The effect of continuing professional development from the perspective of nurses and midwives who participated in continuing education programs offered by Global Health Alliance Western Australia: A mixed-method study

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Chapter 4: Findings

4.1 Introduction

CPD is a mandatory requirement for NMs in developed nations. Its purpose is to engage and enhance their professional growth and expertise. However, in developing countries, there is a lack of access to CE and professional development (Oulton, 2006). The GHAWA is an international health development program of the WA state government that was established as a result of the Australian and Tanzanian Foreign Ministers’ pledge to support development of health outcomes in Tanzania. The mission of this program aligns with the WHO commitment to strengthen the nursing and midwifery workforce, and the MDG for improving maternal and child health. It assists the capacity and capability building of the NM workforce in Tanzania by providing CPD through education to improve health practices and care outcomes. This study sought to examine the effectiveness and sustainability of CPD for TNMs in Dar es Salaam by using education programs offered by GHAWA. The previous chapter explained how the investigation identified the relevant details of the program, such as who, what and where the programs were delivered. This was followed by interviewing the relevant NMs from WA and Tanzania who participated in the GHAWA program. The perceived views from both cohorts about CPD in Tanzania—including its effectiveness and sustainability—were then examined.

Following a systematic methodological framework, as discussed in Chapter 3, this chapter provides a detailed description of the findings from the two phases conducted using quantitative and qualitative methods. This also includes the findings from the two stages conducted during the qualitative research aspect of this study. This chapter is structured as follows:

Phase one: Findings from the quantitative method to review the GHAWA program during the year 2013.

Phase two/stage one: Findings from the focus group and one-on-one interviews with NMs from WA, who participated as GHAWA facilitators to deliver education sessions at various organisations in Dar es Salaam, Tanzania.
Phase two/stage two: Findings from focus group interviews with NMs from Dar es Salaam who attended education sessions provided by GHAWA.

4.2 Phase One: GHAWA Program Data

An investigation of the GHAWA program data occurred during phase one of this study. The emphasis was to review all data relevant to education conducted in the year 2013. Section 4.2.1 presents the NMs’ demographics related to the program, including who, what and where the education was delivered. Section 4.2.2 presents the study findings.

4.2.1 Demographics

In accordance with the methodology, the sampling method used during phase one of this study was discussed in Chapter 3. Using SPSS to manage the information, a thorough analysis of the program data enabled the researcher to answer demographic questions in a distinct manner.

Table 7 summarises the identified demographics. This step validated that GHAWA conducted its program in Tanzania and engaged NMs from WA ($n = 12$) to deliver a range of nursing and midwifery specialty education programs ($n = 3$) to health workers in Dar es Salaam. Twelve courses were delivered in 2013, and were attended by a total of 149 health staff, including NMs and other health workers from various organisations ($n = 8$). Of the eight participating organisations in Dar es Salaam, two were private organisations and six were from the public sector.
Table 7: Phase One—Demographics

<table>
<thead>
<tr>
<th>Demographic Item</th>
<th>Description</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1: Country Location and Region</td>
<td>• Australia—WA</td>
<td>• Two countries: education delivered by WANMs to health workers in Tanzania</td>
</tr>
<tr>
<td></td>
<td>• Tanzania—Dar es Salaam</td>
<td></td>
</tr>
<tr>
<td>Part 2: Role in the Program</td>
<td>• Facilitators</td>
<td>• 12 WA facilitators</td>
</tr>
<tr>
<td></td>
<td>• Attendees</td>
<td>• 149 Tanzania attendees</td>
</tr>
<tr>
<td>Part 3: Position Title</td>
<td>• Registered nurse (RN)</td>
<td>• WA: seven RNs, four RNM, 1 RM</td>
</tr>
<tr>
<td></td>
<td>• Nurse only—exact status unidentified</td>
<td>• Tanzania: 15 nurses, 114 RNM, 20 OHWs</td>
</tr>
<tr>
<td></td>
<td>• Registered nurse midwife (RNM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Registered midwife only (RM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Other health workers (OHWs)</td>
<td></td>
</tr>
<tr>
<td>Part 4: Type of Education</td>
<td>• Three different courses, coded courses one, two and three</td>
<td>• Total of 12 courses delivered in 2013</td>
</tr>
<tr>
<td>Part 5: Participating Organisation in Tanzania</td>
<td>• Eight different organisations, coded organisations one to eight</td>
<td>• Two private and six public organisations in Dar es Salaam, Tanzania</td>
</tr>
</tbody>
</table>

The demographics showed that, in 2013, GHAWA delivered CPD education for NMs in Dar es Salaam. Details of the findings are described in Sections 4.2.2.1 and 4.2.2.2 under the WA and Dar es Salaam cohorts, respectively.

4.2.2 Findings of Phase One

4.2.2.1 Findings of the WA Cohort

The analysis indicated that a total of 12 NMs—11 who worked in the WA public health sector and one from the private sector—travelled to Tanzania with GHAWA in 2013 (Figure 13).
As illustrated in Figures 14 and 15, this cohort consisted of 59% of RNs, 33% of dual registration practising as RNMs, and 8% of RMs. Of these, 11 were females and one was male.

Figure 13: NMs from the WA Health Sector

Figure 14: WANMs—Facilitators’ Designation
These NMs who volunteered with GHAWA had expertise in various speciality areas to facilitate CPD. A total of 12 clinical speciality courses were delivered. The education covered subjects in acute and emergency care that were delivered four times \((n = 4)\), midwifery and neonatal care conducted five times \((n = 5)\) and clinical supervision involving ‘train the trainer’ concepts delivered three times \((n = 3)\) that year. The duration of the clinical supervision course was three days, while the other courses were each delivered over a period of two weeks. These courses comprised theory and clinical practice.

The findings also indicated the personal contact details of the WA cohort. This facilitated communication with the relevant sample of participants to conduct focus group interviews during a later phase of this study. With the findings of the WA cohort completed, the researcher proceeded to establish further information regarding who attended the courses and where in Tanzania these courses were delivered.

### 4.2.2.2 Findings of the Tanzanian Cohort

The analysis of the program data indicated that a total of 149 staff from various health organisations in Dar es Salaam, Tanzania, attended the 12 courses offered by GHAWA in 2013. The attendees were predominantly NMs \((77\%, n = 114)\), while those who identified as nurses \((10\%, n = 15)\) were also included. OHWs \((13\%, n = 20)\) who were non-NM professionals—such as ward assistants or doctors—were excluded from the
study. Of the total number of attendees who identified as nurses and midwives ($n = 129$), 93% of this cohort were females ($n = 120$) and 7% were males ($n = 9$). Figures 16 and 17 illustrate these findings.

![Figure 16: Number of Tanzania Attendees and Their Designation](image)

![Figure 17: Gender Distribution of Tanzania Nursing and Midwifery Cohort](image)

Unlike the dataset for the WA cohort—which was more comprehensive, as it included personal contact details—it was identified during this phase that data pertaining to the Tanzanian attendees were limited to where they worked, what course they attended, and when and where they attended the course. These were the only records documented and
available for the purpose of this study. The researcher realised at this point that the study would have to change the sampling process and methodology of inviting the relevant participants to attend focus group interviews at a later stage of the study, as discussed in Chapter 3. However, the analysis did identify that 90% of the course attendees \((n = 134)\) at the time worked mainly in the public health sector of Tanzania (Figure 18).

Of the 12 courses delivered in Tanzania, 42% of this cohort attended the acute and emergency care course, 31% attended the midwifery and neonatal care course, and 27% attended the clinical supervision course (Figure 19). It was unclear why participants chose to attend specific courses, although this could have been based on the areas of organisational need.

The attendees came from eight organisations, including public hospitals \((n = 5)\), nursing and midwifery education institutions \((n = 2)\) and a private hospital \((n = 1)\) in Dar es Salaam. Only one organisation was located in a rural area, while the remaining organisations were located in the urban area. Figure 20 illustrates the number and percentage of staff from each organisation who attended the GHAWA program.
4.2.3 Summary of Phase One

The key findings of phase one were as follows:

- GHAWA provided a total of 12 courses in 2013. There were three different types of courses delivered: acute and emergency care, maternal and neonatal care, and clinical supervision.
• A total of 12 WANMs delivered education sessions to 149 Tanzanian health staff from eight organisations in Dar es Salaam, including people working in education institutions, public hospitals and private hospitals.

• Of the total number of attendees, 87% ($n = 129$) were NMs. The remaining 13% were identified as OHWs.

• While a clear set of descriptive data was evident, it was identified during this process that there was a lack of recorded personal details of the Tanzanian attendees. This meant that the researcher could not directly target the specific individuals to participate in focus group interviews. Consequently, the sampling process for the next phase of this study had to be modified and an alternate option to invite TNMs to participate was devised. This is discussed further in Section 4.4.

The purpose of phase one was to identify the relevant participants for this research, so that the framing of samples could occur during phase two to prepare and conduct focus groups and interviews with the WA and Tanzanian cohorts. The findings for the next phase of this study are covered in Sections 4.3 and 4.4.

4.3 Phase Two/Stage One: WANMs

Phase two was divided into two stages. The first stage involved conducting semi-structured focus group interviews with NMs who were purposively selected as education facilitators who had delivered CPD in Tanzania. Based on the findings from phase one, the researcher targeted the key informants from WA who could help provide rich information about the study, including their experience of providing CPD in Tanzania.

4.3.1 Demographics

The participants involved were NMs from WA who delivered CPD in Tanzania for GHAWA. Data were collected through focus group and one-on-one interviews. The demographics of these participants are outlined below.

According to the methodology used, the participants for this stage of the study were selected through purposive sampling from the data identified during phase one (discussed in Section 3.9.1). The group of WANMs ($n = 12$) identified as education facilitators were selected based on their expertise in relevant clinical specialities and management. There were seven RNs, four RNMs and one RM. The gender distribution was one male
participant and 11 female participants. Since the nursing and midwifery profession predominantly comprises women, the proportion of men to women in this instance was not unexpected. The findings showed that, in 2013, these participants were in Tanzania to provide relevant education sessions at various health organisations in the Dar es Salaam region. The duration of their stay was between one and three months. This immersion assisted in providing information about their experience and perspective regarding CPD in Tanzania. Thus, they were invited to participate in the study.

As stated in Chapter 3, the plan was to have a minimum of six participants in each focus group. However, because of retrospective data collection and the identified contact details, which were at least two years old, it was unclear whether the available contacts were still current at the time of this study. Thus, the number of participants who could attend the focus group was dependent on the individual responses of those who participated in the 2013 program. Of the 12 WA participants contacted via purposive sampling, six responded and agreed to participate in the study. The number of participants who were interviewed, were one male and five females. One focus group and two one-on-one interviews were conducted. Table 8 presents the demographic data of the participants during this first stage of phase two. The findings of the interviews are described in the subsequent section.

<table>
<thead>
<tr>
<th>Facilitators’ Designation</th>
<th>Gender</th>
<th>Participated in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>4 × female</td>
<td>Focus group and one-on-one interview</td>
</tr>
<tr>
<td></td>
<td>1 × male</td>
<td></td>
</tr>
<tr>
<td>RNM</td>
<td>1 × female</td>
<td>One-on-one interview</td>
</tr>
</tbody>
</table>

4.3.2 Findings of Phase Two/Stage One

Data from the focus group and one-on-one interviews were analysed to examine the WANMs’ perceptions of CPD in Tanzania. This identified the first-hand experience of their encounter with the TNMs who attended the education sessions. Section 4.3.2.1 describes their initial experiences related to language barriers and resistance, which were unique findings uncovered at the start of delivering CPD and are therefore highlighted separately. Additional findings also highlighted the common themes that emerged...
regarding the barriers, enablers, evidence of the program outcomes, and sustainability of CPD in the country. These findings are discussed in detail from Sections 4.3.2.2 to 4.3.2.5, and listed in Figure 21.

4.3.2.1 Initial Experience and Encounter with Tanzania Health Staff

A close examination of the data revealed challenges that the WA cohort encountered during their stay in Dar es Salaam while providing education to the local health staff. These challenges are described under the categories of language barriers and resistance from the local NMs who worked at various organisations in Dar es Salaam.

4.3.2.1.1 Language Barriers

The participants recognised that the main language of Tanzania is Kiswahili; however, the people’s command of the English language is reasonable, as NMs are taught and examined in English as part of their qualification. However, this was not necessarily reflected in the WA cohort’s experience. The interview participants described that some NMs in Tanzania were unable to fully comprehend the education provided:

Generally speaking, I think that [for the] nurses from the peripheral areas, language was more of a problem for them than the ones who were working in [organisation two], for instance. (stage one, focus group one [S1, FG1])
Another participant stated:

I think the lack of Swahili was a hindrance. It would be more meaningful to deliver it [the education] in Swahili. (S1, FG1)

The perceived difficulty was that some TNMs would not be able to engage with the education due to language barriers. Another barrier that was articulated, was the resistance to WANMs providing education.

4.3.2.1.2 Resistance

They further expressed that some Tanzanian staff were resistant to the WANMs, and they felt a sense of despondency from the Tanzanian staff:

[They said] ‘You come here as the white people telling me what to do. You think you are better than me because you are white’. I said, ‘No, I’m not. You cut me, I bleed the same as you do. It’s exactly the same, we are just different colours’. (S1, FG1)

I spent a lot of time talking to them and the reason they were angry … was more despondency, and they said to me, ‘Well, it’s all fine and well for you to come here, you’ve got all the resources and we have nothing’. It doesn’t translate across. (S1, FG1)

To gain an understanding of why some reacted in this manner, the participants from WA approached the situation with open communication and were able to overcome their differences. It was through this process that the group bonded:

[I said] ‘There are some things that you can teach me. This is a two-way street. I’m coming here to try and help you grow. You are giving just as much back to me’. We then sort of connected and had an understanding. It was quite an enlightening conversation. (S1, FG1)

The WA cohort explained that, while they encountered initial challenges in Tanzania and managed to overcome them, they also observed significant barriers faced by the Tanzanian staff. This separate theme is discussed in the next section.

4.3.2.2 Perceived Barriers

According to the WANMs, the barriers that affected the Tanzanian staff’s productivity derived from challenges in the workplace, including environmental concerns (such as
insufficient resources), lack of skills, limited critical thinking ability and a traditional way of learning.

4.3.2.2.1 Environmental Concerns

As a result of the nature of the workplace, an acute shortage of human resources and lack of basic medical equipment were environmental factors that affected the TNMs’ ability to provide appropriate care. Without simple and inexpensive medical resources, the NMs were restricted and unable to provide clinical care that was considered basic best practice. For example:

One of the senior nurses was showing me how they place nasogastric tubes … and I said, ‘How do you know whether that nasal gastric tube is actually in the right place?’; and she said, ‘We used to have litmus pH paper, but the hospital doesn’t have any anymore’. And I said to her, ‘How do you gauge whether you have got it in the right place?’. She said, ‘Well we just have to do the whole listening to see’, which is something that we [in Australia] don’t do anymore because it’s not reliable. She also said, ‘I don’t know why we don’t have litmus paper anymore’. (stage one, interview two [S1, Int2])

They just didn’t have the resources … even simple stuff, like oxygen. If they don’t have oxygen, then they can’t give it. When they did have oxygen, they might have one oxygen concentrator, but have to use that one oxygen concentrator between two wards. They probably could have done with four or five or 10 on a ward. In the emergency department, they only had one. (S1, FG1)

An emergency department of what was really quite a busy hospital had only one blood pressure cuff and just one station where people could get their blood sugars done … people coming in with chest pain, but there is no means of finding out what that chest pain is. There is no ECG [electrocardiogram] machine to do a read out of their chest pain to know what’s causing it. (S1, Int2)

When the WANMs realised the challenges within the hospital environment, they had to adapt the education by providing information that was relevant and by using the practical resources available in the local Tanzanian context:

They didn’t have the resources to be able to put into practice what they learnt. (S1, FG1)
Practical resources that are definitely going to make a huge difference, and you’ve got people resources that make a difference … that coupled with the knowledge … knowing what to do with that information. Because knowing how they might be able to bring change. For a lot of them this is what we have to work with. (S1, Int2)

You can teach them as much stuff as you like. It would be awesome for them to know and I’m sure they would have loved to have been able to do it. But they didn’t have the resources to be able to put into practice what they learnt … so I ended up talking about more conceptual things like, learn what you can, when you can, that are more than specifics at that time. (S1, FG1)

In addition to this, according to the WANMs, the TNMs’ clinical skills were limited, as discussed below.

4.3.2.2.2 Lack of Skills

The WA interview participants explained that TNMs moved between wards regularly. This prevented opportunities for reinforcement of skills and clinical specialisation in high acuity areas. Explanation regarding Tanzania’s rostering system showed that this affected local staff’s ability to provide specialised care, thereby indicating a lack of skill in specific areas:

They change through their areas very quickly. They might be working in a kids ward, and then they are in a maternity pre-eclamptic ward, and then they might be back to an adult ward. So one of the big push is for the professionalisation of midwifery in Africa, and that people can be dedicated and skilled within that area and stay in those areas for a greater length of time … that would have a big impact. (S1, Int1)

Another example was:

The first year I was there, there was a girl who was working in the ICU [intensive care unit] at [organisation two], and everyone spent a lot of time talking to help develop her knowledge. And when I went back the second year, she was working on the dental ward—she wasn’t working in the ICU any more. It turns out that she had been moved by the management—it wasn’t her choice to move. So there is a lot of movement, lack of choice of movement that they get exposed to. (S1, FG1)
One of the WANMs explained:

Certainly with the nurses that we were involved with, many of them were rotating throughout the hospital. Probably a bit more specialised, so that it was actually incorporated into speciality treatment, is probably the most effective. Because you have already got people who have the knowledge, experience and enthusiasm for that area they are working in. Having said that, all of the nurses, in many of the hospitals that we were training the nurses from, actually rotated through constantly. (S1, Int2)

In addition, it was apparent that, while the TNMs were keen to learn, their critical thinking abilities were not developed, as discussed below.

4.3.2.2.3 Critical Thinking Skills

Critical thinking was also seen as a limiting factor of the local staff’s capacity to extend their practice. It was described that their limited ability to critically think was because of differences between the TNMs’ and Australian NMs’ method of learning. For example:

A lot of them are actually really keen to improve their practice and understanding. I did find that they rote learn, so they could flick out the blood values of an ABG [arterial blood gas] … but they couldn’t necessarily put it all together and relate it back to any sort of system. (S1, FG1)

Can only deal with one system, and the basics … can’t link the two and how they work. (S1, FG1)

Seemingly, this notion of critical thinking did not occur to the WANMs until their experience in Tanzania. This was because they saw critical thinking as common practice in Australia. Some examples included:

I never really thought about critical thinking until I went there. They have no critical ability to critically analyse things. (S1, FG1)

They were very literal in what they learn. (S1, FG1)

One of the big things that was quite new to them is the whole area of critical thinking. (S1, Int2)
One participant described this to be a cultural and traditional way of learning:

I am old … it reminds me of my hospital-based training, where you learnt processes and you didn’t have to think … how to connect any of it [systems] together. So it was like, okay … I’ve learnt about gastric ulcers—tick that box. (S1, FG1)

While the barriers above are numerous and broad, some of the issues identified were beyond the NMs’ control. Environmental barriers (such as the lack of equipment and human resources) are system-wide issues that required action from the government and hospital administrations. However, the NMs could alter their level of productivity by the way they thought and practiced, such as applying critical thinking skills through using reflective practice. The WANMs observed the TNMs’ motivation to improve their practices and make positive changes in their workplace and clinical practice. Thus, key enabling factors to overcome the apparent barriers are described further in the following section.

4.3.2.3 Perceived Enablers

The WANMs identified that, through perseverance, relationships were formed between them and the Tanzanian staff. The use of reflective practice and open communication generated a sense of trust, motivation and empowerment. These key enabling factors are described as follows.

4.3.2.3.1 Reflective Practice

Strategies such as reflective practice enabled the facilitators to gain insight to the challenges faced by the local staff in Tanzania. It also identified to the WANMs how local staff felt about their work situation. One participant who used reflective practice as part of the education learning exercise revealed an internal level of distress, such as the helplessness experienced by the TNMs:

When we got people to do reflective stories about specifically positive or negative things that had impacted them, all of a sudden, you got the understanding of what is going on under the surface. So on the surface, ‘well, this is it’, but actually, underneath, their personal experience is expressed in reflection that they were very distressed. They didn’t have the means to be able to help this patient, or, if they had managed to get this patient for a head scan earlier, they may have saved their life. They were actually trying.
Trying to get the appropriate treatment for that patient and really there was nowhere for them to go. (S1, Int2)

In support of the statement above, another WA participant from a focus group described their observation that Tanzanian staff were trying their best under the circumstances:

Some of the handwashing soap had been so diluted that you could barely get a lather up … and you did see some of the gloves being washed again and again. They tried where they could, so there was at least an acknowledgement that that was the right thing to do. (S1, FG1)

Another participant explained that the reflective practice enabled TNMs to examine their existing concerns and consider what can be done differently:

I think the reflective practice was good … it generated some discussion around issues. It also supported people to take on more advocacy roles, in that they can actually report things to supervisors or they had the power to make those changes … give people more autonomy and permission to speak out about what is and what’s not right in their clinical areas. (S1, Int1)

This practice further encouraged better communication between the WA and TNMs.

4.3.2.3.2 Open Communication

The reflection and open communication processes allowed NMs from both countries to understand each other, and for the WANMs to recognise what life was like as a nurse and midwife in Tanzania. A participant stated:

I think it was encouraging for them to be able to share some of their stories—share some of their struggles with other people who would understand from a nursing perspective. (S1, Int2)

This enabled them to build a good rapport, which also fostered a sense of trust and empowerment. To maintain the connection and trust built between those involved, the participants suggested that similar people from WA who had gone to Tanzania with GHAWA in the past could return to continue delivering education. Building on the established relationship was seen as significant to providing ongoing support. For example, one participant explained:
It takes time to get their trust … I spent a lot of time developing that relationship and developing that trust … and that comes back to ongoing support. You can’t just go in because some of them potentially perceive us as another group of Western nurses coming here—we just have to listen to them for a little while and then they will be gone. It’s about that ongoing support and ongoing trust. (S1, FG1)

Other participants discussed how open communication built relationships, reinforced clinical practice development, and developed trust with their counterparts in Tanzania:

Having someone there that gains the trust and respect of the people … because things work very differently. You can’t just go in and say, ‘Hi, I’m such and such, and I’m here to teach you’. You need to have somebody there that goes in regularly. That builds those relationships with the people, builds this trust. It’s like building blocks. It needs to be the same person or a couple of people that are doing it because as soon as you go back with somebody new, it’s starting all over again. (S1, FG1)

It’s about reinforcement of practice … and it takes time to get their trust. (S1, FG1)

The influence of reflective practice not only created trusting relationships, but also gave the NMs an opportunity to have a voice and to be heard. This motivated and empowered the Tanzanian staff to consider how things could be done differently. For example:

We need to go back to basics, like the physical assessment, looking at the IV [intravenous] cannulas … how to prevent infections in IV cannulas. Those sorts of really basic things can actually empower the nurses. (S1, FG1)

We need to empower them with the small things that they are doing, and that comes back to ongoing support. (S1, FG1)

By continually supporting the Tanzanian staff throughout their time in Dar es Salaam, the TNMs’ motivation level became apparent:

Some in our group were more interested than others, and some actually became more interested as the course went along. (S1, FG1)

There may have been one or two individuals who were maybe there because there was an incentive—either financial or some other incentive for them to be there—who perhaps didn’t maybe invest in the program, so wouldn’t have got as much out of it. But they were the minority. (S1, FG1)
The WANMs also revealed that CE empowered the local staff:

For probably the majority of people, they did feel more empowered and able to go and do things, and to change things. (S1, Int2)

It gave them a sense of empowerment from a psychological and learning perspective. It was worth doing just from that. (S1, FG1)

As a consequence of these enablers, the evidence of the program outcomes was apparent to the WA cohort, and the findings are presented as follows.

4.3.2.4 Evidence of Program Outcomes

According to the WANMs, the NMs in Tanzania demonstrated an improved ability to provide education and further became champions of good practice, which led to clinical practice and workplace improvement. There were also indications of local NMs sharing their knowledge gained from the program. These outcomes, as identified by the WANMs, are categorised under ‘champions of good practice’, ‘change in practice’ and ‘TNMs teaching others’.

4.3.2.4.1 Champions of Good Practice

Following the CPD education, the WANMs described that the motivated TNMs felt empowered to challenge their status quo and change the way they practiced. These individuals were observed as champions of good practice. Examples of this included:

What the program did for some of the nurses, the motivated ones, was enable them to become champions within their own clinical areas and that’s a really important thing. (S1, FG1)

When you start sowing that seed where, as an individual, you can actually change practice, you can say, ‘No, we don’t do it like that anymore. We actually understand now that this is a much better way of doing it’. So if you are able to empower somebody individually with that sense of confidence to bring change and to stick at it, I think that is a really positive thing and that is something that has already happened through the GHAWA program, by going back and going back. There are particular individuals who have really taken and run with it, and said, ‘We can do this differently, we can do this better’. (S1, Int2)
These champions had an influence on their workplace by altering their practice, thereby influencing change.

4.3.2.4.2 Change in Practice

The WANMs identified that there were signs of TNMs imparting the knowledge gained from the program to their peers. This led to changes in their clinical practice and work environment. Examples included:

Depending on the degree of motivation, it sparked their interest and it encouraged them to go on to look at their practice more. (S1, FG1)

From the reflective practice … people sort of felt that they could go back to their work environment and say, ‘We need some oxygen tubing’. Or skin to skin, we’ll keep the babies there for a bit longer. So I did notice more basic and more women-centred care. (S1, Int1)

Certainly from the rural area what we noticed, the changes … there was more safe practices. Also at the dispensaries and district hospital, they put in place the eclampsia box and the PPH [postpartum haemorrhage] postpartum box, so there were changes there as well. (S1, Int1)

As a result of the education provided by other previous WANMs of GHAWA, positive changes in the TNMs practice were also noted by these research participants:

Because of previous teams that had gone through, I can remember walking into one of the ward environments and the staff had everything all written down on the board because she was a very enthusiastic person for educating staff. There is no doubt that different people have been taking on board the previous education that they’ve had, and taking it back into the workplace and wanting to implement it in there. And that was good. (S1, Int2)

Definitely effective … absolutely no doubt that, from the areas of midwifery and looking after emergency situations for neonates, I would say definitely there were people who were very enthusiastic, very keen to show that practice had changed and they were doing things differently. (S1, Int2)
Thus, the education helped enhance the NMs’ professional development and resulted in change of practice:

It was a lightbulb moment about some of the things they were seeing in their areas. For example, [in] the eclampsia ward, they knew that the doctors did conscious state on their patients, but the nurses never did them. One of the nurses who was a manager developed a chart for the nurses to do conscious state. So depending on the degree of motivation and the degree of their sparked interest, it encouraged them to go on to look at their practice more. (S1, FG1)

According to the WANMs, these changes created a ripple effect, as local staff imparted their knowledge and skills to their peers in their respective units and organisations.

4.3.2.4.3 TNMs Teaching Others

In 2013, three types of education were delivered. One participant found it advantageous to blend elements of the ‘train the trainer’ course with the midwifery course:

I think when we used some of the concepts from the train the trainer course and blended it into our midwifery course, and had it very targeted to maternal health care, I believe it was effective … that was how we were successful in running the rural program. (S1, Int1)

The WANMs described that the TNMs taught and learnt in a didactic manner. Thus, the WANMs employed an interactive approach when providing education and supporting the local staff, such as using role play and clinical drills. They found that this facilitated better engagement and interaction with the Tanzanian staff who attended their courses. The TNMs who were motivated were also able to identify a different style of teaching, and deliver education themselves:

They need support in what they are teaching. Two of the educators that we worked with, they had planned to put in to their program, such as physical assessment. The way we were teaching it, it was like a revelation to them. (S1, FG1)

They actually did provide some teaching within the clinical ward environment … with other staff members and even doctors, nurses and midwives. We actually saw them run an eclamptic drill and we also had … a real patient. They just pretended that they were having a fit and so everybody did that drill. And what we also noticed was, those
midwives taking them to the rural area, they could actually see the changes that needed to be made in the workplace. (S1, Int1)

The findings described in this section clearly indicate the effectiveness of the program from the perspective of the WANMs, and present suggestions about sustaining the provision of CPD in Tanzania into the future. For this to occur, the WA cohort explained that ongoing support and more work is required. Their perceptions regarding the sustainability of CPD in Tanzania are covered in the section below.

4.3.2.5 **Sustainability of CPD**

The overall consensus from the WA cohort showed that the TNMs were benefiting from CPD. However, while gradual changes were evident, as discussed earlier, because of the diverse and compounding issues faced by the local staff, it is difficult to create sustainable change in Tanzania. The categories of ‘support from higher level’, ‘role models’ and ‘structure for CPD’ described the efforts required to sustain CPD from the perspective of the WANMs.

4.3.2.5.1 Support from Higher Level

Aside from the limited resources and skills, other issues found to be significant in maintaining CPD and ensuring its success were that there was no supervision and monitoring of practices to support and maintain standards. The participants explained:

> I saw in hospitals, there is no real governing nursing body that is going to make sure that you maintain standards. So if you’ve been nursing for 20 years and you come to a course, like some of the participants in our group, you know everything is going to slide if no one is really maintaining standards. It doesn’t mean they didn’t get to learn those things in the first place—they probably did. But as soon as they entered practice, there wasn’t any standard to be maintained really for them. (S1, FG1)

> It is unclear what they are expected to do, and also it’s unclear whether they were doing it. Because if they weren’t attending to what we consider basic nursing care, then I’m not sure what their role was … whether they were doing it or not. (S1, FG1)

The participants also stated the lack of accountability observed in the hospitals. For example:
There is that tidal wave of, well, no one else is worried about that. Whereas it’s about reinforcement of practices that we are trying to change. (S1, FG1)

There is not the accountability there [in Tanzania] that there is for us [in Australia]. (S1, FG1)

Thus, efforts from a higher-level healthcare system standpoint are crucial, and support for the local workforce is needed. One participant described this:

They were saying that they needed more support, so that they would become more confident … there wasn’t the mentorship and the support there, and the sort of government program structure to allow that to occur. (S1, Int1)

Consequently, support in the form of good role models was raised as a strategy to help sustain CPD.

4.3.2.5.2 Role Models

While the above observations provided insight into issues regarding standards, the participants indicated that certain strategies could create sustainable change, such as mentoring local staff to be role models and providing ongoing support for CPD. The following statements highlight the WANMs’ emphasis on the need for role models:

I believe ongoing mentorship in the clinical area is what’s going to make it sustainable. (S1, FG1)

Role modelling and providing support because a lot of them are actually really keen to improve their practice and understanding. (S1, FG1)

I don’t believe this is sustainable unless there is provision for that ongoing support and role modelling and mentorship. (S1, FG1)

It’s not just delivering the information, but actually role modelling what the expectation is. (S1, FG1)

Central to role modelling was also ensuring that continuing education was supported and made available to NMs. The participants stated:

There needs to be continuing education going on because otherwise there is always the risk that the people that have been educated, if they don’t pass that on to the next people,
it will eventually get watered down and lost somewhere in the system. So the revisiting and going over again what’s already been done before, both with those who have been through the course, and also for new people who have joined, actually means that it gets sustained. (S1, Int2)

Sustainable is to build up the capacity of the local workforce and I think that, first, people spending a bit of time training them and mentoring them to run workshops, and then bringing out the champions to actually run the more structured courses, and going from there. We should be able to really wind back the number of people from Australia that we send, and just have a main program person there. That’s why I think the environment and the mentorship is the important part there. (S1, Int1)

Considering these comments, developing an appropriate structure to facilitate opportunities (such as finding time to teach and role model) was perceived by the WANMs as important, so that CPD could become sustainable in the longer term.

4.3.2.5.3 Structure for CPD

The WANMs identified that another sustainability issue to consider—that affected the TNMs’ ability to extend their CPD support locally—was finding the time to provide education. Clearly the wards were busy and understaffed; thus, the situation was not conducive to CPD as the NMs did not have the time to support their colleagues and attend to all their patients’ needs. One participant explained:

Resources of time, resources of people. You know, if you’ve got 30 babies to look after and you are the only person, you know, it’s very difficult to do more than just constantly looking after 30 babies, let alone do anything else when it comes to educational change or training or anything. That would be the biggest thing, I would say. (S1, Int2)

While this is a system issue and a significant hurdle to overcome, finding ways to structure and quarantine time for CPD, as well as creating practical opportunities to ensure its sustainability in the long term, are central to improving knowledge and safeguarding best practice. Another participant addressed this as follows:

The goal of getting … Tanzanians to teach each other, it would make it sustainable. But getting to that point, I’m not sure—that’s a difficult road. (S1, FG1)
The WA cohort agreed that CE is imperative for NMs’ professional development. Although some people would volunteer and offer their expertise, such as those WANMs in this study, the question of longer-term sustainability remains. Mentoring, empowering local staff to be role models and giving local people the confidence, knowledge and time to teach and support their peers are practical ways to encourage CPD. The findings show that, to achieve a sustainable shift, solving environmental issues is just as significant as developing and increasing local opportunities for CPD.

4.3.3 Summary of Phase Two/Stage One

The key messages identified from the findings in stage one indicated that the education provided was effective. Although there were many barriers related to environmental concerns, the use of reflective practice by the WANMs facilitated the TNMs’ learning and stimulated them to examine their existing practices. The outcomes of the education were that it motivated and empowered the TNMs, and gave them the confidence to make changes in their workplace, including to their own clinical practice. The WA cohort articulated that the critical elements to create sustainable change included commitment for ongoing support of CPD, and mentorship through good role modelling.

4.4 Phase Two/Stage Two: TNMs

The focus of stage two was to investigate the views of the TNMs in Dar es Salaam about CPD. This involved conducting semi-structured focus group interviews via convenience sampling with NMs who previously attended CE provided by GHAWA. Before interviews could occur, the relevant participants had to be identified, so that the demographics of these NMs could be reported. As a result, the findings from phase one (as described in Section 4.2.2) were used to facilitate this stage of the study—that is, identifying where GHAWA-related education was delivered in Dar es Salaam and from where the education attendees came. This is presented in Section 4.4.1, followed by the findings detailed in Section 4.4.2.

4.4.1 Demographics

Based on the findings from phase one (Section 4.2.2), the data indicated that 149 health staff from eight organisations in Dar es Salaam attended education sessions offered by GHAWA in 2013. These staff consisted of people working as nurses, nurses/midwives
and OHWs who were non-NMs. Given that this investigation considers the views of NMs, people who identified as nurses or NMs were included in the study. Eighty-seven per cent of those who attended the CPD education were NMs. Figure 22 displays the distribution of NMs and OHWs from the respective organisations that attended GHAWA education.

![Figure 22: Designation of Tanzanian Attendees by Organisation](image)

The researcher originally intended to invite these NMs to participate in focus group interviews; however, because of the limited information (such as the lack of participant contact details), the researcher was unable to locate the specific individuals. Consequently, the alternative was to invite relevant NMs who had previously attended education provided by GHAWA from the eight participating organisations.

Using a convenience sampling approach (see methodology described in Chapter 3), 33 NMs from seven of the eight organisations in Dar es Salaam consented to participate in the study. One organisation (organisation number three) did not participate because they were closed and staff were away during the period when the focus group interviews were conducted. Figure 23 illustrates the distribution of NMs from the respective organisations that participated in the focus group interviews.
For the participants’ convenience, all interviews were conducted onsite at the respective organisations in Dar es Salaam. Organisation numbers one, two, six and seven had a larger number of NMs that attended CPD; however, because of staffing shortages, only a limited number of NMs could attend the focus group interviews. Organisation number eight only had two staff attend CPD in 2013. This was because that was the first year GHAWA had started supporting this rural organisation. Five staff participated in the focus group interview carried out in 2015. All participants at this organisation indicated that they had attended education provided by GHAWA post-2013. Section 4.4.2 details the findings from the seven focus group interviews.

4.4.2 Findings of Phase Two/Stage Two

The data from the focus group interviews were analysed to examine the TNMs’ view of CPD in their country. This study explored the experiences of the NMs who attended the education sessions provided by GHAWA and what they did with the information. Using thematic analysis, themes emerged regarding the barriers and enables for CPD, including evidence of the program outcomes. These NMs also commented on the need for ongoing CPD support to help sustain their development into the future. Details of the findings are discussed in Sections 4.4.2.1 to 4.4.2.4, and summarised in Figure 24.
4.4.2.1 Barriers

The key barriers to CPD identified by the TNMs were issues related to environmental, educational and incentive concerns. The findings of these were categorised accordingly and described as follows.

4.4.2.1.1 Environmental Concerns

The factors that are included in environmental concerns are shortage of staff and lack of medical equipment. The most prevalent factor that limited the TNMs’ ability to participate in CE was a shortage of staff. This affected their time; thus, staff found it difficult to attend and provide CE in their workplace. Below are the participants’ comments regarding the difficulties faced by these NMs:

It’s shortage of staff. You find that maybe on the ward you are the only person. So whom can you teach when you are alone? You can work by experience, but nobody to teach. Unless you are two. You can use that single day to teach others, but we are very few in this block. (S2, FG1)

There are so many patients, so everybody is busy. Each one is our patient, so no time to teach others. (S2, FG5)

I mean, for example, when rostering, if there are three of us, at least one can go and the one that go can teach others. But because we are few, it is difficult to even do this. (S2, FG1)
The limited number of staff caring for the large number of patients identified across various organisations was raised as a major concern that further compounded the TNMs’ inability to attend and provide ongoing CPD locally to their peers. The following are examples of the participants’ descriptions about the dire situation of staff allocated to patients (staff to patient ratio):

In our wards, we have many patients. For example, one ward can contain maybe 40, 50, 38 patients. Maybe only one and another midwife, so there are many duties to do there. So you are looking for criteria, what is important to do first. (S2, FG1)

Sometimes may be two [staff] to 80 [patients], one to 50, or five to 100 babies at neonatal ward. (S2, FG1)

It became apparent in the focus group interviews that NMs were torn between finding the time to attend to their patients and to attend CPD. As clinical health professionals, their patients came first, and this was an obvious priority. As a result of the severe lack of human resources for health, CPD was seen to be of secondary significance. One participant explained:

The lack of human resources, because sometimes you need to attend. But because of the shortage you need, for example, teachers. You have some topics to cover within that short time and you are needed to go to CPD. So what will happen? You need to do your primary role first, and this [CPD] is secondary. (S2, FG4)

Other participants’ comments regarding work prioritisation included:

Prioritise. You are going to help the patient, rather than going to education. (S2, FG1)

We have a lot of sick patients. We have no time to talk because patients are waiting for you for care. (S2, FG2)

Another environmental difficulty experienced by these NMs was the lack of medical equipment. The participants stated that this limited their ability to provide appropriate care. For example:

[We have a] lack of required equipment which will help us to provide the required and good services for our patients. For example, sometimes we have no suction machine or it is not working, and we cannot provide the good care for patients. (S2, FG1)
Some of the instrument which are supposed to be applied during the resuscitation, they are not there and, if there are, there are few. (S2, FG6)

In addition to the limited resources available to these NMs, discussions from the interviews also indicated that, after attending CPD, these NMs became aware of their lack of understanding about using the specific resources available in their workplace. This theme was called educational concern, as described in the following section.

4.4.2.1.2 Educational Concern

Collectively, from the focus group interviews, this cohort recognised their limitations. One participant stated that, while they had limited resources in their workplace, there were occasions when they lacked understanding about how to use the specific resources, including their application from a best-practice standpoint. This was described as follows:

Although we do not have enough instruments to provide healthcare to our patients, but for those equipment, old instruments which we have, sometimes we didn’t use it properly because we don’t know how to use it. Like nasopharyngeal—that is a big change for me on how to use it. (S2, FG2)

Patients on oxygen therapy—now I can apply and know how to use it. You have to change those tubes. May be you have to give naso-tubes [nasal prongs] when the patient oxygen is low. I can change to the mask, and, if not improve, I use another type of mask. (S2, FG2)

When asked if the provision of CE existed in the workplace, the participants responded that they had good intentions to conduct education regularly and that staff were required to participate. However, it was not always possible to do so. Their rationale was again a lack of time. Such education was instead sometimes delivered by students who were on practicum at the hospital. One participant explained:

The one who plan is the block manager, but this year it has gone down. We didn’t do one [CPD] last week because we are busy with patients and, most of the time, the students give the education, not nurses. The students come with their topic and they teach. (S2, FG1)
Another participant added:

Because you need to prepare the topic so you can share with colleagues. But you have lots of patients on the ward, you have to care for the patients, and when you finish you have a lot of self-activities at home and cannot prepare the topic. So you find that the time is limited. (S2, FG1)

The TNMs recognised that they needed to develop professionally, and would attend CPD and further provide education to their peers where possible. However, the findings also showed that NMs working at smaller organisations in particular did not always have regular access to CPD locally, compared with those working at larger hospitals. As one participant explained:

It is in some units only, not everywhere. Most of us don’t get the education because it is not available in our workplace. (S2, FG2)

Further discussions during the interviews revealed enquiries regarding the incentive to participate in CPD. This is described in the following section.

4.4.2.1.3 Incentive Issue

A separate issue regarding incentive to participate in CPD emerged towards the end of some interviews. This arose when the researcher asked, at the end of all seven interviews, if the participants had any further questions or comments to add to the study. Participants from two of the seven organisations raised the issue of financial remuneration for participating in the education. The comments below revealed that fewer staff would attend CPD if there was no remuneration:

If you tell them you have no money to give, very few will come. (S2, FG3)

You know we are given some stimulating issues, maybe money and food. Therefore, this should be increase so that to stimulate and to attract more people. (S2, FG6)

The researcher noted that the GHAWA program was provided at no charge to anyone to attend the education sessions, and while no financial remuneration was given to the attendees, refreshments were provided. This area was investigated further to gain more insight about its influencing factor. The comments highlighted that financial and food
incentives could alter NMs’ attitudes towards attending CPD, and help improve participation. One participant explained that:

They attend, but they say, ‘we go there, but no money’. They complain. They are reacting. But slowly they have to change—it is not all about money. (S2, FG3)

Two participants described that refreshments would be useful to encourage attendance:

If you have no money, then maybe you can have some bites. Something to eat. (S2, FG3)

When you invite someone to participate in your class, if you can encourage to have a tea inside the session. So you improve others to come and participate in the class, more people attend and will participate. (S2, FG6)

It also seemed that some participants’ lack of will to participate in CPD was because of a lack of motivation. As described by a participant:

I think sometimes it’s attitude. You get money if you go and attend the education … It is related to … lack of motivation. (S2, FG3)

The barriers identified from the focus group interviews in Tanzania paved the way to discuss factors that would improve the TNMs’ productivity in their workplace through the use of CPD. This is discussed further in the following section.

4.4.2.2 Enablers

Despite the challenges faced by the TNMs, the focus group interviews also generated a significant amount of information about the enabling features of CPD. It was found that motivated educators and the application of critical thinking facilitated the TNMs’ empowerment and confidence. These were categorised accordingly within the overarching theme of ‘enablers’, and described as follows.

4.4.2.2.1 Motivated Educators

The education facilitators played a significant role in motivating the class participants. As described below, the participants revealed that they influenced the TNMs’ learning:

The kind of teacher who we’re talking about, that are teaching us, they are very good motivators. (S2, FG5)
It was really helpful to us. I upgrade my knowledge and I gave my students new knowledge as well. (S2, FG4)

This was reinforced by an interview with the WA cohort (refer to section 4.3.2.4.3) in the individual’s observation (see quotation from S1, Int1), where some TNMs were motivated to provide education in a non-traditional manner, such as conducting clinical drills and teaching their peers through role play. In addition, this fostered developments in critical thinking.

4.4.2.2.2 Critical Thinking

It was found that the reflective practice applied by the WANMs stimulated the TNMs’ critical thinking abilities. While this cohort did not specifically discuss reflective practice, they gave examples that mirrored the ability to reflect and think critically about issues in their workplace. This stimulated their thinking to alter their nursing and midwifery practice in a positive manner. One participant used the example of trouble-shooting a patient’s care management with oxygen therapy:

 Patients on oxygen therapy—now I can apply and know how to use it. You have to change those tubes. May be you have to give naso-tubes [nasal prongs] when the patient oxygen is low. I can change to the mask, and, if not improve, I use another type of mask. (S2, FG2)

Another participant from a separate focus group interview gave an example of their ability to manage mothers in obstructed labour differently while waiting for medical assistance:

 When you are seeing the gush of blood after delivery, the placenta, first thing I remember that GHAWA told us check the uterus … Don’t run, just palpate the uterus … can help to contract the uterus … and when you are calling for help. Since we finish the course, we change our self and even our friend staff. Now we have good knowledge. We know what to do, and we decrease the number of neonatal and maternal event. (S2, FG5)

As a result, a sense of confidence was generated after attending CPD. This further empowered TNMs to review their practice and strive to uphold better practice.
4.4.2.2.3 Confidence and Empowerment to Change

The participants acknowledged that they gained confidence from their professional development. Instead of accepting the way things were, they were empowered to be proactive and make changes in their workplace. For example:

When the course was finished, I told all staff in my unit that hand washing is very important before touching the patient. All sink and tap water is now working. Before, two taps were not running. After the training, I told them to repair it, so we can do our procedure in handwashing. (S2, FG2)

Me and the floor staff have the responsibility to bring changes. I am junior, so I told my senior in charge of the ward about the whole importance of our training, and I told them what is necessary to be done, and she listen to me and things now are working. (S2, FG2)

I will make sure that my floor staff are responsible and make sure that things like soap are ordered before we run out. (S2, FG2)

Another participant explained that their confidence enabled them to enhance their skill in supervising students. Knowledge sharing with their peers also occurred as a result:

Improvement in the supervision of students in the clinical area, and when I was demonstrating at management stage, I was very confident and I include my peers. (S2, FG4)

It was clearly reflected in the focus group interviews that the education provided to this cohort enabled the participants to examine their own skills, and gave them the confidence to improve their knowledge and clinical practice. Some additional examples of confidence derived from CPD included:

It is effective because it make us to be confident during providing some procedures. (S2, FG1)

Nowadays, we have more confidence to do things, especially for CPR [cardiopulmonary resuscitation] for the adult. (S2, FG1)

I feel very comfortable after attending the course to do my work. If I found someone not breathing properly, I can handle it effectively. It is different from the past, before
the course. When I find patient like this, difficulty breathing, I was frightened: ‘What
is that?’ I then call other staff to help the patient before, but now I can help the patient.
(S2, FG2)

Since the day of the course, we feel very confident to our practice. If I meet a challenge
and when I go back to home, I review the notes. Then I become competent and
confident to what I was having a doubt. (S2, FG6)

There has been some changes compared to the previous days when we provide the
healthcare. It is very important the training for us, because it reminds us on how to
provide emergency care for the patients. Because we forget some procedures on how
to provide CPR, patients who are not breathing, and also I think we did procedures
without using guidelines. So we gain a lot on things on how to provide health and give
care to our patients. (S2, FG2)

From the newfound confidence of these TNMs, they went on to make clinical practice
changes that positively affected their peers, as described in the next section.

4.4.2.2.4 Motivation and Change in Practice

In addition to the positive changes implemented by the participants within their
workplace, they also expressed examples of changes in their practice. The positive effects
they witnessed because of their change in practice affected their morale, motivation and
productivity. The participants gave examples about what they learnt from GHAWA, such
as the significance of repositioning mothers during labour, rather than leaving patients
lying flat on their backs. They learnt how to implement practical techniques that required
no additional equipment, and only required application of their knowledge, such as
getting mothers: ‘to stand up … to squat and do simple exercises … so the pelvic canal
can open … allow the baby to descend … and help the baby to pass easy’ (S2, FG 5).
This resulted in the NMs witnessing the following change at a particular organisation:
‘So the number of obstructed labour decreased’ (S2, FG 5).

Another NM gave a similar example, quoted below, to explain their experience of the
professional development received from GHAWA. They applied what they learnt into
practice and, because of others in the workplace observing their management of care for
a woman in labour, their peers were motivated by the enhanced practice, and wished to
learn from them. This demonstrated a flow-on effect of intrinsic motivation:
What we learn, for example, when you are doing exercise with your mothers, you feel confident, because you teach them, and they respond. They feel some difference. Even our coworkers—hey want to teach their mothers how to do exercise. So everybody follow my example on how we teach their mother. (S2, FG5)

Until now, my gynaecologist in block [number], when I was learning, I was in antenatal, now I am working in labour wards. When I was in antenatal, after I finish my GHAWA program, I was always wake up the mother before ward round to do exercise. Nowadays, the gynaecologist … is missing me: ‘Where is [name]? I need exercise to mothers’. (S2, FG5)

What became evident was the development of champions of good practice and role models, as discussed in the next section.

4.4.2.2.5 Role Model

Two participants raised the notion of role models, and stated that they felt undertaking CE and attending CPD enabled them to become a role model. One example indicated that the CPD has engendered collegial trust and the NM had become the ‘go-to person’ among colleagues in the workplace. Statements to support this are as follows:

We have to be a role model; you have to be an example to others. (S2, FG2)

I think my colleagues are trusting on me. Sometimes a staff will say, [name] has attended the wound course and they are having a problem when dressing a patient’s wound, so they come to me. (S2, FG4)

The findings described in the enablers theme highlighted the factors that enabled TNMs’ productivity in their workplace. This productivity provided evidence of the program outcomes. This is discussed in the following section.

4.4.2.3 Evidence of Program Outcomes

The data from participants revealed positive remarks regarding CPD and the outcome of the program. The participants noted that the program was helpful in terms of education refreshing, and commented that their clinical practice transformed after attending the CE and gave them opportunities to teach their colleagues. There was also a noticeable influence on patient care outcomes and job satisfaction. One participant explained their educational perspective:
It reminded me of things which I learnt from school. So when I came here for the first time, I didn’t remember some of the steps of caring for patients, and, during this course and training, it has changed me. After the training, I now know many things. For example, taking proper history of the patient, so I know what to do. I can help to relieve patient’s pain. So that is some of the things I have learnt from the training. But it is a lot of things I have learnt from this training. (S2, FG2)

Some participants described the areas where knowledge enhancement and improvements were evident in their practice. For example, some noted improvements in maternal and newborn care:

We now helping mother with newborn different from before. Before we do this study from GHAWA, good experience, things that we learn from GHAWA with some we learn from our school. But we have a long time since finishing our school, so GHAWA they wake up and refresh us. (S2, FG5)

Other participants noted improvements in cardiopulmonary resuscitation (CPR) practices:

For me, I didn’t know about adult CPR before. (S2, FG3)

I learn about the emergency care of patient, CPR. Before we did [CPR], but we didn’t do it perfect. But after this knowledge, we are now conducting it perfectly. (S2, FG3)

Other participants noted improvements in managing a deteriorating patient:

There is improvement to resuscitation. Before we just do a few minutes, and then they are not alive, so we stop. Even management of PPH—postpartum haemorrhage. Now it is systematic. We call for help, start IV [intravenous] line, and work faster as a team. (S2, FG3)

Further, participants noted improvements in wound care practices:

Before that seminar, I never knew there are other products for dressing. You know, in this country of ours, we only have Providine, and cleaning the wound with normal saline, dressing with Providine, creams and sometimes honey. Then, after attending the course, I got to know some of the advanced material and products for dressing. We also went out to practice at [hospital name] throughout that week for a beneficial outreach intervention. Then what was very interesting to me was the style of dressing patients’
wounds by closing it everywhere on the outside. Previously, we used to put stripes across the patient’s wound, and, at that time, we came across another style—closing side to side and leaving the wound just in between. (S2, FG4)

Despite the barriers identified earlier, there was evidence of the TNMs showing the ability to teach their colleagues after attending the program. For example, a participant explained:

Since we finish this refresher, we change our self and even our friend staff. After finish learning there, we came here to teach them [colleagues], to wake up them. (S2, FG5)

A participant from another focus group gave examples of their knowledge improvement in the management of maternal care:

We have gained many education. For example, for myself, I have changed my knowledge and care for mothers with shoulder dystocia from learning from GHAWA education. So I know and I am able to teach others to deliver mother with that complication and to care for mothers with postpartum haemorrhage. Also we know how to care for obstetric emergency. So GHAWA helped us to improve our knowledge. (S2, FG1)

In addition, one participant who previously attended the clinical supervision course described that, since attending this education provided by GHAWA, they applied the principles learnt in their workplace. As a result of their progressive performance, this individual has since occasionally worked as an examination supervisor, thereby demonstrating individual career advancement as an outcome of participating in the course. This was described as follows:

I learn how to give feedback from the clinical supervision course. I learn how to apply the principles, how to give strong points, and feedback. Sometimes when you get the knowledge, you get confidence. For me, sometimes I become the supervisors of exams. (S2, FG3)

Another participant explained about changing their clinical guideline regarding the insertion of cannulas. While this study did not measure how the education altered the infection rate of patients on the ward, the implementation noted below was an outcome of the CPD:
For example, about the care of IV [intravenous] line. Before the training, we would leave the cannula in-situ for seven days, but, after the training, we know we must only leave it for no more than 72 hours, three days. That is one of the big achievements. I feel very happy and I feel my patients now are safe. They will not get infection in my unit. Maybe somewhere else, but not in my unit.

4.4.2.3.1 Influence on Patient Care Outcomes

The findings also identified changes in clinical practice specifically for maternal and neonatal care, which resulted in improved patient care outcomes. For example:

We have changes on healthcare of the mother and babies, especially for pregnant women and during labour—for babies, neonates, for caring the mother and how they care for their/her baby. And during labour, when there are some complications, which we make changes from the GHAWA studies. (S2, FG1)

A participant explained about improvements to manage and recognise issues during the delivery of babies and post-delivery:

We have been improving much from GHAWA education. Nowadays, we know how to examine the mothers of the delivery, we know how to diagnose babies with problem, like jaundice. When the mothers are discharged, we taught them to look for dangerous signs of their babies when the mothers go back home. (S2, FG1)

Another participant described how the education improved their ability to manage babies with asphyxia:

On my side, when their baby came, they were not breathing—baby with asphyxia. I know now how to position the baby and how to help the baby to breathe. That’s why I am feeling proud. (S2, FG5)

The participants also gave examples of improved knowledge and skills related to managing emergency and resuscitation:

During the course, it taught us how to resuscitate the newborn babies. So after completion of the course, I got the knowledge and when I am now back at the ward, I know how to resuscitate the baby. Even resuscitation of the adults. So we know the difference between resuscitation of the child and adult. (S2, FG1)
This program teach us more on lifesaving skills, we know for the case of saving lives of the mother and the children. (S2, FG1)

For me, I participated in three courses—maternal and neonatal care, resuscitation and the clinical supervision course. I working in maternity block since 2012, so neonatal resuscitation is almost every day. It is our practice to do the neonatal resuscitation because we conduct deliveries. And for maternal emergency, as you know, in Tanzania, we have a lot of emergency, like postpartum haemorrhage, we have antepartum haemorrhage, pre-eclampsia. So for me it is helpful, I use the knowledge to save the life of mothers. (S2, FG3)

Participants from an organisation that provided education to nursing and midwifery students—including clinical supervision of students who were on practicum at various hospitals—gave explanations that indicated evidence of TNMs using the knowledge gained from the program related to maternal care. This demonstrated that the NMs who attended the GHAWA program were practising what they had learnt. For example:

We had learned about the exercises for the mother during labour. Because otherwise they just lay on the bed, so the labour comes very prolonged. But the exercise we have been taught have been applied in the ward. The exercises have given very good results. And also when we went to [organisation seven], it is also what they did there. I give them a discussion and told them about the importance of the exercises, and that they are no bad effects to them. It will help them because the baby in their tummy is like this and this, so when they stand to do the exercises, the baby is going to go down and, from there, you are going to have more quick, short period delivery. The mothers are appreciative for that at [organisation six], [organisation one] and here at [organisations four and five]. (S2, FG4)

Also the other mothers became very much interested with that, and those who are interested with the exercise they too start singing … it helped them very much with their delivery. (S2, FG4)

As a result of the education and change in practices after attending CPD, the most significant finding was decreased neonatal mortality at two organisations—a large urban hospital and small rural hospital. The participants stated:
It has reduced neonatal death. It has gone down. Here, in 2013, the neonatal death was high. In 2014, at least it has gone down. I don’t know about the other hospitals, but in [organisation two], it has gone down. (S2, FG1)

The course was helpful for the newborn baby. They were dying at the previous, but now after the course we study about resuscitation of the newborn, we know the standard and procedure to resuscitate the newborn. Now the death of the newborn has decreased compared with previous. Approximately, for the month was 10 [deaths]. Now we have maybe three or nothing. (S2, FG6)

Many of the aforementioned remarks highlighted that CE enhanced the participants’ clinical knowledge and skills. In addition, it gave the NMs a sense of satisfaction in their work.

4.4.2.3.2 Job Satisfaction

The outcomes also generated a sense of fulfilment and job satisfaction among the participants:

We feel proud … Among the program of GHAWA, the influencing of the course has facilitated us to improve our practice. (S2, FG6)

We thank GHAWA for giving us the knowledge because it helps us to give care and reduce maternal mortality rate. (S2, FG1)

The findings from the Tanzanian cohort indicated that the outcomes of the GHAWA program were positive and effective. Most importantly, the evidence indicated that, when applied in practice, the influence of CPD resulted in reduced mortality. This was a significant finding of this study. To maintain the momentum of CPD and advance these positive outcomes, the participants were asked about how CPD can be sustainable in Tanzania. The findings are discussed in the next section.

4.4.2.4 Sustainability of CPD

The final question during the focus group interviews explored whether knowledge sharing among the TNMs occurred after attending CPD sessions, and how they viewed CPD could be sustained into the future. The factors that could help sustain CPD included nurses teaching others, TNMs creating a regular schedule to provide education locally, education
materials that are up to date, support from management, and ongoing assistance from dedicated clinical education mentors. The participants’ comments revealed that CPD was occurring, both in the teaching and clinical settings. The participants stated that they were applying the knowledge and using the education materials provided by GHAWA. For example:

I upgrade my knowledge and I gave my students new knowledge as well. (S2, FG4)

Some of my students who are in-services students, they also apply it in our environment. And, you know, our university is very close to these hospitals, [hospital name] and sometimes when I go to visit my students in [hospital name], I do see their nurses doing the patients’ dressing in the very same style. So that workshop was very useful. We are teaching nursing students, and even for MD [Doctor of Medicine] students, they are somehow interested. They come to seek information from us. Because they usually meet with our nursing students in the clinical area, and they see the new technique from our student. So I think, even for the MD, they come together to get this new knowledge. (S2, FG4)

The participants also gave examples of allocating time to deliver CPD, and how this was provided:

Yes, we shared them, the management of our problem, and we make a program to explain what we studied at our course. (S2, FG6)

On Wednesday every week, during the morning after the report, we do 30 minutes with the others who did not attend the course. The subject is according to the curriculum which was in the course. We follow the theories according to our course; therefore, from the first one to the last one. (S2, FG6)

We make it as a point that we use the knowledge that we gain from GHAWA, and make an effort to at least teach once a week to even a few people. (S2, FG1)

However, because of their limited human resources and heavy patient workload, as detailed in Section 4.4.2.1, ongoing provision of CPD was not always possible. According to one participant:

Sometimes, we are very busy. No time to teach others, that’s why, but if you have enough time, we teach others. (S2, FG5)
In addition, the participants commented that, when they were able to provide education, teaching materials would be beneficial. For example:

[We need] posters, so that you can get teach on seeing. (S2, FG5)

I think the most we need are resources. You know, when GHAWA come to us, they always come with their material. And once they go away, they leave some of the material with us, and when we have finish the resources, we have nothing … I think GHAWA should continue and GHAWA is not only for us and other organisations. Maybe they should also discuss with our government to buy enough material. (S2, FG4)

The participants recognised that, for CPD to become sustainable in their workplace, they needed ongoing support. There was consensus and suggestions from participants specifying the continuation of education provided thus far, as well as follow-up from GHAWA:

It should continue and it should be a sustainable program. (S2, FG6)

I think make follow-up by GHAWA and between us. You have to continue and continue. (S2, FG3)

We will try to make a work plan so that we can use that to go on amongst all of us, with other colleagues, to continue teaching, with a bit of follow-up from GHAWA. (S2, FG1)

For me, I see not to remove, but to increase, so that we improve and support. Support for those people who do not know, but need to understand the course. So there is a need for the education, and to support the person. (S2, FG6)

I think to have a sustainable program is there will be continual supervision. So let’s say for every two months or three months, you can supervise from one ward to the next, or one department to the next. Conduct a session about the mother and child care. This will help to sustain the program. (S2, FG6)

In addition, one participant suggested that having dedicated mentors to facilitate the provision of ongoing CPD could help sustain the delivery of CE:

Another one maybe GHAWA and the hospital management should select two or three peer group educator or a mentor, who will be known and given responsibility to conduct that. (S2, FG6)
The findings demonstrated that the TNMs wanted CPD and understood its significance. In response to the existing barriers, a pragmatic approach to staff development, such as the suggestions above, is a starting point to facilitate the sustainability of CPD in Tanzania.

4.4.3 Summary of Phase Two/Stage Two

In summary, the second and final stage of the focus group interviews was conducted in Dar es Salaam, Tanzanian, with 33 NMs at seven organisations. Through using thematic analysis to explore the effectiveness and sustainability of CPD for these NMs, the key barriers and enablers of CPD were identified. The outcomes of the CPD showed that, while the participants faced numerous challenges within their workplace, they were motivated by the CPD and empowered to make changes in both their work environment and clinical practice. As a result, these TNMs expressed that there had been a decrease in maternal and neonatal mortality within their relevant organisations. For CE to be sustainable, ongoing support for CPD and dedicated mentors to continue providing education were significant points identified. This was an important finding from this stage of the study.

4.5 Summary

This chapter has presented the findings from the two phases conducted in this study—the quantitative and qualitative phases. Phase two was divided into two stages, where focus group interviews were undertaken with NMs in WA and Tanzania.

During phase one, a review of the GHAWA program for the year 2013 identified data and information about the education delivered. The findings enabled the researcher to plan for the next phase of this study.

Phase two involved gaining qualitative data about the effectiveness and sustainability of CPD from the perspective of the NMs from WA and Tanzania who participated in the program with GHAWA. To progress the focus group interviews with relevant participants, this phase was separated into two stages. The first stage was conducted in WA, while the second stage was conducted in Tanzania.
A rich collection of data revealed information that was consistent throughout phase two. The findings described the two cohorts’ opinions of CPD in Tanzania. The data highlighted similar themes regarding the perceived barriers identified by the WA cohort, the real barriers experienced by the Tanzanian cohort, the enablers and outcomes of CPD, and how CE can be sustained into the future. Chapter 5 presents a comparison of these findings, including how they compare with the existing literature and relevant theory.