ICEH Webinar: Using Open Education to support local training and capacity building

April 19th 2017
Find out more: http://iceh.lshtm.ac.uk/oer

[Sally] Welcome, everyone. My name is Sally Parsley. I'm the Technical Lead on the Open Education Programme, here at the International Centre for Eye Health, and I'm our webinar host for today. So I'm delighted to introduce this webinar on using open education to support local training and capacity building. And our two speakers, Doctor Nyawira Mwangi from Kenya and Professor Colin Cook from South Africa.

Before we get started, I've got a very quick bit of housekeeping information, and then a little bit of introduction to this term, open education, for those of us who haven't joined us before. So the format is, we'll hear our two presentations of about 10 to 15 minutes each, and then we'll have some time for a short question and answer session at the end. OK?

So this is the fourth in a series of five monthly webinars that we're hosting to explore how we as eye health educators can use digital technologies and this idea of open education to innovate and improve teaching practice, and address some of the big challenges that we face in eye-care training today.

So for anyone who has not attended our webinars before, it's worth just briefly giving a quick definition of what we think open education is. And we think it's any activity that's aimed at reducing barriers to participation in education and learning. It can be by reducing the cost of education, by reaching learners at a distance, or by removing the need for prior qualifications, or different cadres. So for instance, you might educate the ophthalmologists and the nurses together.

It's not a new idea. It's been around for a long time. This is a very interesting graph from a paper on the history of open education, which was published a couple of years ago. And you can see, they think it goes all the way back to the very first universities and public lectures. And one example I'd like to pick is UNISA in South Africa, which in 1946 began its pioneering distance education program for everyone who wished to further their studies and could not attend residential institutions because of personal circumstances or occupational obligations. UNISA teaches about 330,000 students.

So I could talk about this graph for a while, but we want to get on to the meat of the webinar today, so I shall rush on. And I just want to highlight that with the internet and digital technologies, that the focus of open education has really shifted towards open online education, and in particular, open courses in the last few years. And these are courses which are free to anyone to register and participate in, although that is starting to change.

And in particular, massive open online courses on platforms like Coursera and FutureLearn, have been incredibly popular over the last few years, with millions of people signing up to do these free courses. LSHTM has been part of this movement and we've run, I think, five or six open courses on FutureLearn, with about 80,000 learners over the last few years.

So another aspect which is worth talking about is open educational resources. Now these are the course materials that are used in open courses and elsewhere. They are defined by having an open copyright license. And this means anyone can download, use them, change them, share them, for free without asking for the original publisher for permission.

So in 2014, here at the International Centre for Eye Health, we developed our first open course, using open educational resources. So all the materials in the course are OERs and can be downloaded and adapted for free. The course was called Global Blindness: Planning and Managing Eye Care Services. It's an introduction to public health eye care. A topic that's vital for delivering equitable and accessible eye care services.

It's been a huge success. We've had more than 5,000 people take the course. But here at LSHTM, we felt that to really make a difference in eye care training, and for this training to become sustainable in the truest sense of the word, this training needed to be delivered by local faculty who really knew what the education needs were around public health and eye care in their own settings.

So to take this further, we developed partnerships with eye care leaders in three settings, who agreed to adapt the global blindness course and use it to support training in Kenya, South Africa, and Nigeria. And I'm really delighted today to welcome our two presenters from those partners-- Two of the partners to present on their experiences today. Dr. Mwangi from KMTC [corrected] in Kenya, who's sitting here with me. And Professor Cook, who is joining from South Africa.

So we're going to share their experiences of adapting this course, why they decided to do it, the approach they took, who it was for, what they changed and so on, what the challenges have been, and also what the impact and the change for them has been and for their learners. OK. So I hope that wasn't too much of a rush. You've kind of got a sense of what these presentations are going to be about.

So first of all, our first presenter is Dr. Nyawira Mwangi, an eye health system specialist and an educator. She had her medical training, ophthalmology training, and health systems training in Kenya. And she later took a master's in public health for eye care here at the London School, and is currently a research fellow with us.

She is the principal lecturer for ophthalmology programs at the Kenya Medical Training College in Nairobi. This institution runs various training programs for Frontline ophthalmic workers, including ophthalmic clinical officers, cataract surgeons, ophthalmic nurses, optometrists, and low vision specialists. Nyawira, it's so great you can join us today. Thank you, so much. And I'm really looking forward to hearing you talk about your experiences.

[Nyawira] Thank you, Sally. I'm glad to have the opportunity to talk about our experience in using OER within the COECSA, College of Ophthalmology of Eastern, Central, and South Africa, which includes Kenya. So the map shows the COECSA region, what those countries have in common, you see, is the Great Rift Valley runs somewhere along those countries and we work together under this college.

So we have been doing the adaptation with this picture in mind, that we need to increase the opportunities for learning. And that access and participation are two important issues to consider when you're talking about opportunity for learning. If you want to create a more

enabling environment for learners, we need to think about what factors affect access, what factors affect participation in their own learning, and remove barriers in those aspects of education. So that process of really adaptation, is about removing those barriers.

Four important questions need to be asked before you begin to adapt an OER course. One, is there and need and what is it? Two, what options do you have to meet that need? Three, are there particular opportunities that you can leverage on at that particular time? And Four, we need to anticipate potential challenges, potential barriers. So with those four things in mind, one can begin the process of planning for adaptation.

For one case, we began with a need. We have our region and we have this cause that the International Centre for Eye Health Department developed. And it was a good course. So as educators, as health workers, we identified this was good material that would benefit more people in our region, and what we needed to do was to contextualise it for the users in this region. So that was our need.

When we think about our users, we are targeting a wide group of people. We have various kinds of ophthalmic workers. So we have nurses, we have clinical officers, optometrists. We have a wide range of them. We also have the inservice training for those particular cadres. We have programme officers. This would be managers, but they may also be the same health workers working as programme officers. We also have educators running these programs. They are also health workers, heath care workers, also giving clinical services. In our situation there's a number of roles. And we needed to target people who are cutting out all these different roles. So we have to be able to reach them. And to make sure that the material is accessible to them.

Thinking about the options, when you have a course to adapt, you have options to change lots of things, or change just a few, or to take it as it is. So there are many options. For our case, we had a lot of things we did not change in the original course. We only changed a small part of the pie. So the bigger pie remained unchanged.

We didn't change anything on the name. We didn't change their objectives. We didn't change the sequence of the modules. We didn't change the content, or the quizzes, or the time requirements. You still need four hours every week. It's still in English, and the users can access the materials from different parts using different appliances at different times. And they learn at their own pace. So we still maintain the ethos of this training.

So what did we change then? A few things were changed. One, changed the lead educator to have a local lead educator. We changed some photos. We have one additional video, actually. We changed the narration. And we wanted to use local case studies. OK, we have maintained some local ones but we also are going to add some more.

So a few things were changed. The main purpose of changing was to contextualize the material. We wanted to reflect maybe the users' circumstances, or the ethos or the language of the users. So that they can identify with it and be able to navigate with it. So this was the ethos of our adaptation.

The other question was what are the opportunities? There are big opportunities for course adaptation. One of them being copyrights. You need to understand copyright. And this material is published in open licensing which allows us to use it, to share it, to the re-mix it,

and re-use it. This, therefore, set the ground for us to adapt it for our purposes. We're still maintaining its integrity and its objectives.

The second good thing that we had a chance to participate in the course when it was first run. A number of people from the region took the course so we knew the benefit. We understood the material, and we saw how relevant it was for us.

We can download the materials, and they are good quality materials. Can download transcripts for the videos. And that is a good opportunity because you have a chance to go and use it and share it and even change it to the way you would like.

Institutional support has come in quite handy. For example, we have the support of the Minister of Health in the area of policy. We have the support of training institutions. We have support of professional institutions. We are able to accredit this course. We're able to give CPD points. We are able to give certificates. So institutional support is a very good opportunity that you can leverage on.

Technical expertise. A lot of that is required. And this has been a variable. We need expertise in terms of IT as you do course adaptation. We need expertise in terms of the modular content. You need the expertise of educationalists. So different kinds of expertise are important and as you adapt the course.

A lot of stakeholders play a role. So for our case, we had the government-- that's the Ministry of Health-- involved. We have had professional bodies-- the College of Ophthalmology coming in. We have had collaboration with the University of Cape Town, the London School of Hygiene and Tropical Medicine. So a number of people have come here. Collaboration is definitely a strength that to make things easier and better.

Funding is required for various things. So funding actually does help. There is need for finances for travel during the course of adaptation. Getting a platform for running it. So funding helps and it should be available. It helps.

But most important is to understand why you're adapting the material and how to adapt it. The user is central to the process of adaptation, because we need them to be able to use the material. For us, we wanted to do a survey first-- an initial survey-- to see the needs of the users. We wanted to find out how they'd done new articles before and what lessons can be learned from there. That was a good opportunity that has really been of help. There are more opportunities, but perhaps I will just list those.

There are also challenges that one needs to think about. First one being that this is a time intensive process. So one needs to commit enough time to it. It's also cost intensive so there's a need for finances. Technology is very important. You're going to shoot some videos with the technology. You're going to run the course on a platform. You need that technology. And you also need rigour, so there's a need for commitment, continued commitment, to quality.

There must be mechanisms for quality assurance, of which one of them is having a pilot test. And secondly the technical expertise also contributes to quality assurance. So this is a great need. And we have had a good opportunity to learn about quality assurance.

We must be aware of the barriers that users face. We may have reduced access to the internet. So it is good when the materials are downloadable so that people can be able to access that at their own time. They should also be able to use the course on your phone. They may not have computers but they can use their phone. These are barriers that need to be aware of. We need to understand. And we need to design the course for that.

The number of assumptions that one may come in. You might think that I'll begin adaptation point a, and progress to point z. What we have found is that it's not truly linear, so you would want to come back. It's lost it's cyclic, really. At many intervals it's cyclic, so one must be prepared to come back and say, oh, I need to get that video done again. Or that case study, I need to do a second one. So there are assumptions that we may come with but what we have learned is that we need to be aware of the assumptions.

We must reach the target to users to create awareness of this course its benefits. So we need to advertise the course. We need to make sure that we are reaching all those users.

Having an appropriate software is good. At the moment we are using Google platform. We adapted the course from FutureLearn. So there's a change in the platform, and we must anticipate the needs of that.

With that experience, what would be my key take home points? Just a few points. One, you must plan. It's good to plan. A lot of planning went into it. And we have not regretted. Two, you need technical expertise. So it's good to leverage on people with various types of expertise. Three, you find stakeholders to come in. That might be different individuals, different institutions, different sources of funding. Important.

Do the pilot test for quality assurance. Very, very important. We have found it's good to have champions who come out and run with this course. It could be one, could be two, very important.

Thirdly, surprises are on the way. So it would anticipate them. As you do the pilot test you find out because change in software, this is not exactly how I have planned it. So let's anticipate surprises. It's a learning point.

So with that, I want to thank those that have really helped us. These corporations have really been of help. And we also want to thank those that have participated in this process. Thank you very much. Thank you, Sally.

[Sally] Thank you so much, Nyawira. That was so interesting.

I'm laughing because I'm looking at a picture of myself looking a little bit surprised on the screen. I think it's so great that you focused on the need in your setting and to address the need. And also your take homes were absolutely-- it's very interesting your identification of champions. I might ask about that in the Q&A if I get a chance.

So thank you so much. It was so interesting. So, let me-- so native Zimbabwean ophthalmologist Professor Colin Cook, is the professor and head of the division of Ophthalmology at the University of Cape Town. Groote Schuur Hospital, hope that's not too awful a pronunciation, Colin. He has oversight of the clinical service delivery, teaching, and research undertaken by the division.

Colin has a long-standing and special interest in community eye health, and he was previously the course convener for the post-graduate diploma in Community Eye Health. And he's now the convener for the Community Eye Health track of the Master's in Public Health at UCT.

He's also care advisor to CBM for the southern Africa region. Before taking up his current post as part of Groote Schuur Hospital, vision 20/20 project, Colin worked as an ophthalmologist at Edendale hospital in KwaZulu-Natal in South Africa.

Thank you so much, Colin, for agreeing to present on your experiences of adapting the global blindness course in your context, at UCT in South Africa.

[Colin] OK. Well, thank you for that, and thank you for the opportunity to share our experience with the Open Education Resource at UCT. It was very interesting for me to hear Nyawira's presentation from COECSA.

What has been our experience-- just go on to the next slide. So I have to say that when we first heard about this new initiative from Daksha and Sally and others at ICEH, we were suitably sort of skeptical about it. I mean they're all such nice people. Everyone at ICEH is-- Daksha and Sally and everyone-- and we thought well, what is all this newfangled stuff that they're on about. But of course we will be giving any support that they request from us, just because they're nice people. But we weren't sort of convinced of the real value of it. But I have to say, that having worked with the team at ICEH over the last few years, and I'm using it now for the courses that we run here. We now are very firmly convinced of the benefit of this.

We run a community eye health workshop for registrars or residents in South Africa, which we've run at UCT since 2005. Basically involving registrars coming from other centers in the country to Cape Town, which has been all good. But this year it's been replaced by the ICEH course-- the planning and managing course. So we, for the first time, are not needing to actually bring everyone together here. We'll make it available as the ICEH OER course. And that's on the ICEH or the London School platform, so it hasn't been adapted for local need. And we are not monitoring that at all we've just publicized the availability of that to everyone. The registrars have to do this training as part of their exam preparation. So we're not monitoring at all but the facility is available for them.

The postgraduate diploma in Community Eye Health-- we've been running this course since 2010. Deon Minnies, who's one of my colleagues who's the director of our community Health Institute, convenes the course. I'm just listening to a very noisy group of patients and I'm going to close the door. Hold on one minute.

Apologies for that. I'm back. Some somewhat happy, noisy patients just outside the door. So the postgraduate diploma started in 2010. Basically the structure of this diploma has been previously 10 weeks on campus, four weeks community eye health, two weeks health promotion human resource development, and then four weeks of management. And then taking two weeks off campus. And then back again at the end of the year.

What we've done from this year, is that the first course-- the first four weeks, the community eye health-- has being replaced by the ICEH OER course which is run on our University of Cape Town Vula platform, and has been customized with some local content.

So my colleague, Dr. Karin Lecuona, has been the one that's has been responsible for that. And what we have found basically looking at the contents there, Daksha was encouraging us to change as much as we sort of felt necessary to change. But in looking at it, we didn't feel the need to change an awful lot. Perhaps even less than COECSA has done. So for example, we were very comfortable just keeping a lot of the case studies that the London School had included. So we think that the content has been sufficiently sort of customized for local use. A lot of the participants in the postgraduate diploma are from outside of the southern Africa region anyway. So we'll see how it goes.

This is the first year that we're doing it. The students will be with us in a few weeks time, at the end of this month, and we will hear from them firsthand what their experience has been using the OER course for this first course of the diploma.

Interestingly what the plan is, based on that experience, next year the contact time course two and for course three will be replaced by a similar UCT course. And that'll be developed by Deon with assistance from Greg here at UCT to replace it as a distance learning. And of course, the obvious advantage there, is that we think it will reduce the cost for the students and improves the accessibility for the course. Students won't actually need to come to Cape Town at all. It will be then a distance learning course.

And then the third course that we run is the Master's in Public Health, Community Eye Health track. The MPH at UCT has been running since 1999. The Community Eye Health track was a new track started in 2012. So it's been going for about five years now. It's basically run over one and a half years if it's taken full time. Up to four years if it's taken part time. And it's very much geared to be taken, but it can be run or taken as a part time degree for people living in Cape Town.

The Community Eye Health track-- most of the participants that we've had thus far have taken it as a full time course. They would then do 10 courses over one year. Five courses in semester one, five courses is semester two, and then they complete their dissertation in the first semester of the second year. The Community Eye Health track has two community eye health courses, and then the other eight courses the students choose from a sort of bouquet of 25 different courses that they can choose from.

And so this year for the first time, the contact time for the community eye health one course has largely been replaced by the ICEH course, planning and managing eye care services. Which has been customized for local use. And is available on the UCT Vula platform.

The community eye health two course has been replaced largely by the epidemiology for eye health. Which is not available to us, hasn't been customized at all. It's not available on the UCT platform. But the students are accessing that on the London School platform. We have a cohort group of six students who presently enrolled for the Community Eye Health track this year. And they are one third of the way through that community eye health two course at the moment. So again, we still have contact time with them once a week. But most of the contact time has been replaced by the OER courses.

So that basically summarizes our experience at UCT. It's work in progress and we will see what our experience is, what the experiences of our students are over the next few years. But it's obviously been a huge value add for us in running the community eye health training that we run at UCT.

[Sally] Thank you so much Colin. Thank you just un-muting myself there. That was so interesting. The thing I've been so surprised about is the different direction that Nyawira, and Kenya, and Nigeria, and South Africa have all taken the content, because your contexts are so different. And I thin it's really showing the need for this kind of collaboration-- and working together. I'm very excited you're working with them-- you're working to create more OER, Colin. That's a very exciting development with Greg.

[Colin] So that's the sort of direct lesson that we've learned from this is sort of recognizing the value add. And therefore this time next year we'll see what our experience with that is. But as I say, we hope that it will open up the availability of the post-graduate diploma to a lot of people who otherwise find it difficult to get away from their work and come to Cape Town-- and will improve the accessibility.

[Sally] Yes, and that's true for both of you, isn't it? We have had a question in from Daksha, which I think is really aimed at Nyawira, which is, practically, with COECSA, how do you go about accreditation at the local level?

[Nyawira] Thank you. So this being a very good incentive, we are looking at it from three options. So you have three institutions which will gain accreditation. And the user has a choice. So they have choice. There is COECSA, there is UCT short courses, and also the South African Council. So what happens is COECSA can give CPD. It can give such a certificate. And UCT short courses can give certificate at a fee. And the South Africa Council can also give CPD. So users have a choice. They can pick one of them.

[Sally] What's best for them.

[Nyawira] Yes.

[Sally] Then I have a question for both of you actually. Colin, if you could have a go first and then we're come back to Nyawira. And that is, as an educator-- for both of you this is the first time -- we kind of threw this at you. What would be your one piece of advice for other eye care educators who have been attending our webinars and thinking this content looks like it could be useful? What would your advice to them to get started?

[Colin] Nyawira, do you want to go first? I'm going to think about that.

[Nyawira] OK. Thank you. It's my immediate thought is at first you need to know your target user. So for example, one difference in our two programs [INAUDIBLE]. For example, with us, we are focusing on the mid- level of workers, as well as ophthalmologists. But we don't have a formal training programme right now. You can come in and take up this course. UCT is doing something with the existing courses. Changing the existing course. So we need to think, who is the user you're targeting for this particular time? But then you can adapt [INAUDIBLE].

[Colin] I think if I would add to that, it would basically-- from what Nyawira is saying-- the sort of experience that we have with the three courses that we offer. The community eye health training for registrars, they need to just get a broad brush stroke sort of understanding of the principles of community eye health. And the course that has been developed by ICEH is entirely suitable for that. So we are very comfortable with the idea that course on its own covers the need there.

The post graduate diploma in the MPH courses, without trying to change the content of those courses too much-- just leaving it as it is. Because basically it's good as is. And then we are able to complement that with local activity, or local inputs to sort of make it suitable for the particular targets and the particular level of the course that we are offering. I don't know if that helps, but it's basically the OER material is sound, and provides a very sound sort of base on which other material might perhaps be added to complement it.

[Sally] That's a great point. So balancing your needs with what's available, what you can make use of in your capacity. Thank you both.

I have another question for both of you. Maybe Nyawira first, here. What are the perceived benefits of OER for capacity building for local faculty.

[Nyawira] OK. Thank you. There are benefits actually at many levels. There are individual benefits, and there are also institutional level benefits. So for the individual trainers, you get access to the course, the one yourself runs, and also to get to know what is available for your learners. You can look at quality, and look at material notes available and then assess the quality. And determine what will need to ensure benefit learners.

And you can actually determine how to use it to increase learning. So you can put it a short course, or you can use the advice and to build and have a look at it. You can use quizzes. So you can utilize the materials in various ways.

For the institution, because we know, in Sub-Saharan Africa, we have a limit of health workers. So we have a big need. So if you have these avenues for training, it might contribute to using the available health workers more efficiently and more effectively. Because they can do some directed learning, and also the trainees can do the same. Thirdly, when you get to develop your staff, and your capacity and your ability to run other trainings [INAUDIBLE]. So I would say there are multiple benefits.

[Sally] Thank you.

Colin?

[Colin] Sally, from our side I'd have to say the main benefit is that it lets us off the hook. That our faculty, the people to teach in our courses, the local faculty are all busy, busy, busy clinicians. And getting them to be available for teaching on the course is always a challenge. And so it's fantastic, at the click of a button, for the students to be exposed to all these very bright, capable, interesting people that ICEH. All the resource that is available there is just sort of beamed into their computers. And so whereas previously we would be having to get faculty to come from London to teach on the course and getting local colleagues sort available for days at a time to teach. It makes life much easier now, knowing that there's very good quality teaching available online. And it just makes life much easier. So in a sense, it's doing nothing to develop local capacity. It's just giving us a bit of breathing space and saying well, this is great. We can continue to provide what we think is good quality training. But with this expertise from London.

[Sally] Yes. And Thank you so much, Colin. I guess I'm hearing from you both, it's kind of a mix of-- it's an opportunity for personal development and empowerment as an educator. It gives you a chance to reflect and change your practice, and it's a time saver and support when

you're completely overstretched and trying to get work done. It provides that efficiency and save you time, sorry. And then on the other hand, this is an opportunity to reach these students. Once we start to get online and start to get access.

[Nyawira] Exactly.

[Sally] I have lots of questions, as you can possibly tell, but unfortunately we're nearly out of time. And I just want to thank you both so much. That was really interesting. It's so exciting for us to hear your-- Ah, I've had a final question, and I'm going to run over time because it's in from Daksha. The question she's asked, Colin, is would you consider yourself as an open education practitioner now, Colin. What a mean question.

I need to turn the question around an ask Daksha what she thinks that we are. I think that we're kind of into it now and we've got a lot to learn, and a long way to go. But we are very committed to it. We really do appreciate and understand the value of it now. It has been and is a huge value add for us. So we're certainly on the journey and I think it's definitely the right way to go.

[Sally] Very interested to see-- because I know you're going to evaluate this experience this year-- but how it moves forward with your own content. It will be interesting to see. Thank you so much, Colin. And Nyawira, are you an open practitioner?

[Nyawira] I would say-- thinking about it, there is something that provokes my thinking. On what is my role in relation and to what extent have I agreed to take on this course. So say, so far, I am beginning to think about it. I'm not yet sure I'm there, but I'm perhaps going in the right direction.

[Sally] Thank you, Nyawira. OK. I'm going to wrap up incredibly quickly now, because we are kind of out of time. Thank you again for really interesting presentations. I really enjoyed those. Just to let you know that our final webinar will be in May on the 24th. And this takes us to a practical level where we're joined by Dr. Glenda Cox and Mr Gregory Doyle from the University of Cape Town. And they're going to be talking about creating and sharing your own open educational resources as an open practitioner. Dr. Cox is going to talk about some of the research findings that her PhD has found about the enablers and constraints that educators face and start to integrate this approach. And then Mr. Doyle-- Greg's going to talk about how you get sources. Some practical tips and how-tos. So I very much hope you can join us. Thank you to everyone, our presenters and our audience members. And take care, and I hope to see you in May. Thank you. Goodbye.

[Colin] Thank you, Sally. Bye.

[Nyawira] Thank you.