programme is the demand for respect by senior nurses from their subordinates (junior cadre). The participants of this study reported that both cadres of nurses should not be put together to undertake the same workshop. The junior cadres of nurses reported feeling that the senior cadres demand too much respect, an attribute that is believed to be earned and not demanded. The senior cadres on the other hand feel that the junior cadres do not give them the respect due them.

4.4.3 Expectations from MCPDP

With the introduction of the MCPDP and its subsequent implementation, nurses had different perceptions and these gave rise to varied expectations among participants of

MCPDP. The findings of this study captured what nurses expected and whether or not their expectations were met. While the expectations of some nurses who participated in the MCPDP were met, others said their expectations were exceeded beyond measure. For others it was not what they expected. Some participants went to the programme without having any preconceived expectations in their minds. The expressions below cover those whose expectations were exceeded:

“Beyond my expectation. I was thinking it’s the normal nursing issues anything that is being organized by nurses you will see that it’s not tasking, not challenging, not mind blowing only for me to get there and what I met was positively beyond my expectations”.

Nihad, age 31years

Hawa expressed:

“Yeah for the ones I attended, I think it met my needs and will I say it exceeded my expectation. Actually, when I went I was thinking it was going to be all about practical nursing and on getting there research was also taught; its principles and other things. I was thinking it was going to be all about practical nursing and the normal thing they do in the clinical area but I got to understand that it wasn’t what I thought”.

Hawa, age 31 years

The participants who had their expectations met also made comments in that regards:

“Well the quality of the programme met my expectations; the quality of what I thought met my expectations”.

Obama, age 56 years

“...But when it comes to what they are learning, I think they are getting what they expect because at the end of the day, they are happy they feel fulfilled that they have learnt something. So from what they expect to learn, it meets their expectations”.

Rochelle, age 46 years

Zuma added that her expectations were met but that the module was not directly related to her unit of practice:

“I was not disappointed with the modules that were discussed despite the fact that they were not related to where I was directly I was reminded of certain things I had actually forgotten so, I think it met my expectations”.

Zuma, age 32 years.

Also, the participants at the MCPDP who did not have their expectations fully met in relation to practicum and timing expressed:

“...No it did not meet my expectations especially the time frame. I was expecting the training will not be that tedious to the extent that I will get tired and be longing for the time for the programme to just elapse. So I was expecting the time bound between presentation and any other exercise will not be as lengthy as it was because we normally go there in the morning and close in the evening already tired, so it met some and it did not meet some of my expectations.”

Mitchell, age 26 years

Zira mentioned:

“... It hasn't really met all that is expected of it. Most times you see the way they appreciate (evaluate) the programme at the end of it all before the closure. Most problems that we encounter that I observe has to do with issues of accommodation, then their welfare to an extent”.

Zira, age 32 years

4.5. Nurses' attitudes towards MCPDP

The attitudes of nurses, which emerged as a major theme had two (2) sub-themes namely; pre- and post- MCPDP attitude and mixed feelings about MCPDP. Most of the participants were indifferent or had negative attitudes towards the programme before they attended. When they finally attended the programme, there was a change from indifference and negative attitude to that of appreciation and positive attitudes. Those who still had negative attitudes were reportedly in the minority. The nurses whose attitudes changed from negative to positive after attending cited some challenges which if tackled would create more positive attitudes among them.

4.5.1 Pre- and post- MCPDP attitudes

A critical look at the views of the nurses suggest that the nurses had negative attitudes before the workshop/programme and positive attitudes after the programme:

“Actually before my being involved in MCPDP I was actually somehow relaxed or I didn't feel there was the need for me to attend the MCPDP and that is quite common with the nurses in the practical area because I have not heard my colleagues yearn or desire to go for MCPDP. But for me, as a person after the first MCPDP I attended, I wish to attend more of it. I am sure if I have opportunity to attend again I will go without hesitation”. So the attitude before attendance is lukewarm and after attending it is positive”.

Hawa, age 31years

Other participants observed:

“Yes I developed a positive attitude towards the MCPDP after attending the programme. My colleagues felt the same way but the only thing is the monetary aspect of it. That is the only problem that they have. If not after the programme they all said it's good”.

Mitchell, age 26 years

“Yes it is not negative rather it is positive like I told you there are some things the organizers have to do to actually to polish the programme; that is orientation and re orientation”.

Zuma, age 35 years

Although nurses' attitudes were said to change from negative before attending the programme to positive after attending it, some participants in this study described the nurses' attitude as “lukewarm” and others as “average” adding that a definitive conclusion could not be drawn:

“Some lukewarm, some positive a very few number are positive but majority are just lukewarm because it's just a requirement for them to renew their license. The way they tagged it with license is the best if not we nurses don't like anything like workshop or anything that will further our education or things like that. So majority of us are lukewarm while others are having a positive attitude towards it”.

Nihad, age 31 years

Ahmed said:

“No their attitude is... I will rate it as average that is not too positive and not lukewarm because the programme is still young. May be with time most of them will be able to understand the benefits of the MCPDP, but for now it's not up to 5 years but at least people are coming up. May be with time they will be able to understand the importance of it. So we cannot just conclude”.

Ahmed, age 38 years

To some participants in this study, the attitudes of nurses are generally negative towards MCPDP; nurses reportedly attend MCPDP to renew their licenses. Also, the attitude of nurses before and after the MCPDP was said to be positive for nurses who want the standard of nursing raised and negative for those against raising nursing standards. Some nurses have also said that the attitude of nurses towards MCPDP is difficult to say:

“... In two ways for some of them it is positive and for a lot it is negative. That is to say those who are not in support of the standardization of nursing practice; for them the idea is negative but those who want the standard of nursing practice to improve, I can see positivity in their own thinking about MCPDP”.

Tijani, age 53 years.

“You know it is very hard to tell because just like the way I said it before, I feel most of the participants are coming because they want to renew their licenses”.

Zira, age 32 years

4.5.2 Mixed feelings about MCPDP

While the participants of this study appreciated the MCPDP as a highly educative one, they expressed mixed feelings about the mandatory nature of the programme. They thought nurses should be able to go on their own volition and not coerced to do so. They also worry about the sustainability of the programme because if the programme is not mandatory nurses might not go for updates:

“I feel you can still go on your own without any license attachment but everything that has a value you have to give out something to gain it. If participants don't pay, how will the programme be sustained? I feel nurses will be relaxed about it, they will feel it's not a serious programme”.

Hawa, age 31 years

According to Nihad, if the programme had not been held within the hospital environment where she works, it would have been difficult for her and her colleagues to participate. Since five (5) out of seven (7) participated in the programme were from the same ward:

“Yes there was no way I would have been able to do it. Just imagine for instance, in my unit we are like 7 nurses in the ward and you noticed that 5 out of 7 nurses actually participated in the programme; the two left would not have been able to cover the ward”.

Nihad, age 31 years

Many participants worry that although the programme is mandatory; consideration was not given to the challenges that affect participation in the programme. The challenges that hinder the participation are reportedly beyond the control of the nurses and sometimes also beyond the control of the head/senior nurses in the facilities where they work. The difficulties in releasing willing participants who want to sponsor themselves for the MCPD programme due to shortage of staff is a major problem participants of this study reported on.

4. 6 Impact of MCPDP.

The impact of MCPDP is one of the major themes that emerged in this study. The sub-themes from this major theme included: Effects of programme on nurses, effects of programme on nursing practice and effects of programme on patients. The views of the participants of this study were that the impact of the MCPDP on nursing practice has not been measured empirically. The impact of the programme on both nurses and the clients are however, available in the form of anecdotal evidence.

4.6.1 Effects of programme on nurses

The effects of MCPDP on nurses were described as positive. A participant stated that there is no evidence of any study going on to evaluate the effects the programme has had on nurses. Some participants therefore said that there is the need to find out the effects

of the programme in order to serve as a feedback since the programme has been going on for more than 4 years:

“Not really to my knowledge and I think we have not really done anything like that but I think it is very important if after a series of this programme an assessment is carried out to see how much good it has done to our patients? Now I am not too sure there is something like that. I cannot remember discussing it in the meetings we have had. To my knowledge there is no study to measure the impact of MCPDP”.

Rochelle, age 46 years

Another participant shared his view:

“Surely, I don't know for now whether they have, but there is none yet on ground and there is need for it, so that they will find out the feedback. Because just as I have said it's a forum organized so that professionals come and dialogue and find solutions on how to give better care to the clients. So if the programme is not being assessed to find out whether the programme is achieving the aim and objectives of why the MCPDP is being established, that means we will not have a feedback that will help us to adjust so that it will be for the benefit of the nursing profession”.

Ahmed, age 38 years

Zira expressed:

“I have never encountered anyone that has come to assess the impact of MCPDP, I for one have not gone into one and I have not come in contact with any material, or any questionnaire or any data collection that has to do with the impact of this MCPDP on nurses or the administrators in nursing services”.

Zira, age 32 years

The participants further said that although there is no known formal study on the impact of MCPDP on nurses, the benefits are showing owing to the changes they have either observed in themselves or in other nurses. Many participants added that the impact is gradual but steadily taking place and will be seen at all the units with time:

“Well actually not a formal study but from interactions with some of the participants and the resource persons, I can see that it has a great impact on the participants' behaviours to colleagues, to their patients and the general public and in fact even to the profession. So despite the fact that we have not done any formal study, the impact is known. From the changes we are experiencing and the

nursing care people are giving and the awareness of some important precautions especially in rendering care, the impact is known”.

Tijani, age 53 years

Zuma said that he learnt new ways of management of disease conditions and new ways of doing things which reflected in the way he took care of patients:

“Just like I told you earlier it had a big impact on me. It actually reflected in the way we took care of our patients forthwith. I learnt new ways of management of conditions, new ways of doing things, so I think it had a big impact on me as well as my management skills”.

Zuma, age 35 years

Zira, added that that things were reportedly beginning to take shape on the wards. There were reported changes in attitude and approach to clients. Administrators also were noted to have changed:

“Yes, great impact, I meet nurses and they tell me how much things are beginning to take better shape in the hospital. Some have actually told me how their ward managers attended the workshop and they came back with some changes; change in attitude, change in the way they approach their clients and in the way they administer their own managerial functions. So the change has not actually occurred in full but it's a process and they have started implementing it bit by bit in different hospitals, different units and even the administrative positions so the change is coming and people have started feeling the impact of this very MCPDP in their various units”.

Zira, age 32 years

A participant said that unless a study is being carried out, the impact of the programme on nurses cannot be said to be known:

“Yeah they may know some of the impact because of the little interaction they have with the participants but it is not something that you will generalize. Different places different venues different people attended the programme. The people that may attend in northern senatorial zone may be different from the people that attended from the central, as well as the southern senatorial zone, so only a proper sampling will give a conclusive result”.

Ahmed, age 38 years

4.6.2 Effects of programme on practice

The MCPDP, according to the nurses in this study has effects on nursing practice. The participants agreed that the nurse gains new knowledge which should enhance her practice of nursing:

“In the hospital where I work, the few nurses that attended it show a bit of improvement from where they were before and after attending the programme. At least what they learnt has a little bit changed the way they approach issues and the way they see things. They step down knowledge to other nurses because when they see you doing something that is obsolete they will caution; this is how we learn recently at the MCPDP”.

Obama, age 56 years

Tijani added that he observed the effects of a presentation he made at the programme on ward management and prevention of cross infection being practised:

“Yes there is a great improvement because I remember as a facilitator (resource person) there was a time I presented a paper on ward management and prevention of cross infection. When I went to one of the wards and I saw someone practicing and straight away he said ‘let’s do it as we were thought in MCPDP’ that’s an impact really that he is practicing what he was taught in MCPDP”.

Tijani, age 53 years

Zira expressed that from his interaction with nurses on the ward, there is a little bit of change especially in the nurse-patient relationship.

“well in a way it has gone a long way to improve them, with the number of times that I come in contact with nurses on the ward, most times there is a little bit of change in the way they approach their patients and there is a type of facial change that I normally notice when they communicate with their patients when giving their nursing care. Most of the participants that attend that workshop normally have a form of little change, in their attitude and their reception, the way they attend to their clients, the way they talk to them, and nurse- client relationship has really improved to an extent”.

Zira, age 32 years

Participants who reported that they saw the impact of MCPDP on others also shared their experiences. One said it improved her skills in hand washing which she was careless about

before she attended MCPDP. Another said he got the latest management of malaria which was later implemented in his facility for the treatment of patients:

“Yes it improved my practice on the patients. Before the MCPDP, I used to be careless on hand washing. However, during the MCPDP, we had one of the participants who taught us the universal standards of hand washing, so after the programme the way I wash my hands changed”.

Mitchell, age 26 years

“In 2012, during the programme we read straight some documents directly from World Health Organization on the resistance of antimalarials. I went back to meet my medical director and we discussed it. He saw reasons why we should change some things and the result was actually positive, so the impact is there.”

Zuma, age 35 years

For some of the nurses, knowledge gained is not necessarily practised especially when it is not in one's specialty area. Also, participants reported not knowing whether the impact reflected on other colleague nurses except themselves:

“Definitely, I told you I learnt a lot, though not in my specialty area. I have also improved my knowledge on what is actually happening in the maternity ward because formerly I knew little. I learnt about haemorrhage, postnatal haemorrhage and the dangers in it even its prevalence. So if I see I will caution about the dangers even in my community; if I see I will caution”.

Obama, age 56 years

Some participants indicated that the programme had positive impacts on them and their practice but they were not sure of the programme's impact on others:

“I cannot say anything about the impact of MCPDP in terms of other people's practice. I am putting it into my practice for my own self but I cannot say of others”.

Nihad, age 31 years

“Personally I feel the services I offer to them (patients) are better off after the training than before”.

Mitchell, age 26 years

Another participant expressed that the impact of MCPDP on the practice of nursing has seemingly improved but there is a problem assessing the impact on nursing practice owing largely to the shortage of nursing staff on the ward:

“Yes it does, even though we cannot see it significantly because of the shortage of manpower that we have in our facilities but it has. When you find one nurse nursing about thirty something patients, even if they are able to put in their best, with those large numbers, you may not see the significance of the programme”.

Ahmed, age 38 years

4.6.3 Effects of programme on Patients

The effects of MCPDP on patients was one area noted by the respondents of this study. Rochelle said that she has witnessed such instances on the ward:

“Yes, there are many. I can remember there was this case of a patient who came. He had surgery and he had severe pain. What I used to see; I have come across a nurse who had said: this guy is exaggerating this pain, but this time around the patient's pain was alleviated and the nurse demonstrated she appreciated what that patient was going through, especially that it was a child you could see how she appreciated the fact that this child was in pain and she went and did what she could do. So I know it has had impact on the patients”.

Rochelle, age 46 years

Nihad also expressed that she has become more tolerant and explains many things to patients in her practice now, after attending the programme than before:

“I have become more explanatory in my practice to the patient. Unlike before I did not take time to explain to the patient but they won't understand that it's because I have gone to a workshop. They won't know that it's as a result of the impact of a workshop that I care for them. So for me I feel that there is a little improvement that is as a result of some workshop I attended”.

Nihad, age 31years

Some participants in this study said they could not tell whether there was an improvement in patients' care or not post MCPDP as they have not interacted with the patients to elicit that or heard patients make positive comments with respect to the care they receive:

"Yes, actually I didn't interact with the patient, but personally I feel the services I offer to them is better off after the training than before".

Mitchell, age 26 years

Nihad expressed:

"No, no, no I have not had any interaction with patients to elicit any response from that internal improvement that I feel within me"

Nihad, age 31 years

Ahmed observed:

"Well I can't say because I have not met the patients so far to ascertain whether they have felt or noticed some changes or some improvements in the services since I am not based in the clinic..."

Ahmed, age 38 years

4.7 Challenges of MCPDP

The participants of this study reported a number of challenges affecting the participation of MCPDP. This major theme had four (4) sub-themes. The sub-themes were: programme accessibility, funding of MCPDP, administrative barriers and shortage of nurses. These challenges, according to participants of this study hinder participation in MCPDP.

4.7.1 Programme accessibility

Programme accessibility was prominent among the factors that affected participation in MCPDP. Participants in this study cited distance as the main problem affecting participation. The form of distance varied. One type of distance the participants in this study reported was physical distance, in terms of kilometres to and from the venue

of the workshop. In other instances, the venue may not be significantly far from the workplace of the MCPDP participants but because they have to report to duty while attending MCPDP, the distance may not be feasible enough for them to combine work and the workshop. In instances where the MCPDP is held within the facility of the nurse, it becomes easy for them to combine both work and the workshop. Organizing the MCPDP in each hospital facility is not feasible owing to the cost of the programme. According to the facilitators, workshops that have been held in a particular zone within the three (3) zones were not cost effective. Family responsibilities were also said to discourage the participants from travelling far away from their children. Some nurses reportedly created these challenges themselves by waiting for their license to either get close to expiring or to expire before they rush to go for the programme at the next available zone:

“Well, the challenges are many. Some of the challenges we normally see is distance, since we have placed the programme in 3 senatorial zones and so those who have missed the closest MCPDP that is holding closer to them will have to travel to a much further distance to attend and so the issue of leaving one’s primary environment to another strange environment to stay for 5 days is a serious challenge to them”.

Zira, age 35 years

Zuma Said:

“Like for me, personally the issue of decentralizing MCPDP is one of the major problems that we have. Though it is decentralized into three zones yet you notice that some people within the rural area still find it difficult to attend”.

Zuma, age 35years

Rochelle expressed:

“...It should get close as much as possible. I think the facilitators (organizers) have also looked at that for example, taking the programme to Zaria. The challenge the facilitators (organizers) had was that the majority of the participants

there will not even come out to show that they want to participate in the programme. You find out that when you are expecting about 50 participants in such a programme that you have taken home to them, you may just end up with 10 and that will not cover most of the expenses that will be made. I think though the facilitators plan they also face some challenges. For others too, they will wait till it is dine minute to renew their license then they will now follow that programme wherever it will take place thereby making it more distant for themselves”.

Rochelle, age 46years

4.7.2 Funding for MCPDP

The cost of the MCPDP is another major issue participants said affects the participation of MCPDP. The cost of attending MCPDP includes transportation, accommodation and feeding and not just paying the registration fee. The participants felt the cost of MCPDP is high and requires adequate planning if one must prepare to bear the cost. Short notices for MCPDP programmes put the prospective participating nurses under difficult budgetary conditions:

“... You accommodate yourself and most of the time you see people travelling to strange places where they have to pay for accommodation and also pay for the MCPDP. I think the cost of transportation because of the distance is a challenge and may be the money used for the programme is also a challenge. These are the things that make people feel; they don't want to travel down but will have to wait for the programme that will come up around their zone”.

Hawa, age 31 years

Rochelle expressed:

“I already started saying them, the finance that is, for now every nurse sponsors him or herself to undergo the programme”.

Rochelle, age 46years

Mitchell added:

“...Actually there were people that came all the way from Zaria and some from Jos. Let's say Jos is closer to Kafanchan but from Zaria to Kafanchan is long a distance. Some of them said their colleagues wanted to come but the money for registration and also what they will be feeding on at dinner so... distance also affects participation”.

Mitchell, age 26years

Participants in this study said many nurses felt the cost of the programme is high. The registration fee, they reported should be affordable to all cadres of nurses in both public and private sectors. A reduction of the cost of the programme, they maintained will be a good idea to encourage participation:

“Other challenges which I can say are the challenges of finances. Most of the nurses complained of the registration fees and sometimes if they have to go and rent a hotel if the venue is far away; that too is a challenge of finances”.

Tijani, age 53years

Nihad said she sees the MCPDP to be expensive and that it is difficult raising money when the notice about the programme is short:

“Oh, for now I see the MCPDP to be expensive. Some of us are not working in federal government hospitals. They pay them as much as like three (3) times of the salary of some that work in the private hospitals. The time was short for people to raise the money and pay the registration fee; it was not an easy thing raising money for the registration”.

Nihad, age 31years

Zira added:

“Then finances, virtually all the workshops come with this challenge. Some of them feel the money to be paid is too much. Most of them feel the money should not be high if they are going to pay. The amount should just be a meagre amount, since they are going to pay for their licenses”.

Zira, age 32years

A participant stated that self-sponsored programmes are deemed more valuable than government sponsored ones. Participants cautioned that sponsorship of MCPDP should not be handed over to organizations or institutions as this may delay the release of funds for timely and regular implementation of the update programme in Kaduna State. It was found that while some hospitals provide sponsorship for their nursing staff, the public sector in Kaduna State does not do so for its nurses.

“Yeah I have two things to talk about in terms of sponsorship., You know sometimes when you are sponsored you don't value the programme but when you pay yourself, you value it because if you have worked for the money and you pay,

you attach some importance to what you are going for, but if the government pays, you will just say it is the government's money".

Ahmed, age 38years

Zira stated:

"Sponsorship is a good form of motivation for them to attend. It's a very good initiative. Some people are enjoying that sponsorship. But when the programme is fully sponsored by the organization or institution there could be so many challenges and the maintenance of the programme itself, government or institution should take over sponsorship of the programme on condition that release of funds is guaranteed as at when needed. Else, the nurses for now can bear the burden for the mean time".

Zira, age 32years

4.7.3 Administrative barriers

Pertinent to the attendance of MCPDP is the release of nurses by the organization or institutions where they work. Nurse participants in this study complained that though they do not get sponsorship, releasing them to attend the programme on self-sponsorship basis is a problem. Some participants who attended these workshops had to make internal arrangements to commute between the workplace and the programme venues. Superiors and administrators were urged to release their nurses to update their knowledge in order to enhance practice:

"The issue of ... they normally have the challenge of release from their places of work to attend the MCPDP. Hardly are they released for this programme. If we should make it mandatory and a professional development programme then we should take note that it has to do with professional updates so the release should be made readily available to them and if someone should apply to be in attendance, the person should be released".

Zira, age 32years

Some participants shared their sentiments:

"You see, some people complain of how much they will pay, so in this case you are working with the state government and nobody cares to give you anything for that.

In fact, to even release you, because of the acute shortage of nurses is a problem. So these are some of the problems”.

Zuma, age 35years

“Some of us are on morning duty; others on afternoon duty, some of us are even on night duty so you will just come out from duty and join the workshop since it's within the hospital. I was not released and you cannot afford to leave the patients lying while you go for a workshop. They will tell you that whatever you want to do, this ward must be covered. The employers should create more time for us to attend the workshop because when we come back we apply the knowledge on the patients we care for. Also, if they can sponsor us it will be good or even if it is part sponsorship it will be good too”.

Nihad, age 31years

4.7.4 Shortage of nurses.

Many participants expressed their concerns about the major factor that hinders nurses from being released for the programme. Shortage of nursing staff was reported to be the reason. Administrators were said to be handicapped when it comes to the release of nurses. They allow them to commute between the workshop venues and their work places. While some participants were bitter about that, other nurses seem to agree with the administrators:

“Yes there are challenges and the chief among them is the lack of manpower in most of the state government hospitals because programmes like this come up and you find out that the 5 to 6 days of the programme will be very, very tight for some, so they will not be able to attend because of lack of adequate manpower in the hospitals”.

Tijani, age 53years

“...because of the shortage, you are not officially released and you find that the people want to attend so that they meet their update requirements... You find that some hospitals, if everybody would want to attend, will almost be empty so that causes a lot of problems. We in the hierarchy, I mean hierarchy of the nursing profession find it difficult to release a number of nurses otherwise it will mean some departments will have to be closed”.

Obama, age 56years

Rochelle added:

“The other challenge is release, as I said there is shortage of man power. If you are on duty and the programme is going on, it is difficult for you to go and there is not much support in some of our facilities. They refuse to arrange to release those who have not participated in the programme”.

Rochelle, age 46years

The public hospitals are not exempted from the challenge of shortage of nurses. Participants in this study reported that some participants of MCPDP workshop do not have the chance to commute between the hospital and the venue of the programme:

“Yeah because if you take a look at public hospitals, in some hospitals you find that you have only 3 staff nurses in a ward and they run 24 hours shift. When it comes to MCPDP and one of them wants to go, who are they going to leave the patient for? So that will hinder participation not only MCPDP but on furthering their education”.

Ahmadu, age 53years

Ahmed added:

“One of the challenges I see is that because of the shortage of manpower, sometimes for them to leave their facility to attend is becoming more difficult. Some, during the programme, they may be highly engaged, they may not have time to attend because nobody will take over the facility for them to be able to attend. So I think that is one of the problems”.

Ahmed, age 38years

4.8 Strategies for improving participation in MCPDP

This major theme had 3 sub-themes under it. These sub-themes included: needs assessment for MCPDP, sensitization of stakeholders and enforcement of regulations. The MCPDP has been running for some years and the participants have made their evaluation of the programme. They have made suggestions they think will be useful for improving participation in MCPDP. Participants of this study expect that MCPDP should be brought as close as possible to the people as a way of reducing distance to enable more nurses to

participate. Others expect a restructuring of the programme to address challenges that were not envisaged at the inception of MCPDP.

4.8.1 Needs assessment for MCPDP.

This study found from participants that, a rigorous needs assessment or identification of training needs of participants is important for the improvement and sustainability of the MCPDP. The annual planning of schedules for nurses to attend the MCPDP was suggested for organizations to adopt. The need to evaluate the impact of the programme beyond the nurse to the patient was also seen as an effective feedback to make use of. Nurses with specialties also expect modules that will meet their personal and professional needs to be added to the repertoire of modules at MCPDP. Furthermore, designing special modules that will help address some of the challenges administrators are confronted with will enhance their sensitization and release of staff for professional development. The number of participants and timing of the programme were other areas the participants felt needed to be looked into:

“... They will have to plan each year based on the staff they have; who and when to attend the programme. Nurses are expected to attend the programme at least twice in three years, so with good planning and scheduling, I think it will go a long way to ease the challenge of release each year. We need to reassess MCPDP from the beginning, to know how the programme is fairing, so that we can see the areas that need to be reviewed”.

Ahmed, age 38years

Zira expressed:

“We need a very efficient form of MCPDP. I feel they should try to section it so that there could be some modules for those who are in the administrative position, those who are in the clinical area and those who are in the teaching field. We should have some different sections of MCPDP so that we will just go along with our various areas of specialties and even our rank and it will go a long way to help”.

Zira, age 32years

Ahmadu added:

“Actually there is supposed to be some adjustments and amendments in the organizational structure of the MCPDP. The number of participants and the timing are very important. When you have a rowdy environment; you will end up wasting time because when the place is rowdy people will not be attentive. There will be distractions one way or the other. Also, I have the opinion that whoever is going for MCPDP at a stipulated time of the year should register before that date. There should be no registration on the day the programme is starting which tends to delay the time of take-off of the programme. Then there should be a limit to the number of participants per workshop”.

Ahmadu, age 53years

4.8.2 Sensitization of stakeholders of MCPDP

The stakeholders here include the nurses, the nurse leaders, the administrators that direct the affairs of nursing, the training schools and colleges as well as the regulatory body of Nursing and Midwifery. Sensitization, according to the participants involves creating awareness about the importance of the programme. The participants suggested also that the compulsory nature of the programme should be discontinued so that nurses do not only become participants who are there because of relicensure but for knowledge acquisition which the programme hopes will transform the practice of nursing:

“As I said it should not be a compulsory issue rather it should be explained to us to understand its importance because when they say something is compulsory somebody may just attend for attending sake; just to get the certificate but when you willingly go with adequate knowledge and education that this thing is meant to help you even if you are paying its going to help you personally to fully participate”.

Obama, age 56years

Ahmadu said:

“That attachment to license is what is making people to learn. We should have an atmosphere whereby you enlighten people. It's not that attachment to license that is needed for them to go for that programme, because majority go for renewal”.

Ahmadu, age 53 years

Zira added:

“If we are able to capture those at the top and make them see reasons why the nurses should attend, it will go a long way to help them hasten up to release nurses

and they can programme it in such a way that those who are going for MCPDP will not be placed on duty so if only they have been keyed into it and they accept it fully as a professional development programme it will go a long way to hasten up the issue and then erase the issue of release or failure to release participants for the workshop so they have very mighty work to do as administrators to be releasing these participants for the workshop”.

Zira, age 32years

4.8.3 Enforcement of regulation

Participants in this study reported that the majority of nurses attend MCPDP because they want to renew their licenses. They reported that it is possible nurses do not attend MCPDP to update knowledge. Participants said enforcement of the provision of professional standards, which requires a nurse to have current knowledge and skills, is not necessarily achieved by making MCPDP compulsory. However, they believed that it will help in making nurses who are resistant to updates attend since the initial attendance may trigger positive attitudes towards the programme. Participants suggested that the regulatory body of Nursing and Midwifery in Nigeria should ensure that there is wide sensitization of nurses about the need for MCPDP. Also, the relevant laws that are attached to relicensure should be enforced. The participants said doing so will make participation more effective. A participant in this study said that yearly renewal of licenses can be done as against the 3 – year option which is now being done. The participant added that deduction of MCPDP registration fee from source as it applies to the deduction of monthly union dues can improve compliance to the programme. Another participant suggested that the regulatory body should consider the different financial capacities of nurses working in various organizations and direct the implementation committees to reduce the registration fee:

“I come to realize that many people actually attend MCPDP because they want to renew their license since Nursing and Midwifery Council of Nigeria made it compulsory to have MCPDP certificate for renewal ...they just go for the sake of

renewal... There is the need for adequate publicity regarding the importance of the MCPDP. It should be well explained to nurses”.

Zuma, age 35 years

Ahmadu said:

“Eighty (80) out of hundred (100) percent of people are there because their license is expired. Updates in nursing are compulsory by law, so it can be made compulsory once in a year, once you know you want to practice nursing. But sensitization by going through all avenues that you think are needed to sensitize people is necessary to achieve that”.

Ahmadu, age 53 years

Nihad expressed:

“I will ask you to tell the Registrar to extend the hours please. The cost should also be reduced because there are those who will not complain about the cost but then some of us in the private sector are not finding it easy, if we really want nursing to grow we need to take every other person into consideration”.

Nihad, age 31 years

In summary, this chapter presented the findings of this study and laid the foundation for further discussion in the next chapter in relation to the literature reviewed earlier. The chapter presented seven (7) major themes and 23 sub-themes.

Participants reported being satisfied with the organisation and planning of MCPDP as they rated the organisers of the programme above average. The rationale for MCPDP was also reported to be for the purpose of maintaining competence and skills. They stressed the need for improved publicity and sensitization about the programme.

Relicensure was the major factor that influenced participants to attend MCPDP. Knowledge acquired at the programme was reported to encourage participation while some negative factors such as late publicity discouraged nurses from participation.

Participants reported good perceptions about the MCPDP with a few reservations. They stated that the programme has its merits such as bringing changes in nursing in Kaduna State and demerits such as relevance of course to participants as it relates to their practice areas. Most expectations were met except in the aspect of practicum where improvement was said to be needed.

The attitudes of nurses before participating in the MCPDP were said to be negative. These attitudes however reportedly altered to become positive after participating in the workshop. Some mixed feelings, including the mandatory nature of the programme, its cost implications and some dividends gained were expressed by the participants. They suggested alternative means to be used to sustain the programme.

The participants reported that although the impact of the programme was not yet known through empirical studies, it could be said that the impact is positive among nurses in practice. Notably, some participants reported observed changes in their practice of nursing, post MCPDP.

Participants in this study shared concerns about MCPDP programme including accessibility, especially distance from their work places or homes to venues of the programme, lack of funding and administrative barriers which prevents them from being released for the programme. Shortage of nurses was reported to be a major reason responsible for the administrative barriers confronting nurses in Kaduna State.

Strategies for improvement and mitigating the challenges of MCPDP were suggested by participants of this study. A needs assessment for nurses before developing the content of the programme was suggested and provision of specialty modules for specialty groups were seen to be vital to improve the programme. Sensitization of all

programme stakeholders and enforcement of the regulations guiding nursing practice were suggested to help improve MCPDP.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter presents a discussion of the findings in relation to literature reviewed. The aim of the study was to elicit nurses' perceptions about MCPDP. The specific objectives were to:

- Identify how registered nurses in Kaduna State view mandatory continuing professional development programme.
- Determine nurses' view on the impact of the programme on quality of nursing care in Kaduna state.
- Determine the attitudes of nurses towards the MCPDP programme in Kaduna State.
- Identify barriers to mandatory continuing professional development programme experienced by registered nurses in Kaduna State.

The discussion is based on the major themes and sub-themes presented in the previous chapter and the objectives the study set out to achieve. The discussion initially presents the key findings of the study, relates them to previous related literature and finally contextualises the findings within the body of nursing knowledge.

5.1 Socio demographic characteristics of participants

The characteristics of the participants of this study suggest there were more male than female participants. Since nursing is a female- dominated profession, it was expected that females would outnumber the males but this was not the case. This occurrence could be attributed to the sampling method. The participants were drawn from the Public (federal, state and local government) health facilities and private health facilities. The

participants worked in urban and rural based health facilities. Also, the retirees were represented in this study. The findings show that the distribution of participants in this study covered all the MCPD programmes that held from 2011 – 2014. The demographic characteristics also suggest that there is a mixture of both young and old nurses with varied years of experiences that attend MCPDP.

5.2 MCPDP programme planning and organization

The participants of this study said the organization of MCPDP was overall above average. This finding agrees with a study in which Lesotho nursing council developed a successful national CPD programme in 2010 (Moetsana-Poka et al., 2014). The participants of this study also described the conduct of the organizers as friendly and approachable but noted that there were areas that needed to be improved upon. This finding also agrees with the recommendation of Volunteers overcoming poverty (2013), that in many sub-Saharan African countries, there is a need to further develop CPD models and establish legal frameworks, policies and structures to support CPD. Considering the fact that participants were happy with the organisers, there is the likelihood that the areas the participants suggested needed to be improved upon were not within the mandate of the programme organizer to address. There is a need to further evaluate the areas needing improvement and direct them to the appropriate authorities to solve. Efforts should be made to address those grey areas within the purview of the organizers.

Rationale for MCPDP

Participants in this study said the rationale for MCPDP is professional development and standardization of nursing practice as it relates to the changing demands of patients and the dynamics of health needs. This finding concurs with that of American Nurses

Association, (2013; Lucy et al., (2012) and Xiao, (2010) that MCPDP serves as a means to assure the public in various states of the continuing competency for practice of the professional nurse. As one participant in the study noted, the rationale for MCPDP is to offer an opportunity for nurses to attend a post qualification training which is uniquely organised for nurses and by nurses. This signifies that regulatory bodies (NMCN) and nurses together recognise the need to protect public interest as far as the practice of nursing is concerned. Nursing care is dynamic, new trends emerge all the time and updates for nurses is pivotal to make them knowledgeable concerning recent advances in the discipline. It is thus expedient that there is a platform for nurses to update what they know and to have the opportunity to use evidence based practice.

Many patients the world over, seek value for their monies worth. They expect high quality nursing and medical care from health professionals. A continuing educational programme for nurses would help inform, equip and update nurses which may lead to effectiveness and efficiency in their practice. Some of the dividends or benefits that may be derived from MCPDP may be transformation of nurses based on what they are taught at these programmes.

Publicity of MCPDP

The views of participants differed on the publicity of MCPDP in Kaduna State. Some were of the view that although the publicity is not one hundred percent (100 %), much effort is put in to publicise the programme each time it is scheduled to take place. The methods used for publicising the programme included SMS sent to participants, facility visits by the publicity committee to deliver invitation letters and posters about the programme, radio messages and from sources other than the organizers of the programme such as when nurses go for relicensure at the NMCN office or ask colleagues how to go

about relicensure. It was found that the private health facilities were usually neglected when it comes to publicising MCPDP. The methods reportedly adopted for publicising the programme seemed good thus the complaints about poor publicity of the programme could either mean that the methods were not effectively utilized or that there was a gap in their implementation. The private sector was either not represented in the state implementation committee or there was no effective mechanism to reach nurses in the private sector. There was paucity of literature on this finding as the researcher could not access any literature in which publicity of MCPDP was a challenge. This may mean that publicity is not a common problem associated with the organisation of MCPDP globally. The only study in Nigeria (Nsemo et al., 2013) reviewed did not report publicity as a challenge for MCPDP meaning it could be a problem peculiar to Kaduna State. It is not certain whether the geographical topography, large land mass and nature of the distribution of health care facilities in the state could explain this challenge posed by publicity of the programme.

Course content

The course content and its delivery were applauded by the participants of this study. The academic qualifications of faculty members were adjudged to be good with the lowest qualification being a first degree in nursing. This finding contrasts the findings of previous studies where the relevance of content was questioned by the participants. In their view, MCPDP requires a framework that allows nurses to express their choices of topics for CPD (Gould et al., 2007; Govranos & Newton, 2014; Lucy et al., 2012; Thomas, 2012). This contrast could be due to the fact that the CPD in Australia is in its early stages since it was only introduced in 2010. Awareness of the CPD could be a possible reason for the challenges about the course content in Australia.

Participants of this study however, noted some reservations about the delivery of courses. These included the late arrival of faculty members, keeping to the arrangement and flow of the topics to be presented during the programme, time available for the faculty to make their presentations and poor presentation skills on the part of some faculty members. This means that participants in this study had some problems with the delivery of courses at MCPDP. This finding correlates with some UK based studies which reported that the method of delivery of courses were heavily criticised. According to the authors, the delivery method did not consider what was to be taught (Drey et al., 2009; Gould et al., 2007). The variation in the findings of the two studies may be because of cultural differences; the modus operandi of the programme in UK may differ from that of Kaduna state. The late arrival of faculty members may have been responsible for the alteration in the flow of topics presented at the programme. When it is time for a particular topic to be presented and the faculty member is absent or yet to arrive, another presentation scheduled to be presented later may be presented instead, especially if the faculty member who is to take that later presentation is within reach. Also, if the programme begins late as reported in some cases by the participants, the organizers of the programme reduce the time allotted to a faculty member in order to make up for the schedules of the day. This results in presentations being done hurriedly giving rise to the complaints from the participants.

Presentations on nursing management of patients' disease conditions were also reported to be diminishing; emphasis was rather laid on the medical/surgical management of the conditions. This was not in the interest of the participating nurses since as nurses, the focus should be on 'nursing care' and not medical care.

The practicum/clinical aspect of the programme were reported to be insufficient. This finding is in tandem with the findings of Gould et al. (2007), which showed that content was not sufficiently related to practice. This indicates that the challenges associated with

practicum are not peculiar to Kaduna state but also affects high income countries. In terms of context, there may be differences between the high income and low income countries. Low income countries may have additional challenges such as inadequate logistics, equipment and experts in the field to help boost up the nursing practicum.

Role of NMCN in MCPDP

As a regulatory body mandated to regulate nursing education and practice, the NMCN required 5 days each for each of the 3 credits required to make up the 6 credits required for relicensure. Many participants in this study suggested an extension of the duration of the programme from 5 to 7 or 10 days in order for the programme to achieve its aim of imparting knowledge. However, a few participants advocated a reduction in the duration of the programme from 5 days to 3 days. The reviewed literature did not emphasize days but hours and number of credit units. Malaysian nurses' board made continuing education mandatory and every year, nurses were required to participate in a minimum number of hours of education and training. In USA, 20 contact hours are required by the Texas board of examiners, while the Australian health practitioner regulatory agency required every health practitioner, including nurses to earn 30 points before relicensure. In China, teaching rounds, seminars, academic meetings and case discussions during CPD last 5 days or less (Chong et al., 2011; Ni et al., 2014; Sovie, 2011; Volunteers overcoming poverty, 2013). These variations may be linked to the modus operandi of the MCPDP. In these countries, MCPDP is run by accredited bodies and the manner in which one earns the hours or credit units is based on one's convenience and specialty. In Nigeria, the MCPDP is such that the credit units a nurse can earn is a minimum of 3 in 5 days. Earning 6 credit units will require 10 days at the MCPDP training. Participants seemed not to understand what the credit unit system means. The majority of participants were products of nursing schools whose training protocols do not actually use the credit units system.

It is not certain whether the running of MCPDP for 5 continuous days promote learning among the nurses. Possible reasons why some nurses advocated an increase in the number of days of the programme may be due to the genuine desire to learn or to take a break from

work related stress especially for nurses in the public sector. On the other hand, the desire not to stay away from work for long, especially for those in the private sector, may be reasons for suggesting the reduction in the days for the workshop. Old age, family roles and fatigue were also strong differentials for the desire to increase or reduce the workshop days among some participants.

5.3 Factors influencing MCPDP participation

The factors that influence nurses' participation in MCPDP were found to be either negative or positive. There were some factors that were neutral. These factors are vital to the success or failure of MCPDP. The programme was reported by the participants in this study to be a success in Kaduna State despite the influencing factors. According to literature MCPDP failed in China in 1996 owing to non-realistic standards (Xiao, 2010). This is not the case in Kaduna State, Nigeria.

Reasons why nurses attend MCPDP

Participants in this study reported that the main reasons why they attend MCPDP is for purposes of relicensure. This policy of coercion generated much controversy among nurse participants of the programme and there used to be resistance to participate in the programme. Participation in the programme soon became compulsory as nurses who attempted to renew their licenses without the MCPDP were refused relicensure. Confronted with such reality, nurses were reported to start participating in the programme in order to renew their licenses. There is a dearth of literature on MCPDP studies and none of the few studies reported nurses participating in the programme because it is compulsory, however some studies reported that MCPDP was being attended by nurses to keep their jobs (Chong et al., 2011; Drey et al., 2009; James & Francis, 2011). This

finding points to the possibility of nurses in Kaduna State also attending MCPDP in order to satisfy relicensure requirements rather than for the purpose of knowledge acquisition. In situations where update programmes are attended because it is mandatory, some authors have posited that this affect knowledge and practice.

Many nurses who participated in this study suggested that the compulsory nature of MCPDP should be maintained but some said it is better to make participation voluntary suggesting the creation of awareness and sensitization as means of encouraging nurses to participate. This mix of opinions is in line with the findings of Chong et al. (2011), who noted that participation of nurses at a workshop was not affected despite being made compulsory amidst complaints of hindering factors. But James and Francis (2011), suggested that making MCPDP voluntary is recommended for attaining its goals. Waddell (2001), supported this assertion when he found that up to 75% attendance was recorded in voluntary CPD in response to proposals made by the Pew Commission Taskforce on Health Care Workforce Regulation and the National Council of State Boards of Nursing on how to assess continued competence using mandatory continuing professional education. The 25% who failed to attend MCPDP, he reported were those who were resistant to change in the skills they have and were not ready to lose them and learn new skills. Similarly, Eustace, (2001) found in Mississippi that attendance had increased with MCPDP being made compulsory but only one state reported decrease in disciplinary action on substandard nursing care.

The compulsory nature of CPD in Nigeria may or may not impact on the standard of care. Nurses have however reported in this study of gradual positive changes observed among nurse practitioners. The practice environment, qualifications and orientation of nurses in Mississippi may not be the same given that Nigeria is a low income country.

Participants in this study opined that MCPDP should remain compulsory to enhance participation and updates for nurses.

Positive factors

Positive factors motivate nurses to participate in MCPDP. Participants reported that the mandatory nature of updates motivates them to participate in the update programmes. Before the introduction of MCPDP, nurses attended update programmes in the various specialties. After the introduction of MCPDP, the various specialties update programmes have not stopped. Participants therefore feel that the update requirement for relicensure should not be strictly MCPDP. This observation is in line with the finding of Nsemo et al. (2013), which outlined that other update programmes are not recognised as updates since there are no credit units attached to their certificates and therefore not accepted for relicensure. The argument that other update courses should be accepted for updates is valid, however the NMCN has directed that all specialties who want their update programmes allocated credit units should submit their training modules for evaluation by the central committee of NMCN on MCPDP (Garba, 2011). The psychiatric and midwifery training modules having complied with the directive have thus been approved and are now being used as update CPD acceptable for relicensure. This initiative is a laudable idea as it will ensure standards in update programmes. Some participants said that they attended MCPDP for relicensure but after the first experience, they were encouraged to attend more programmes. This means that the first experience became a motivation for them not only to support the compulsory programme but also to attend more CPD programmes.

Participants also reported that the programme they attended gave them the opportunity to gain knowledge in specialties. Experiences such as this could be an eye opener for general nurse practitioners to make informed choices of specialty areas in nursing.

Negative factors

These are factors that discourage participants from participating in MCPDP programmes. Participants noted that early notices help them to get their registration fees ready for participation in the programme. They also reported that even if nurses get prepared to bear the cost of the programme, the early notices are important to help them make arrangements from work to attend the programme. In the event that obtaining a release from work to attend the programme is not feasible, early notices would allow nurses ample time to arrange their off duty periods to fall within the update programme schedule. Nurses were not comfortable with situations where they had to commute between work and the venues for the update programmes. This is because full attendance is required to earn the certificate for relicensure. Some nurses were reported not to have obtained certificates owing to poor attendance; they had to shuttle between work and the CPD programme. This finding is consistent with the findings of other authors that the wards could be too busy for the nurse to run between the venue of the programme and the ward (Chong et al., 2011; Gould et al., 2007; Ni et al., 2014; Nsemo et al., 2013; Yfantis et al., 2010). In view of the cost of the programme and other challenges, it is necessary that early notices be given to nurses to enable them plan for maximum rather than irregular participation in the programme.

Other factors

These are factors that were neither positive nor negative. A participant observed that the combination of all cadres of nurses in the same programme make some young nurses uncomfortable. This discomfort might be due to the respect participants said the senior nurses demand from them. Heads of organisations in some cases were reported to discourage nurses from participating in the programme. This agrees with the findings of

Pool, Poel, & Cate (2013), which shared that age related differences in CPD exist and different phases in life may require different approaches to teaching and learning. Participants in the study of Pool et al. (2013), however said there are experiences to share between young and older nurses except that there is too much formalisation at the training venue. In Kaduna State, the use of computers seems to create a gap between the young and old nurses. Complaints against the use of soft copy workshop materials came from the older nurses who usually prefer hard copies. Faculty members also have to consider the adult learning principles in their presentations. A feeling that the old nurses slow down the learning process among the young ones cannot be ruled out hence the problem of combining old and young nurses in one programme. For some nurses, this combination discourages them from participating while for others, the shared experience motivates participation. Family demands discourage participation according to some participants in this study; this finding conforms with that of Gould et al. (2007), that domestic responsibilities also affect participation at MCPDP. Other participants said family responsibilities should not be a discouragement to participation and that nurses should be able to combine their professional roles and family obligations without letting any of these areas suffer unduly.

5.4 Perceptions of MCPDP

The perceptions of participants concerning MCPDP were also looked at in terms of its merits, demerits as well as expectations of the programme. Participants' responses showed that they were generally happy that the programme was initiated to update nurses. They expressed areas of dissatisfaction and requested those areas to be addressed. The participants also stated their expectations that were met by the programme as well as those

that were yet to be met. The overall perception of the programme however, was good; MCPDP was considered a welcome development for the nursing profession.

Merits of MCPDP

Participants perceived the programme as good, beneficial and positive drive for them as well as the nursing profession. The initiators and organisers of the programme were commended and it is hoped that the programme will be sustained. This finding is in line with UK based studies which reported that nurses perceived MCPDP as important to bridge the gap between theory and practice as well as enhancing career development (Drey et al., 2009; Gould et al., 2007). The current study's findings also agreed with studies in Canada, China, Las Vegas, Greece, Scotland and a solitary study in Nigeria which shared that MCPDP is important, necessary and invaluable for practice (Baxter et al., 2013; Landers et al., 2010; Ni et al., 2014; Stout, 2013; Yfantis et al., 2010). The findings of this study however, disagreed with findings of some studies in Australia, where nurses negatively described the programme as being solely in the form of workshops and conferences adding that the role of CPD was not clearly defined. The Australian nurses further said that the MCPDP programme does not allow nurses to express their choices in topics for CPD. The studies in Australia also viewed the MCPDP as a requirement for relicensure (Gould et al., 2007; Govranos & Newton, 2014; Lucy et al., 2012; Thomas, 2012). The different views of MCPDP that on one hand, it is a good programme and on another, it is not clearly defined and yet another, that it bridges gap between theory and practice in different countries suggest that although the intention for introducing the programme was to maintain competence, the mode of implementation in different setting might have created wrong notions about the programme. It is important that in places where the programme is viewed as positive, efforts should be made to

maintain and sustain it, while in areas where negative notions are held, efforts should be made to address the concerns of nurses.

Participants in this study also viewed MCPDP as an avenue to meet experienced nurses and exchange various experiences gathered over time in the profession of nursing. Participants suggested that the programme should cover topics that are beneficial to all nurses irrespective of specialty. They also suggested that modules for specialist groups in nursing should be added. This appears to be a laudable suggestion which could be considered if it is plausible.

5.5 Demerits of MCPDP

Participants also expressed their views on the demerits of MCPDP. Participants indicted that when an update programme is taken in an area where one does not practise, the aim of the update programme is defeated. A participant who practises in the labour unit said she learnt about the nursing process but was not putting it to practice. This finding is in line with that of Gould et al. (2007), which shared that the relevance of the content of programmes is sometimes questionable. There is sometimes no link between CPD and the ward context which makes it difficult to achieve improved patient outcomes and to maintain competency and currency. The MCPDP programme in Kaduna State as structured by the NMCN has topics that are of benefit to all nurses. This however does not necessarily meet the specialty needs of specialist groups who need to maintain currency and competency in practice.

Participants also noted that the programme is loaded and strenuous; others felt that the timing is appropriate for the credit units allotted. This feeling among the participants may be due to the fact that they are not used to long hours of teaching and learning.

Participants also identified the practice of having one programme as an umbrella for all cadres of nursing and specialist groups as a demerit of MCPDP. This finding is in keeping with that of Gould et al. (2007), which found that the learning needs of junior and more senior nurses are not the same and that novice nurses require more opportunities to develop and refine their skills. Once competence had been achieved, the need to keep abreast with new developments is associated with update programmes and increasing length of practice.

Expectations from MCPDP

While the expectations of some nurses who participated in the MCPDP were met, others said their expectations were exceeded. There were also participants whose expectations were not met in some aspects of the programme and others went to the programme with no expectations.

Some participants in this study said their expectations were not only met but exceeded. Others reported that their expectations were met even though the knowledge gained was not relevant to their current area of practice. This finding corroborates with the finding of Stout (2013), in Scotland where the nurses expressed that their expectations were met via face to face and e-learning. This study's finding however, is in conflict with the findings of Baxter et al. (2013), and Nsemo et al. (2013), in Canada and Nigeria respectively, where participants perceived the programme as not based on their learning needs. The Nigerian study further reported that not enough time was given for questions. The participants of the study in Scotland were said to have highly motivated facilitators who taught after the programme on the wards as a sustained guidance to learning. The case was not the same for the Canadian and Nigerian studies, hence a cue could be taken from the Scottish study's example to ensure participants' satisfaction.

The participants in this study who did not have their expectations fully met said it was in the aspects of the practicum. They were not as satisfied with the clinical aspects of the programme as in the theoretical aspects. This finding also agreed with that of Smith (2004), and Nsemo et al. (2013), where limited time was given for practical demonstration. Smith (2004), further found that the MCPDP appeared to contribute solely to hours of attendance at CPD activities that did not have significant relevance to areas of participants' employment or interest. This indicates that more efforts need to be put in to address participants' expectations with respect to practical demonstration.

The category of participants who went to the programme without any expectations said they were not disappointed with the package of the programme.

5.6 Nurses attitudes towards MCPDP

The attitudes nurses display is vital to MCPDP participation. The attitudes of nurses before and after participating in MCPDP and the mixed feelings associated with the programme is discussed here. Nurses' attitudes were positive, negative and mixed.

Pre- and post- MCPDP attitudes

The majority of the participants reported that nurses had negative attitudes before attending the programme but developed positive attitudes after going through it. The finding agrees with that of previous studies that nurses have a positive attitude towards MCPDP especially when motivated (Altmann, 2008; Fahey & Monaghan, 2005; Hayajneh, 2009; Jaradeh & Hamdeh, 2010; Naicker, 2006; Timmins, 2008). The participants suggested that sensitization will go a long way in changing nurses' impressions about MCPDP. From the findings of this study, it could be inferred that nurses did not have enough sensitization on the aim of the programme before they attended it. The cost of the programme was probably a source of concern because MCPDP

is a new programme and nurses are not used to spending on personal professional development in Kaduna State. However, when they reluctantly come to get certificates for the renewal of their licenses, they become sensitized about the programme and develop interest in it.

Mixed feelings about MCPDP

Participants in this study expressed some mixed feelings about the mandatory nature of the programme. They felt that nurses should be able to go on their own for the updates. In a related finding, Stout (2013), reported that nurses in Scotland said they will still go for CPD updates whether it is made mandatory or not. This was because nurses and facilitators were highly motivated; the facilitators were highly skilled and continued to provide skilled support beyond the workshop/seminar time. In studies (Chong et al., 2011; Gould et al., 2007; Nsemo et al., 2013), where nurses expressed dissatisfaction with CPD, nurses' motivation was likely low and the facilitators were said to be unskilled. In a UK study, Gould et al. (2007), reported that heavy investments were made by the authorities to provide for nurses CPD, but nurses were dissatisfied with the programme and so not much value was reported to be added to the practice of nursing.

Participants also reported that nurses who were willing to participate in the programme were sometimes handicapped by challenges which were beyond the capacity of the immediate superiors to handle. A participant reported being able to attend the programme because it was organized within her practice environment. The nurses wondered whether the regulatory body and the organizers of the CPD were aware of their challenges and demanded full (100%) participation before certificates are awarded to participants who go through a lot to attend the programme.

5.7 Impact of MCPDP

The impact of MCPDP refers to the effect it has on the nurse, the practice of nursing and patients as well. The perceptions of the participants of this study were that the impact of the MCPDP has not been measured empirically but that the impact of the programme on both nurses and clients is observable in actions and by verbalisation.

Effects of programme on nurses

Participants described the effects of MCPDP on nurses as positive. They however noted that there is no on-going study to determine the impact and suggested that there is the need for a study to ascertain the impact of the programme in order to get feedback that will be used to improve the programme. This finding is in contrast with the findings of James and Francis (2011), which reported that litigation seemed to have increased with the making of MCPDP as a requirement for relicensure. According to the authors the prognosis of MCPDP is yet to be made clear. What is clear now is the fact that CPD is a requirement by the nursing profession for nurses to maintain competence in their practice and a consequential guarantee that the public will receive the best possible health outcomes. The finding that no study has yet been done to evaluate the impact of CPD however, agreed with findings of Govranos and Newton (2014), James and Francis (2011), Lucy et al. (2012) and Nsemo et al. (2013), that it is difficult to know the impact of the programme on the quality of care of patients since there is no monitoring to ensure that knowledge gained is used in practice.

Participants added that the positive effects of MCPDP on patients care can only be ascertained when a study is carried out to determine it. This underscores the need to initiate studies that will evaluate the impact of MCPDP on nurses and their care in Kaduna state.

Effects of programme on practice

Participants said that the programme has enhanced nursing practice going by what they observed. Some of them said once knowledge is gained, it translates into better practice. This is however, debatable. To buttress this point, participants cited how participating in the programme has led to better practice on their part. This finding contrasts with those of previous studies which found that there is no empirical evidence to show that MCPDP improves clinical skills and professional practice (Lucy et al., 2012; Thomas, 2012).

Some participants differed on the subject that when knowledge gained is not relevant to one's area of practice then there is no way practice can be enhanced. Although the researcher did not find any literature related to this finding, it is known that practice results in proficiency, so when one learns something he would not use, the likelihood of losing that skill is high.

The effects of MCPDP on practice may not also be recognizable owing to the shortage of staff which increases the nurses' workload. This agrees with the finding that nurse staffing shortage increased workload, and unstable nursing unit environments were linked to negative patient outcomes including falls and medication errors on medical/surgical units (Duffield et al., 2011).

Effects of programme on Patients

Although participants did not interact with patients to elicit their perception on the care given to them after MCPDP participation, some reported that they felt the improvement within them in the way they cared for patients after undertaking the MCPDP. Others reported they observed changes as nurses who have undergone MCPDP rendered care to patients. The findings on the impact of care on patients seemingly

contrast with previous studies which reported that there are no improvements in patients' outcomes. (James & Francis, 2011; Lucy et al., 2012).

5.8 Challenges of MCPDP

The challenges confronting the MCPDP were viewed under four sub-themes. These included: programme accessibility, funding of MCPDP, administrative barriers and shortage of nurses. These challenges affected nurses' participation in MCPDP.

Programme accessibility

Participants reported that programme accessibility is the main challenge confronting nurses regarding participating in update programmes. Distance, was mentioned as one of the challenges and was said to confront them in different ways. Distance from ones' place of work/residence to the venue of the programme was a problem for many. This finding concurs with the finding of some authors which revealed that distance is a problem to attending MCPDP among nurses in the rural area; Update programmes are reportedly mostly held in urban centres (Hegney et al., 2010; Maharaj, 2013; Nsemo et al., 2013). Also, a nurse may be forced to combine work with the update programme. If the programme is held close to the facility where the nurse works, participation becomes easier, otherwise it becomes difficult to leave patients to go for updates. This finding agrees with those of Chong et al. (2011), Eustace (2001), Gould et al. (2007), Ni et al. (2014) and Nsemo et al. (2013). Running the programme hospital by hospital is reported not feasible owing to the cost implications. Participants fail to take advantage of the proximity of programmes held in their zones hence the organisers run at a loss in that zone. Family responsibilities were also said to discourage the participants from travelling out of the sight of their children. Nsemo et al. (2013) and Gould et al. (2007), found that the demands of undertaking MCPDP with home and domestic commitments, including

arranging child care, combined with the distance to MCPDP centres are significant barriers. Some nurses reportedly created the challenges for themselves by waiting for their license to either get close to expiry or completely get expired before they rush to go for the programme at the next available zone.

5.8.1 Funding for MCPDP

According to participants in this study, the cost of attending MCPDP includes transportation, accommodation and feeding (dinner) and not just paying the registration fee. The participants felt that the cost was high and required a lot of time and planning to prepare to pay. Participants also claimed that the registration fee for the programme was high and not readily affordable for all cadres of nurses. They therefore requested for a reduction in the registration fee. This finding is in line with the findings of Hegney, Tuckett, Parker, and Robert (2010), that cost to attending MCPDP was a problem among nurses in the rural area. This is because nurses from the rural areas would have to spend on transportation and accommodation in addition to the registration fee for the programme. In this study, participants from the urban areas also complained about costs especially registration fees; a finding that is similar to those of Chong et al. (2011), Gould et al. (2007) and Nsemo et al. (2013), that cost is a barrier to nurses' participation in MCPDP. Short notices about MCPDP put the prospective participating nurses under tight budgetary dilemmas and therefore affect participation. This finding is also in keeping with the findings of other authors that participation in MCPDP is higher when it is scheduled at the time of need by the participants; unsuitable conference dates also affect participation (Chong et al., 2011; James & Francis, 2011; Ni et al., 2014; Nsemo et al., 2013). Also, reported was the issue of sponsorship for the programme in which participants suggested that sponsorship should be by their employers. This finding correlates with

those of Gould et al. (2007), Maharaj (2013), and Nsemo et al. (2013), that managers should be responsible for sponsoring CPD since the hospital management benefits more from the knowledge acquired at the programmes but managers feel otherwise. Maharaj (2013) and Stout (2013), however reported that some managers provide funding and support for CPD training and implementation. Participants in this study however cautioned that sponsorship of MCPDP should not be handed over to organizations or institutions as this may delay the release of funds for timely and regular implementation of the update programme in the State. This is one reason why some have suggested that nurses pay for the programme especially as budgetary constraints affect the allocation of funds for the programme. In cases where budgetary allocation is done, financial backing and subsequent release of the fund is not timely therefore affecting the smooth running of MCPDP.

5.8.2 Administrative barriers

The most prominent administrative barrier revealed by participants in this study was the release of nurses for the programme. In addition to lack of sponsorship, releasing nurses to attend the programme on self-sponsorship basis is difficult to get from their employers. Some nurses have had to make internal arrangements to combine work and MCPDP workshops. Superiors and administrators were to help plan the release of their nurses to update their knowledge in order to enhance practice. This finding concurs with the findings of Chong et al., (2011), Gould et al. (2007), Ni et al. (2014), Nsemo et al. (2013) and Yfantis et al. (2010), that sometimes, the nurse manager will not be willing to release nurses, perhaps because there is no nurse to cover up their duty schedules. It was also reported that nurses do not have their managers' support to go for MCPDP. Some managers make unfavourable policies to hinder the nurse from participation. Other managers reportedly, do not provide the right environment and support to implement knowledge and skills acquired from CPD. This means that either release of nurses for

programmes is beyond the capacity of the manager to manage due to shortage of staff or there is a feeling that the knowledge nurses acquire does not improve patients' outcome.

5.9 Shortage of nurses

Shortage of nurses was reported by the participants in this study to be the major reason for non-release of nurses to participate in MCPDP. Administrators were reported to be handicapped when it comes to release of nurses but they sometimes allowed them to shuttle between the venue of the programme and the ward. The shortage of staff was said to affect both private and public hospitals/health institutions. This finding is in tandem with those of James and Francis (2011), Maharaj (2013) and Singchungchai et al. (2009), that shortage of nurses increases pressure on the few nurse practitioners thereby making it difficult to attend MCPDP within or outside the hospital environment. Nurses who managed to combine work and MCPDP in Kaduna state, where shortage of nursing staff was reported in both public and private health institutions were most likely disrupted by work on the wards and did not gain much from the programme.

5.10 Strategies for improving participation in MCPDP

Needs assessment for MCPDP, sensitization of stakeholders and enforcement of regulations were the sub-themes that emerged from this major theme. Participants of this study expected that MCPDP should be brought as close as possible to the people as a way of reducing distance for more nurses to participate. Others expected a restructuring of the programme to address emerging challenges that were not foreseen at the inception of MCPDP.

Needs assessment for MCPDP

Participants suggested that it is high time the programme is evaluated for its improvement and sustainability. The evaluation of the impact of the programme, participants suggested should be done on both nursing practice and patients' outcomes. This is in line with the findings of Nsemo et al. (2013) that the learning needs of nurses are usually not considered and also that of Baxter et al. (2013), in Canada that CPD was perceived as not based on learning needs. The participants of the current study believed that any feedback of the programme so far will go a long way in revealing its strengths and weaknesses to help improve on areas that may need to be improved upon. Also, participants suggested that to mitigate the challenge of release of staff to attend MCPDP, an annual scheduling of the nurses who may need to go for updates is necessary.

Furthermore, participants suggested that there is the need to restructure the MCPDP programme to include various modules that will fit the personal and professional needs of nurses.

Designing special modules for administrators was one of the suggestions made by the participants of this study.

On the number of participants to admit at the workshop and timing of the programme, the participants felt there was the need to adhere strictly to recommended standards. These issues were genuine concerns for the participants and failure to take them seriously may lead to a feeling of neglect and subsequently negative experiences by participants of MCPDP programmes. Chong et al. (2007) and Ni et al. (2014), reported nurses' negative experiences in previous MCPDP workshops attended. The suggestions of the participants therefore should be noted for possible action.

Sensitization of stakeholders of MCPDP

Sensitization as suggested by the participants, involved creating awareness about the importance of the programme among stakeholders of MCPDP. Others suggested that the compulsory nature of the programme should be discontinued so that relicensure does not become the major reason for nurses' participation in MCPDP. There is paucity of literature in this area but further studies can be done to determine whether sensitization will enhance attendance and learning at MCPDP.

Enforcement of regulation

To make participation more effective, a participant of this study suggested an aggressive approach to creating awareness among nurses about the CPD programme to make it possible for a yearly update programme and yearly renewal of licenses as against the current practice of every 3 years.

The harmonised code of ethics for Nigerian nurses actually states that a nurse must continuously update her knowledge and skills throughout her working life in order to develop and maintain competence. There are however challenges with MCPDP being the only programme accepted for relicensure; it requires the nurse to earn 6 credit units in 2 years. The feasibility of yearly updates depends on the ability of the regulatory body to cope with the pressure that will result from yearly relicensure and the efficiency in providing the training for the teeming nurses in Nigeria.

There were suggestions for the deduction of MCPDP registration fee at source as it is done with the deduction of the monthly union dues. If this suggestion is accepted, nurses practising in Kaduna State can only attend MCPDP in the state. This is because the registration fee is not transferrable to other states in Nigeria.

There were calls from the participants for a reduction in the registration fee for MCPDP. As long as the cost of running the programme is realised, reducing the cost to ease any perceived burden for the nurses in Kaduna State is welcomed.

Overall, the findings of this study show that nurses' perceptions towards MCPDP in Kaduna state is positive. The rationale for the programme was intended to update the knowledge of nurses in order to enhance practice. The conduct of the programme in the state was said to be satisfactory but some areas were recommended for improvement. Participants also expressed satisfaction with the course content. They however, suggested improvement in the practicum and some aspects in connection with the resource persons. The study also showed that participants agreed that although there is no empirical study that monitored the impact of MCPDP in Kaduna State, the MCPDP has had an overall positive impact on the nurse, nursing practice and the patients as well. Participants described the attitudes of nurses towards the programme as largely positive and they were satisfied with the overall programme. The major barriers identified were lack of sponsorship, problems associated with the release from work, and distance. Participants made various suggestions that could improve the MCPDP and maximize its gains.

CHAPTER SIX

SUMMARY, IMPLICATIONS, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of the entire study, implications, conclusion and recommendations. The limitation of the study is also presented.

6.1 Summary

The purpose of this study was to elicit and describe perceptions of registered nurses and midwives in Kaduna State about mandatory continuing professional development programme. Relevant literature was reviewed globally to provide the researcher with baseline information about the programme and the depth of literature on the perception of MCPDP among nurses globally and in Nigeria.

An exploratory descriptive qualitative design was used to explore and describe the perceptions of registered nurses and midwives in Kaduna State about mandatory continuing professional development programme. Ten (10) participants provided data for this study using a semi structured interview guide until there was no new information. Data analysis was done using content analysis which yielded 7 major themes with 23 sub-themes.

The key findings of this study revealed that participants have an overall good perception of the MCPDP programme in Kaduna state. The impact of the MCPDP programme was said to be beneficial to both patients and nurses despite the absence of an empirical study to determine that. Nurses were also found to have positive attitudes towards the programme especially after having participated in it.

The major barriers that affected participation in the programme were programme accessibility, funding of the programme, administrative barriers and the perennial shortage of nursing staff. The nurses suggested the use of needs assessment, sensitization of

stakeholders and enforcement of regulations as strategies for improving participation and achieving the goals of the MCPD programme. Notwithstanding the challenges that confront MCPDP participation, the nurses' perspectives towards the programme is encouraging and reflect the nurses' desire to continue to learn for the purpose of improving care and patient outcomes.

6.2 Implications

The findings of this study have implications for nursing education, nursing practice and nursing research.

For Nursing Education

From the findings of this study, it is clear that continuing education for nurses is necessary for the maintenance of competency in nursing practice. The awareness of the rationale for the programme was poor and many nurses came into contact with the programme initially only when their licences were expiring or had expired. The study also revealed that after attending the programme, the nurses appreciate the programme. This implies that lack of awareness of nurses of policies makes it difficult for them to accept the policies. The findings of the study also demonstrated that nurses are reluctant to spend money for their personal development. The orientation towards personal development should be emphasized in nursing institutions since employers are reluctant to sponsor nurses for continuing education.

Novice nurses will have to be taught by skilled and experienced nurses. If the knowledge and skills of the experienced nurses become obsolete then the knowledge and skills that will be transferred to the novice nurses will be obsolete too. The only avenue for both experienced and newly qualified nurses to keep updated and competent is through continuing professional development. However, the complaints about lack of a needs

assessment to identify the learning needs of nurses was a major issue in the study. Continuing education cannot be said to provide competency until it provides the desired knowledge that is required for improved practice. Therefore the learning needs of the participants must be properly assessed to meet their expectations. The teaching of the harmonised code of nursing ethics should be emphasized at all levels of nursing education when teaching nursing ethics and etiquette. The rationale for MCPDP and its modus operandi should be included as well.

For Nursing Practice

MCPDP is key for maintaining competence and practice of nursing. The findings of this study showed that participants complained about the practicum aspect of MCPDP not meeting their expectations. The absence of modules in specialty areas imply that practicum on many specialties is not available. Deficiency in practicum limits the achievement of the goals of the MCPDP which aims at providing skilled knowledge. The art of nursing can only be acquired through practice. These skills are acquired by practising and on the job training to attain proficiency. The programme must therefore find means to introduce specialty modules and ensure skilled personnel are recruited to deliver the content. The current situation in Kaduna state where ranking is based on the number of years of service must be reviewed to include skills acquisition in order to serve the mentorship role that is required of the ranks.

For Future Nursing Research

The findings of this study have exposed the challenges associated with the MCPDP in Kaduna State. These challenges included programme accessibility, funding, administrative barriers and shortage of nurses. These challenges are not peculiar to Nigeria but a global phenomenon affecting MCPDP. There was paucity of literature on the impact of MCPDP on patients' outcomes. There is the need to repeat this study using a

quantitative approach to determine the general perspectives nurses hold on the MCPDP in Kaduna State and other states in Nigeria. Studies that aim at identifying the impact of MCPDP on nurses, nursing practice and patients' outcomes over a specified period of time in Nigeria should be initiated.

6.3 Limitation

This study had participants who participated in all the MCPD programmes held in Kaduna State. The private hospitals/clinics and all levels of the public sector were also represented (Tertiary, secondary, and primary levels of health care) but the sample used for this study was not large enough to reflect the views of the teeming nurses in Kaduna State about MCPDP.

6.4 Conclusion

Although the perspectives of nurses concerning the MCPDP in this study were positive, there are challenges that hinder maximising the benefits of the programme for better patient outcomes. The skills acquisition component or practical aspect of the programme was an area that majority of nurses expressed dissatisfaction with and needed to be addressed. The availability of various specialist modules will be the climax of efforts towards improving the quality of patients' care. Furthermore decentralization of the MCPDP and accrediting more independent bodies to run update courses for nurses would be beneficial. If with the current state of the programme only minimal benefits are realized accentuating efforts to address the hindrances that confront participants will go a long way to improve the nursing profession in Kaduna state.

6.5 Recommendations

Based on the findings of this study, recommendations have been made to the Nursing and Midwifery Council of Nigeria, the Ministry of Health Kaduna State and the Kaduna State Implementation Committee of MCPDP.

To the Nursing and Midwifery Council of Nigeria

The nursing and midwifery council of Nigeria should:

- Continue to explore ways to protect public interest in relation to the practice of nursing in Nigeria through update programmes.
- Consider developing a system that allows nurses to earn six (6) credit units at different times within 3 years before relicensure.
- Organize the workshop in smaller credit units to run concurrently in order to reduce the number of days.
- Accredite more bodies to run the MCPDP instead of allowing only one body to undertake this task.
- Develop more modules for specialised groups. The various specialty groups should have members appointed to oversee continuing education matters for the specialty group.
- Encourage organizers of other update nursing programmes not accepted for relicensure to liaise with the MCPDP central committees for allocation of credit units so that they can be valid for relicensure.
- Direct all MCPDP programme facilitators in the states to augment sensitization of the rationale for MCPDP to enhance free will participation and utilization of knowledge acquired during CPD programmes.

- Direct the organisers of the programme to initiate a study in each state of Nigeria to monitor the impact of MCPDP on nurses, practice and patients' outcomes over a specified period of time.

To Kaduna State Ministry of Health

Kaduna State ministry of health should:

- Ensure that challenges in relation to the release of nurses to attend MCPDP which are beyond the capacity of both nurses and superiors should be resolved through meetings between the organizers, employers and the nurses to ease participation in the mandatory CPD which nurses struggle to attend.
- Collaborate with the MCPDP state implementation committee members to carry out needs assessment related to education of the nurses in the state.

To Kaduna State Implementation Committee of MCPDP

The Kaduna State Implementation Committee should:

- Step up publicity on MCPDP in Kaduna State. The use of social media, functional mobile phone numbers of nurses and a data base for nurses practising within the state may be helpful.
- Improve on the overall organization of the programme especially areas of concern raised by participants in this study.
- Maintain the quality of the presentations at MCPDP
- Direct faculty members to emphasize the nursing management aspect of patients during presentations.
- Ensure the practicum component of the programme is enhanced to meet the needs and expectations of participants.
- Ensure the maximum number of participants stipulated by the regulatory body is not exceeded.

- Ensure that nurses in Kaduna State are sensitised about the rationale for MCPDP.

The organisation of MCPDP is commendable in Kaduna State but there is a need to further evaluate the areas needing improvement and direct those areas to the appropriate authorities to solve. The state committee should however address those grey areas within its mandates

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APPENDICES

Appendix A: Interview Guide

Section A: Demographic data

Please provide information about yourself

1. Age?
2. Sex?
3. Your marital status?
4. How many children do you have?
5. Ward/unit?
6. Your present Rank?
7. Place of work?
8. Your highest post registration qualification
9. How many years elapsed before you undertook and obtained your first post basic qualification
10. Years of experience since qualification as a nurse?
11. When last did you attend MCPDP?

Section B

Perceptions.

Please tell me about the MCPDP programme in the state? (Probe)

- a. Should it be compulsory or not?
- b. meeting learning needs?
- c. does it meet your expectations?

Section C.

Perception of impact

What is the impact if (any) of MCPDP on your practice? (Probe)

- a. You as a person?
- b. Your patients? Can you be specific?
- c. Do you think other nurses in your hospital share the same opinion?
- d. How exactly do you know (c) above?
- e. Do you think the impact is known?

Section D

Barriers

- a. Are there any challenges that affect participation in MCPDP? (Probe)
- b. What are those problems?
- c. How would you confirm that the actually affect participation?
- d. Can you be specific?

Is there anything more you want to tell me more about MCPDP?

Thank you for your time.

Table 4.1. Socio demographic characteristics of participants.

Pseudonyms	Age	Gender	Marital status	Work Health facility	Qualification	Work experience	Last MCPDP update
Hawa	31	Female	Single	State	Double/ degree	6yrs	2014
Obama	56	Male	Married	State	Double	32yrs	2013
Rochelle	46	Female	Married	Federal	Triple/degree	25yrs	2014
Ahmadu	53	Male	Married	Private	Double	34yrs	2014
Mitchell	26	Female	Married	Local government	Single	3yrs	2014
Tijani	53	Male	Married	State	Double	32yrs	2014
Nihad	31	Female	Married	Private	Double	7yrs	2014
Ahmed	38	Male	Single	State	Single/degree	7yrs	2012
Zuma	35	Male	Married	State	Single/degree	5yrs	2014
Zira	32	Male	Married	State	Single/degree	7yrs	2014

Appendix B: Ethical Clearance

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979 *A Constituent of the College of Health Sciences*
University of Ghana

INSTITUTIONAL REVIEW BOARD

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My Ref. No: DF.22
Your Ref. No:

4th March, 2015

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 048/14-15 **IORG 0000908**

On 4th March, 2015, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Mandatory Continuing Professional Development Programme (MCPDP) in Kaduna State, Nigeria: Perspectives of Nurses**

PRINCIPAL INVESTIGATOR : **Afoi Barry Baidy, MSc Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 3rd March, 2016. You are to submit annual reports for continuing review.

Signature of Chair:
Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

cc: Professor Kwadwo Koram
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

Appendix C: Consent Form

CONSENT FORM

Title: Mandatory Continuing Professional Development Programme (MCPDP) in Kaduna State, Nigeria: Perspectives Of Nurses.

Principal investigator: Afoi Baidy Barry


Address: Department of community Health, School of Nursing University of Ghana, Legon,

Email: afoibarry@yahoo.com.

General Information about Research

This research is on the perspectives of nurses on mandatory continuing professional development programme (MCPDP) in Kaduna State, The study specifically seek to determine how registered nurses in Kaduna State view mandatory continuing professional development programme. If you agree to participate, you will be required to sign this form. The research will be in form of interview which will give you time and opportunity to express your views on MCPDP. The process will take around 30-40 minutes so there is need for you to schedule a time for the interview at a place that is convenient for you. The interview guide will comprise of 4 parts. First part will seek to know about you, excluding your name to ensure your privacy. The second part will seek to elicit information regarding your perception of MCPDP. The third part will elicit the impact of MCPDP, while the fourth part will ask about the challenges that hinder participation in MCPDP. I proposed to have the interview at a place that you suggest is comfortable for you. In course of the interview you can stop or withdraw if you feel like doing so. I will make sure you are comfortable before we start the interview. You are kindly informed that, the questions you will be asked are for academic purposes and that, they are not meant to cause you any pain. This information sheet will be given to you to read at home in a relaxed atmosphere, so that if you have any questions before we start the interview, you will be free to ask and I will answer them. The interview will be recorded using an audio-recorder and I will take field notes from observations.

1



Possible Risks and Discomfort

The study is not associated with any physical, social or psychological harm. However, you may find some discomfort in answering some questions due to your personal values or experiences. In case you experience any severe discomfort you will be referred to a clinical psychologist for further counseling. I will foot your transport fare only.

Possible Benefits

This will benefit you directly and indirectly, directly because any policy change arising from the findings of this study may make your employer more supportive than before or sustain the support he earlier started. Indirectly, because the findings at the end of the study will be communicated to the concerned authorities which will in turn shape the policies guiding MCPDP.

Confidentiality: No identifiable information about you will be collected. All identifiable information about you such as your name or signature on the consent form will be de-identified, labeled with a protected number and locked by me. Only the researcher and his supervisor will have access to the information, and you will not be mention in any of the research report. All study information will be destroyed five years after the study. Also any publication from this study will not include any identifiable information, only group data (themes) will be use.

Compensation: you will be given snacks for refreshment, you have the option to ask for food at a cost equivalent to that of the snacks. You would be given transportation fare after the interview.

Voluntary Participation

For your information, this research is voluntary and you have the right to decide whether to participate or not. You can also withdraw if you wish without any worry or penalty from any one.



2

Termination of Participation by the Researcher

Your participation in the study will be terminated if you do not sign the consent form.

Notification of Significant New Findings

The researcher will notify you later about the significant findings of this study.

Contacts for Additional Information

If you need more clarification about this research you can contact me or my supervisor through the following contacts:

Barry Baidy Afoi (Researcher)

School of Nursing, College of Health Science, University of Ghana, Legon.

+233242020796, +2348037008815, Email: afoibarry@gmail.com.

Dr. Patience Aniteye, Lecturer, School of Nursing, College of health Sciences University of

Ghana, Legon. Phone number: +233244681352, Email: patienceaniteye@yahoo.co.uk

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline +233302916438 or email addresses: nirb@noguchi.mimcom.org



VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research titled **"Mandatory Continuing Professional Development Programme (MCPDP) in Kaduna State, Nigeria: Perspectives of Nurses."** has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date_____
Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research

Date_____
Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date_____
Name Signature of Person Who Obtained Consent